Home Office

Home Office Response to:
Tavistock Institute's Review of Mental Health Issues in Immigration Removal Centres

February 2015

The following table sets out the recommendations made by the Tavistock Institute in the report of their review of mental health issues in immigration removal centres. The Government response is set out alongside each recommendation.

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No.	RECOMMENDATION	RESPONSE
1	Appropriate levels of training in mental health awareness and treatment should be extended to all staff who have contact with, or make decisions in relation to, people who are detained.	We accept this recommendation in part and will consider how best to meet it. Training needs will differ significantly between the various groups of staff concerned depending on the nature of their interactions with and responsibilities for detainees. Detainee Custody Officers (DCOs) already receive training in this area and we will explore how it might be enhanced. We will also scope a training package for Immigration Enforcement staff working in Immigration Removal Centres (IRCs). There are many more decision makers with a wide range of responsibilities. As such, we will need to consider how this recommendation might be achieved for them.
2	The provision of more staff qualified in assessing the individual's previous mental health condition and history, e.g. Registered Mental Nurses (RMN).	We accept this recommendation. As part of the transfer of IRC healthcare commissioning to NHS England, a Health and Wellbeing Needs Analysis (HWNA) was carried out across the detention estate. Mental health was identified as one of the key issues. The results of the HWNA have been incorporated into NHS England's "Strategy and Five Year Action Plan for Healthcare Delivery in IRCs" and, as such, will be used to inform decisions on the future commissioning of health services in IRCs, including staffing levels and competencies.
3	As far as is possible, multi-disciplinary teams should be established in the IRCs. The ideal membership of the multi-disciplinary teams would consist of custody staff, social workers (if possible), counsellors, psychologists, caseworkers and faith leaders.	We accept this recommendation. We are keen to improve safeguarding arrangements in IRCs, building on the existing arrangements centred on the Assessment Care in Detention and Teamwork (ACDT) system, which includes the use of multi-disciplinary panels to monitor and review vulnerable or 'at risk' detainees. We are developing proposals for a new

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		Detention Services Order (DSO) on safeguarding.
4	There should be a pilot project in an identified IRC to embed a new task culture that integrates the task of detention and return with care and welfare to drive improvements in the identification of mental health and its management.	We accept this recommendation and agree that this proposal is worth exploring, subject to practical and resource constraints. We will seek to identify an appropriate IRC in which to run a pilot.
5	Detention custody staff need more sophisticated working relationships with healthcare staff to prevent flaws with medication, delayed care, etc. All staff should be better acquainted through training with the diversity of the detainees, i.e. the wide variety of cultures, faiths, disadvantaged backgrounds; the effects of loss and bereavement on a person's mental health. The work of detention custody staff and healthcare staff in IRCs can be improved through the following practical operational changes: a) understanding the difficult arena and the complicated task of the application of immigration legislation and the complexity of the unique population; b) a commitment to working with the emotional well-being of detainees to promote their mental health; c) establishing a more effective administrative and communications process between custody staff and healthcare staff; d) there is a need to improve the screening for mental	a) Accept. DCO training should already cover this but we will review the relevant part of the DCO training course to see whether additional training is required. b) Accept. There is already a commitment to this but, as part of the work to develop the new DSO on safeguarding, we will reinforce this commitment. c) Accept. As part of the transfer of IRC healthcare commissioning to NHS England, Healthcare Partnership Boards are being established in all IRCs. These will meet monthly and have representatives from the IRC operator, IRC healthcare, Home Office Immigration Enforcement and NHS England. These Boards will build stronger relationships between staff in these areas. d) Accept. NHS England has recommended that IRC healthcare commissioners adopt a standard health assessment tool for detainees on reception, which should help to address this concern. e) Accept in part. While we are committed, if possible, to

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	health problems at reception. If IRCs do not carry out the same level of assessment as prisons, especially with respect to risk of self-harm, this could impact on the mental health of detainees; e) if health screening at reception is carried out at night time, and often after a lengthy journey, detainees' answers may well not reflect the true state of their health; f) if the majority of screenings are done by languageline or with no interpreter, it may lead to inaccurate assessments of detainees' mental health; g) attention needs to be paid to the possible insufficient RMN assessments and referral to psychiatric units; h) it was reported that monitoring information for patients on ACDT is done on the wing by detention custody staff who are not clinically trained. Their notes are not in the healthcare system, so when doctors assess patients who are being monitored for self-harm risk in the healthcare centre, healthcare staff there do not know what information is held on the ACDT system. Consequently, it may be difficult to find out this information and integrate the systems; i) it is reported that the 'culture of disbelief' is pervasive in IRCs and affects how staff assess health complaints and especially self-harm, which can be	keeping night moves of detainees to a minimum in order to avoid this, we have to recognise that there will be a continuing need for late arrivals at IRCs due to practicalities and operational requirements. However, we will explore whether late arrivals, or those who have had very long journeys, should be followed up after the initial health screening. f) Accept in part. Although interpreters being physically present may be the ideal position, this is not practicable for the vast majority of health screenings and a telephone-based interpreting service has to be used instead. g) Accept. NHS England has recommended that IRC healthcare commissioners ensure that staffing levels include a minimum number of RMNs; include in their service specifications local area arrangements for access to specialist psychiatric services; and ensure that detainees have access to trained counsellors, including provision that is culturally sensitive and/or delivered in the detainees' own languages. NHS England will also ensure that there are appropriate processes in place to support effective and timely transfer to secure hospitals where required. h) Accept. The ACDT system, which relies in large part on non-clinically trained custody staff to monitor detainees in their care, already requires a multi-disciplinary approach to monitoring and review, including by healthcare staff. Although the ACDT system requires information sharing

