

# Mental health services inside immigration removal centres.

*(Access, perceived quality of health care and the  
ACDT process in IRC Morton Hall.)*

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April 2017

## **Executive summary**

Drawing on targeted, exploratory interviews with a small number of staff and detainees conducted in February 2017, this report sets out a series of common practices and issues relating to services access and quality of mental health service provision, including ACDT plans in Morton Hall IRC. While many of the findings are negative, including high levels of distress among detainees, and uncertainty among staff of how to manage mental health problems among the detained community, the report also identifies some areas of good practice and support. It offers suggestions for improved sign-posting to available services, while identifying additional areas of possible development.

## **Distress, isolation, support and signposting**

Detainees in Morton Hall reported high levels of distress and isolation. Many kept themselves to themselves, to avoid being affected by the negative emotions of others. On the other hand, some detainees were positive about the services they received in Morton Hall. They singled out ease of access and quality of services. Among the services that some detainees reported as regularly used were relaxation classes, psychologists, and mental health team. Other activities like gym and religious services were also reported as very helpful in terms of coping with detention.

Knowledge of mental health services appeared to be limited. Although some detainees could access existing services and reported positive experiences of having done so, others were unwilling to admit to mental health concerns due to concerns it might have negative consequences for them and their immigration cases. Other barriers to accessing mental health services included language, lack of repeated formal assessments, trust, and volume and fluidity of the population. Detainees were worried about how seeking help might be perceived by other detainees and staff.

Centre staff had a key role in signposting detainees to mental health services. However, staff expressed concerns that they did not have the adequate training to make confident decisions in terms of mental health issues. While staff were familiar with ACDT plans and procedures, most were not confident in the professional capacities of non-mental health staff to conduct complex assessments. Some staff mentioned concerns with safety and understaffing as barriers to carrying out ACDT procedures or otherwise responding to emergencies effectively.

A positive contributor to accessing help was the positive relationship between staff and detainees. Staff were committed and caring, but also reported high levels of distress, pressure due to the understaffing and concerns with safety. Staff were supportive of each other, but to deal with their distress they required more formal and substantive support.

## Recommendations for Morton Hall

### **System and auditing**

Some of the concerns raised in this report could be addressed within a system with a clear structure and auditing process. This could include:

- Regular assessment of detainees' ability to cope with detention, mental health and self-harm. This should be repeated over time to account for the changing needs of long-term detainees. Regular reassessment can also identify issues missed in the first assessment upon arrival.
- Non-English speakers struggle to understand available services. Regular assessments with professional translators would facilitate communication. Interpretation is particularly important for identifying mental health concerns. Accurate and sensitive discussion of mental health issues requires a higher threshold than everyday communication skills.
- Use of referral forms for those who want to self-refer to mental health services could be beneficial. If such forms do exist they should be more clearly signposted so both staff and detainees are familiar with them.
- Provision/transfer to specialised facilities for the seriously mentally ill. This would address their needs as well as avoid distress and safety concerns for other detainees and staff.
- Addressing the concerns that staff have in relation to safety and staffing would reduce their stress and impact positively in their ability to deal with the psychological impact of the job. Staff who deal with particularly stressful situations should be offered independent psychological support as well as opportunity to take time off. Where support was available this was perceived as very beneficial for staff.
- Integrating health services with practical support towards a holistic approach would be more beneficial. There were reports of this being the current model of care provision but it was not clear how it took place in practice and detainees and staff provided different views on efficacy of the provision so far.
- Encourage better communication among staff and between staff and detainees to make sure problems are identified and mental health issues discussed especially in terms of self-harm/suicide. There is already evidence that some staff could do this effectively within their existing roles.
- The delivery of medication for those with mental health problems or currently on ACDT plan could be regulated further to ensure consistent timing. This is beneficial and reduces the distress of the detainees themselves but also facilitates the work of the units and care staff.
- To address the loneliness and isolation reported by detainees, activities that encourage interaction with other detainees and staff, or activities that facilitate access and maintenance of outside relationships, would be beneficial.

