Home Office

Detention Services Order 04/2020

Mental vulnerability and immigration detention: non-clinical guidance

July 2023

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Document details

Process: To provide staff with the guidance necessary to ensure that appropriate support is offered to: those who lack decision making capacity, those with disability arising from mental impairment and those who have a mental health condition; and that, for those with a disability, adjustments are made to support the individual whilst in immigration detention.

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Contains Mandatory Instructions

For Action: All Home Office staff and suppliers operating in immigration removal centres (IRCs), Gatwick pre-departure accommodation (PDA) and residential short-term holding facilities (RSTHFs); the Detainee Escorting Population Management Unit (DEPMU) staff; escort supplier staff; and Home Office caseworkers

Author and Unit: Jumoke Erin-Oluwa, Returns, Enforcement and Detention (RED) Policy team

Owner: Bethany Farr, Adults at Risk Policy in Immigration Detention Lead, RED Policy team

Contact Point: Bethany Farr, Adults at Risk in Immigration Detention Policy Lead, RED Policy team

Processes Affected: This DSO sets out instructions to ensure that all staff working in the detention environment refer to healthcare services those individuals who may have a disability arising from mental impairment or may have a mental health condition, and that they and healthcare take all necessary steps to support these individuals and any individuals who may lack capacity.

Instruction

Introduction and purpose

1. The **purpose** of this Detention Services Order (DSO) is to provide non-clinical staff in immigration removal centres (IRCs), pre-departure accommodation (PDA) and residential short-term holding facilities (RSTHFs) with instructions on how to identify individuals who may:

    - lack capacity (see paragraph 14 below);
    - have a disability arising from mental impairment;
    - have a mental health condition.

    This is with a view to referring them, where appropriate, for assessment and setting up a process to ensure that appropriate support and, for those with a disability, reasonable adjustments are in place. This guidance is not intended to replace a clinical or professional mental health assessment.

2. For the purpose of this guidance, “centre” refers to IRCs, RSTHFs and the Gatwick Pre-Departure Accommodation.

3. Two separate Home Office teams operate in IRCs:
    - Detention and Escorting Services Compliance team (Compliance team);
    - Immigration Enforcement Detention Engagement team (DET).

4. The **Compliance teams** are responsible for all on-site commercial and contract monitoring work. The **DETs** interact with detained individuals face-to-face within the IRCs, on behalf of caseworkers. They focus on communicating and engaging with people detained in IRCs, helping them to understand their cases and detention.

5. There are no DETs at RSTHFs or the Gatwick PDA. In RSTHFs, functions which would be the responsibility of the DET in an IRC are carried out by the Service Provider and are overseen by the Escort Contract Monitoring Team. In the Gatwick PDA the role of DET is covered by the local Compliance Team.

Legislative and policy framework

6. This guidance should be considered alongside guidance on the **Management of adults at risk in immigration detention, DSO 8/2016**. The adults at risk policy sets out a process for making decisions on the appropriateness of the detention of vulnerable individuals.

7. This guidance should also be read alongside the Equality Act 2010, the UK Mental Capacity legislation (namely, the Mental Capacity Act 2005 (for England and Wales),

the Adults with Incapacity (Scotland) Act 2000 and the Mental Capacity Act (Northern Ireland) 2016) and also the Mental Capacity Act Code of Practice, which provides guidance to anyone who is working with adults who may lack the capacity to make particular decisions.

To whom is this DSO relevant?

8. This DSO relates to the appropriate care and management in immigration detention of people who lack decision making capacity; who have a mental health condition, or who are disabled under the Equality Act 2010 definition by reason of a mental impairment. The Equality Act 2010 states that a disability is a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities. The Equality Act 2010 places a duty on public bodies which, in summary, requires them to make reasonable adjustments for such individuals so that they are not disadvantaged. This could relate to one or more of the following types of impairment: a learning disability, cognitive disorder, or mental health condition.

9. A **learning disability** affects the ways in which an individual understands information and communicates. An individual with a learning disability can have difficulty understanding new or complex information, learning new skills and coping independently. Such a disability affects a person for the rest of their life but most people with mild disability can live independently. However, regardless of the degree of severity, all individuals will need support.

10. **Cognitive disorders** are a category of disorders that mainly affect memory, problem solving, learning and perception (e.g. Alzheimer's disease).

11. There are many different types of **conditions affecting mental health and/or function** which can, depending on their severity, impact and duration, constitute a disability, including:

    - dementia;
    - depression;
    - bipolar disorder;
    - obsessive compulsive disorder;
    - schizophrenia;
    - personality disorder;
    - post-traumatic disorder;
    - generalised anxiety disorder;
    - autism spectrum disorder.