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	viewed by some staff as attention-seeking behaviour; j) the problem of compromised dual obligation of healthcare staff who are employed by an outsourced agency may impact of the standards of their assessment. Standards should be benchmarked against the equivalent NHS and/or prisons services.	across all disciplines within the IRC, including healthcare, there is no specific requirement in the relevant DSO for information gathered under an ACDT plan to be recorded in the individual detainee's healthcare records. We will close this gap. i) Accept in part. Although we do not necessarily accept that a 'culture of disbelief' in relation to self-harm is pervasive in IRCs, the undertaking to improve training (see the responses to recommendations 1 and 5(a) above) should address this reported concern. j) Accept. Any concerns on this issue should be addressed by the transfer of healthcare commissioning to NHS England, who will benchmark standards against the NHS outcome framework. It is already the case in NOMS-run IRCs.
6	The [immigration] system needs to be simplified to reduce the volume of transactions and the inevitable misunderstandings and delays that take place with the current structure. Looking at the various sub-system relationships in operation and how to reduce the multiple hand-offs between different parts of the business may be the best way to address these issues.	We accept this recommendation. The immigration system is necessarily complex but, through the Immigration Act 2014, we have replaced numerous different decisions which an illegal migrant will receive with a single removal decision, which will make it much clearer for them when and whether they are liable to removal. We are also requiring all reasons, such as human rights or asylum claims, which would give the migrant a right to stay in the UK to be brought forward at the earliest possible opportunity. These changes will both speed up the system and remove a great deal of the uncertainty which can lead to mental health issues. We will continue to look at legislative and process improvements which can be

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		made to the system to speed up decision making further.
7	Psychiatric advice should be available to the [Mentally Disordered Offenders] team in order to provide a stronger basis for decision-making. The criminal cases case-workers need more training in mental health. Size of caseload for staff – i.e. average number of cases per case owner – should be reviewed as, often, one or two complex cases can dominate a caseworker's caseload. This may lead to lack of oversight of other problematic cases. This may well apply to the National Removals Command, Third Country Unit, Returns Casework, Enforcement, Judicial Review and Litigation Team.	We accept this recommendation in part. Given the way in which cases progress through even a simplified system under the new Act, with migrants given time to, for example, seek an administrative review of a decision, a case worker will always be handling multiple cases at any one time. We will, however, explore how the recommendation relating to the provision of psychiatric advice for caseworkers might be achieved.
8	In order to improve caseworker understanding of mental health issues and their impact on people in detention, we recommend a review is conducted of the structures and working relationships between sub-systems within the IRCs; between IRCs and other Home Office departments; between Home Office departments and other external institutions, organisations, companies and agencies; and between the IRCs themselves which have different ethos, arrangements and treatment approaches to mental health problems.	We accept this recommendation. Immigration Enforcement is conducting a review of detained casework co-ordination across all Home Office business areas that have a role in this casework. The review is considering mechanisms for information sharing (including healthcare information) between IRCs, caseowners and Detention Operations (specifically the Detainee Escorting & Population Management Unit). It is assessing whether existing processes result in the timely sharing of appropriate, complete and accurate information to ensure detention and removal operations are better informed, especially in respect of more vulnerable individuals. The review will identify and recommend practical improvements to support the delivery of effective and consistent systems of sharing relevant information. It is anticipated that the review will address some of the issues identified in this recommendation. Findings are

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		due in January 2015. We will assess any further requirements once those findings have been produced.
9	We recommend shortening the literal and structural disconnection from the healthcare workers in the IRCs with their casework colleagues, plus having more direct contact with other agencies to mitigate the impact on detainees' mental health when flights are cancelled, vehicles delayed, etc.	We accept this recommendation. As in the response to recommendation 8, the detained casework co-ordination review will consider aspects of the disconnect and make practical recommendations accordingly.
10	Boundary transactions are again problematic and need attention. As said previously, the number of transactions across a boundary increase the probability that key decision points are open to failure. This will lead to poor decision-making on the management of individual detainees and their mental health. To address this problem, a review of the sub-system structure should focus on key decision points and the location of the decision-making to reduce the numbers of staff involved in any one decision.	We accept this recommendation. As in the response to recommendations 8 and 9, the detained casework co-ordination review will consider aspects of the disconnect, which includes boundary transactions, and make practical recommendations accordingly.
11	Mechanisms need to be established for improving the working relationship with external stakeholders in order to make use of experiences, suggestions and actions that will promote the mental welfare of detainees.	We accept this recommendation. Quarterly meetings between the Home Office and a wide range of NGOs have been re-established.