## Training

Training could bring benefits in several areas but it does need to be informed by a systematic analysis of detainees' needs, models of care and training needs. As such training could contribute towards:

- Creating an atmosphere where detainees are encouraged to express their mental health struggles. There is evidence that this is taking place already so lessons could be learned from such positive examples.
- Regular ACDT training is required with two aims: refreshment of new evidence and policies, providing a forum for staff to discuss their concerns and ways of dealing with ACDT affects them. Although some of the experienced ACDT staff did not consider regular refreshers as essential, there are aspects of ACDT training that would be useful both to introduce new evidence and for allowing staff a forum to discuss issues that relate to centre specific problems at the time.
- Provision of Mental Health training for DCOs would be beneficial especially considering their central role of liaisons and signposting between detainees and mental health staff. This could be useful when looking for issues that raise concern, understanding the psychological impact of detention on themselves and detainees, and ways to engage in sensitive conversations. Although care should be taken to not extend the roles of DCOs into healthcare workers, basic training would enable staff to be more confident in their decisions and avoid where possible causing harm.
- The role of staff care team could be more efficient if the team receives further training and spaces are created for more formal and regular meetings where issues about potential staff stressors are identified and discussed.
- Given the amount of distress reported by staff it is important to support staff to improve their wellbeing, which would enable building a more capable and healthy workforce. Unless staff feel they can manage their own distress and are competent in dealing with the needs of detainees they will not benefit simply from additional knowledge. Training staff on monitoring and addressing their own needs would impact positively on their work and meeting the needs of detainees.

## Recommendations for IRCs in general

### Research

The following recommendations are based on the research conducted for this report in Morton Hall, research conducted in Yarl's Wood during June 2016 (Kellezi & Bosworth, 2016) exploring similar issues, and the wider research programme conducted by the authors inside IRCs since 2009. In addition to issues with accessing health services, our research programme has identified the presence of a range of complex, diverse needs and symptoms in detainees. Whilst our research has systematically measured depression, self-harm and suicide (e.g. Kellezi, Bosworth, Slade, 2017), it has also identified additional symptoms in detainees including; changes in behaviour, unusual beliefs, hallucinations, developmental disabilities, and even indications of traumatic reactions.

- Further research is required to map the mental health symptoms most frequently present in detainees across IRCs. A needs analysis would inform model of health care and the training needs for centre staff.
- Once the systematic mapping of symptoms has taken place, research is needed also to understand the models of mental health care provision to such a diverse population and symptoms. This systematic analysis and evaluation would be able to identify existing good practices within IRCs which could be a useful model for the other centres.
- Understanding of the models of care would require a systematic analysis of the training needs of staff.

## Introduction

The negative psychological impact of detention is well documented (Bosworth & Kellezi, 2012: 2015; Gerlach & Bosworth, 2016; Shaw, 2016, especially Appendix 5). Research conducted by the authors with 377 male and female detainees in Yarl's Wood, Brook House, Tinsley House, Campsfield and Dover IRCs has identified high levels of depression (81% met the case threshold), suicidal thoughts (20%) and self-harm in detention (10%) (Kellezi, Bosworth, & Slade, 2017). A number of factors have been shown to predict mental health outcome including concerns with safety inside immigration removal centre, asylum applications and time spent in UK prior to detention (Kellezi, Bosworth, & Slade, 2017). Most of those who reported suicidal thoughts (70%) and self-harm inside detention (78%) had not been part of ACDT (Assessment, Care in Detention and Teamwork) plans in detention. The reasons for such gaps are not yet clearly understood. The authors conducted an interview study with women in 2016 in Yarl's Wood IRC (Kellezi & Bosworth, 2016) to identify reasons for such gaps in service access but such findings might not apply to male IRCs.

In addition, to date, there has been no systematic research on how immigration removal centres in the UK deal with the distress detainees face. In a bid to start filling these gaps, this report explores issues of identification, assessment and support offered for the mental health issues detainees face. It focuses on how staff and detainees understand and speak about mental health issues, help-seeking, access and signposting of support services and their experiences of care provided in Morton Hall, a male immigration removal centre run by HM Prison Service. It is based on in-depth interviews with a small group of detainees (n=15) and staff (n=15) conducted in February 2017. Some of the detainee participants in this research (n=3) were purposefully sampled to include individuals who had been or were on ACDT plans in Morton Hall. Their opinions did not substantially diverge from those who were not on, or had never been on, ACDT plans. Perspectives of mental health staff could not be systematically investigated in this study. The choice of participants was limited by availability at the time of the study. Detainees were identified by staff, and staff themselves were selected based on availability rather than random selection. Due to these method of participant selection, it is possible that the needs of some detainees and views of some of the staff are not represented in this report.