12. The following signs may indicate that an individual has a **mental health condition,** or that their **mental health may be deteriorating**:

    - self harm or suicidal thoughts;
    - a change in behaviour, becoming agitated, being low in mood, being quiet, being boisterous, becoming tearful, being angry;
    - becoming disorientated or having confused thinking;
    - feelings of extreme highs and lows or excessive fears, worries and anxieties;
    - strange thoughts (delusions), flashbacks and nightmares;
    - seeing or hearing things that aren't there (hallucinations);
    - changes in sleeping or eating habits (other than cultural needs) e.g. refusing food and/or fluids, binge eating, excessive exercise;
    - poor hygiene;
    - growing inability to cope with daily problems and activities;
    - social withdrawal.

    This list is not exhaustive.

13. If someone possesses **mental capacity**, they can make decisions for themselves. This includes the ability to make a decision that affects daily life as well as significant decisions, including those that may have legal consequences.

14. The principles of the UK Mental Capacity legislation apply to all persons, including those in immigration detention. These include the principle that individuals **should be assumed to possess capacity** unless it is established otherwise on the balance of probabilities. Simply because an individual makes a decision (or decisions) that appear unwise, this does not necessarily mean that they lack the capacity to make that decision. Decision making capacity can fluctuate and varies according to cognitive function at the time at which the decision is being made, and the level of the decision to be made.

15. Someone who **lacks capacity** cannot do one or more of the following four things in relation to a decision:

    - understand information given to them;
    - retain that information long enough to be able to make the decision;
    - weigh up the information available to make the decision and likely consequences of making – or not making – the decision;
    - communicate their decision.

    If an individual is unable to do one or more of these things in relation to a particular task or question, then their capacity to make a particular decision in relationship to that same task **may** be in doubt.

16. An individual may lack capacity to make a decision for a broad range of reasons. The following are examples of potential causes of mental incapacity:

    - a stroke, head or brain injury;
    - a mental health condition or symptom such as delusional belief;
    - dementia or other neurological condition;
    - a learning disability;
    - confusion, drowsiness or unconsciousness because of an illness or because of treatment for that illness; or substance or alcohol misuse.

17. Evidence of a mental health condition does not necessarily mean that an individual has a mental impairment or lacks decision-making capacity. A lack of capacity is not a medical condition. An individual's mental capacity relates to their ability to make a particular decision or take a particular action at the time at which the decision or action needs to be taken. This means that a person can lack capacity to make a particular decision but retain capacity to make other decisions. Equally a person can lack capacity for a time but subsequently regain capacity.

18. The types of decision for which a person may lack capacity range from day-to-day decisions about things such as what to wear or eat, through to more serious decisions such as choosing accommodation, deciding whether or not to have an operation, disposing of money and property, or, in the immigration context, challenging an immigration decision.

Process to follow when there are concerns that an individual may lack capacity, have a mental health condition, or disability arising from mental impairment

19. When interacting with individuals, from induction and throughout their time in detention, if staff become aware of indicators of disability arising from mental impairment; of a mental health condition; or that an individual may lack capacity; or if DET staff detect such indicators from information provided by the caseworker, the following actions must be taken:

    I. The individual's case must be brought to the attention of the **IRC supplier Duty Manager and vulnerability lead (on-site supplier manager in STHFs)** and then (in cases in which there are indicators of disability arising from mental impairment or of a mental health condition), to Healthcare, with the request that Healthcare carry out an initial assessment.

    II. Additionally, the individual's case must be brought to the attention of the IRC supplier Duty Manager and vulnerability lead (on-site supplier manager in STHFs) if there are concerns about an individual's decision making ability relating to immigration issues and processes, or if there are concerns that the

individual is at risk of abuse from others (including institutional, physical or financial) or is vulnerable to harm in any way.

III. The person who initially flags any concerns outlined above (or has identified a wider mental capacity issue relating to immigration issues) must, within 24 hours, complete an **IS91RA Part C form**. The Part C should be sent to DEPMU and, in IRCs, to the DET, who should forward it to case owners. DEPMU should forward to case owners any Part C that originates from a STHF. It should be copied to Healthcare, for information, and, in IRCs, the Home Office Compliance team. Upon receipt of the IS91RA Part C, the case owner must complete a Detention and Case Progression Review authorised at the appropriate level and open an 'Adult at Risk' (AAR) level 1 flag on ATLAS (level 2 in cases in which the individual may lack capacity).

IV. Healthcare referrals and assessments will take place as described in the service specification. Ahead of transfer, Healthcare in STHFs must flag to Healthcare in the receiving IRC that there is the need for an assessment.

V. If Healthcare believes that further support is required, or that the individual is a vulnerable adult, Healthcare must inform the DET, who must liaise with case owners, copying the Detained Vulnerability Assurance and Advice Team (DVAAT) inbox into that notification. The outcome of the assessment must be recorded and urgently disseminated to the DET and onwards to the responsible caseworker, copied to DVAAT for record keeping purposes.

VI. If the assessment confirms any concerns or highlights other vulnerabilities, the case owner must complete a Detention and Case Progression Review under the AAR policy, which must be authorised at the appropriate level, in the light of any new information that has emerged and note the outcome of that review on ATLAS. In cases where the individual does not consent to any appointment, staff should take all reasonable steps to encourage attendance. If the individual continues to refuse, Healthcare should make an assessment of the individual's capacity and on-going needs, based on their observations and any other available information.

20. It is important to obtain the individual's consent for sharing medical information in any of the circumstances set out above, in particular the findings of a mental health assessment. Any sharing of information, with or without consent, must adhere to the Data Protection Act 2018 and the General Data Protection Regulation and be relevant, proportionate and for a specific purpose. The purpose of sharing information is to enable IRC staff to properly support the individual and to inform caseworkers of all relevant information when considering on-going detention.

21. **Staff should take all reasonable steps to support the individual to enable them to understand, communicate and make their own decisions, including any**

steps specified in the care plan. This may include paraphrasing, using simple language to explain documents, options and consequences of decisions, and using interpretation services if the person is not fluent in English. Staff should consider the situation in which the engagement with the individual is taking place, for example whether there is background noise or other distractions and whether the individual has just taken medication or may be hungry and so unable to concentrate. The time of day may be relevant as some people are more alert or engaged at different times in the day.

22. In cases in which the individual may lack capacity in respect of a particular decision, the member of staff who has identified the possible lack of capacity should take any necessary steps to ensure that the individual has access to legal representation and that any necessary reasonable adjustments are made to accommodate this or to facilitate any daily living issues experienced by the individuals. Where appropriate, this consideration should be carried out with the support of healthcare and other members of staff.

23. **DET staff must take all reasonable steps to ensure that the individual understands all papers that they serve, through personal engagement.** They must signpost the individual to the provision of legal representation. Anyone who does not speak English as their first language must be offered the use of interpretation services.

24. If there is a decision to maintain detention, IRC supplier staff, with support from Healthcare, must initiate and complete a **Vulnerable Adult Care Plan** (VACP) (DSO 08/2016 – Management of Adults at Risk refers).Care should be taken to ensure that the most recent and correct documentation is used. The plan should record the vulnerabilities identified and set out what additional support is needed to enable the individual to carry out day to day activities and to access any part of the IRC regime and services, including any reasonable adjustments where the individual has a disability.

25. The plan must be in place within 24 hours to ensure that the wellbeing of the individual is safeguarded. IRC supplier staff must provide the individual with a copy of the care plan. A summary of the support offered and, where the individual has a disability, any adjustments made or recommended, should also go to DETs for onward transmission to the responsible caseworker(s). A Personal Emergency Evacuation Plan (PEEP) should be put in place by IRC supplier staff, if required. Taking into account rostering, the plans should note the name(s) of the supplier Detainee Custody Officer(s) responsible for overseeing the individual's day to day care.

26. The supplier, in conjunction with Healthcare and, where necessary, the case owner and the Compliance team, must **review the care plan** weekly as a minimum, and when a significant change in the individual's condition is identified. Each review must

be clearly documented, including the date of the review, details of those who attended the review meeting, and a summary of the discussion. If a review leads to a collective decision that a care plan is no longer needed, the plan should be formally closed but records retained and reopened if circumstances further change.

27. If an individual is **transferred to another IRC**, having confirmed with Healthcare that the individual is fit to travel, supplier staff must send a copy of the existing care plan to the receiving centre in advance of transfer, for reference and to inform the development of a new care plan on arrival. Escorting staff must also have a copy for reference during transfer.

28. The local Compliance team must ensure that care plans are completed appropriately.

29. **The individual must be placed on the list of individuals whose cases are discussed at the weekly complex healthcare / AAR cases meeting in the IRC.**

30. **If an individual is removed from association or placed in temporary confinement (Rule 40 / 42; Rule 35 / 37 for RSTHF)** please refer to DSO 2/2017 for detail about the process to be followed.

31. For the process to follow when an individual is to be **released or removed**, please refer to DSO 8/2016, management of adults at risk within immigration detention.

32. It is essential that detailed **records** are maintained, both locally in the IRC and on Atlas. Alongside usual case working records, this would include a copy of the Part C, and notes to confirm when Healthcare and psychiatric assessments take place. Service of papers and other engagements by the DET team should be detailed on ATLAS, along with a note of steps taken to ensure comprehension.

33. Each IRC must keep records of the numbers of people referred for an assessment of capacity, along with the outcome of that assessment. As noted in paragraph 19.V, DET staff must inform DVAAT of all cases that are referred for assessment and updated as to the outcome using the Mental Vulnerability Log. This log should be emailed to the DVAAT Inbox each time any additional information becomes available including removal, release, referral for assessment or transfer under the Mental Health Act 1983 (MHA). DVAAT will maintain a record of all cases where concerns are raised.

34. **All onsite Home Office and Contractor IRC staff should receive training on identifying, support and management of individuals in detention who have mental health conditions, including mental incapacity.** This training will, where appropriate, be linked to the wider vulnerability and safeguarding training.

Revision History

Review date	Reviewed by	Review outcome	Next review
July 2020	Jumoke Erin-Oluwa	General reformat.	July 2022
July 2023	T Amisu	Minor update to adults at risk guidance.	July 2025