Issues highlighted in this report need to be understood in terms of the diverse needs of detainees and the ways they engage with health service provision. For this reason, rather than focus on issues unique to specific detainees, this report will instead discuss a set of communalities in the experiences of detainees and staff. The issues identified in this report related to the male detainees and were influenced by the recent deaths in this particular IRC. It is possible that detainees in other men's IRCs face different issues in relation to health services access. Some similar issues were identified in Yarl's Wood, a female immigration removal centre during research conducted in June 2016 (Kellezi & Bosworth, 2016). Differences have also been identified in how women and men cope with detention, their perceptions of safety and concerns with suicide. The differences between the two centres are not the focus of this report and will be addressed elsewhere.<sup>1</sup>

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<sup>1</sup> Several publications relating to these issues are currently in preparation. For more information contact the authors.

## **Mental health impact and ways of coping with detention**

All the detainee participants described an intense negative psychological impact of the experience of detention. Nearly all reported suffering from depression within Morton Hall. Some had also suffered and had been treated for depression before arrival.

Detainees struggled with the uncertainty about their futures, the monotony of daily life in the institution, feelings of helplessness, hopelessness, fears of losing their mental capacities, concerns about safety and fears of self-harm and suicide. Those who were afraid they might self-harm or try to take their own lives included detainees on ACDT plans as well as those who were not. Some of the men described ways in which the recent deaths in custody reminded them of their fragile mental states in that regard.

The negative impact of others' distress as well as generally low levels of trust led to a number of detainees reporting that they preferred solitude, not talking to others when distressed and being alone in their room. This tendency towards isolation has two potential negative consequences. Firstly, detainees who sequester themselves may lose the benefits of social support in terms of making sense and dealing with detention. Secondly, they are at a higher risk of not being identified by staff and as such not being referred to existing formal and informal support within the centre. Some of those who wanted to avoid being affected by the distress of other detainees had found some relief whilst working and attending activities like gym and education.

Both staff and detainees remarked upon the high levels of distress experienced by detainees. Both sides recognised the negative psychological impact of the experience of detention and uncertainty about the future. While some officers were very willing to acknowledge the mental health needs of detainees, few were confident the existing system was able to deal with the more severe cases.

## **Mental health services**

### **Service knowledge and access**

Some detainees were unable to list the existing mental health services available to them in Morton Hall, or the role of different mental health professionals. For example, one of the men who was waiting for an appointment with a health professional had to be assured a number of times by the researcher that the research interview was not the appointment they were waiting for. This same detainee, despite having a very good command of English, could not subsequently explain to the researcher what the appointment he was waiting for was about or with whom it was scheduled.

In addition to confusion about existing services, some of the detainees reported that they were reluctant to admit to their mental health problems, self-harm or suicidal thoughts. Detainees feared that help-seeking and expressing distress would harm their legal case, or be perceived as trouble making by staff, or that other detainees would react negatively and perceive them as mentally unstable. Some believed that asking for help would make them seem vulnerable and it

was perceived to be humiliating. A minority of detainees believed that expressing distress, even though self-harm, was the only way they could have their voices heard. Officers were more ambivalent about the expression of distress and self-harm. Some believed detainees acted manipulatively, in a bid to influence their immigration case. Such fears, whether grounded in reality or not, acted as a barrier to self-referral to mental health services. They also made it difficult for centre staff to identify specific individuals who needed signposting to the existing services. Some staff and detainees reported that these issues had been overcome in some instances through establishing positive relationships. However, the turnover of detainees and their numbers relative to officers, make such relationships difficult to forge. Other barriers, including language, are also hard to overcome.

The main pathway of referral to the mental health services included follow-up of issues identified at initial assessment upon arrival in the centre. Although reported efficient as a method, the initial assessment occurs at a time where many detainees are confused, disoriented and distressed, limiting its efficiency. No additional assessment were reported unless detainees were referred to and accepted by the mental health services.

While some detainees were reluctant to engage with the mental health services, others appeared to be more willing. However, some of those who desired assistance did not fully understand the roles of the different health professionals because of their limited knowledge of the UK mental health services and language issues. Mental health staff also identified language and appropriate cultural expressions and communication of mental health issues as some of the main barriers to engaging with mental health services.

ACDT and vulnerable adults' plans are the main methods of managing mental health vulnerabilities in detention. Yet, some detainees expressed some reluctance about the plans as they felt it was not sufficiently private or confidential. According to some detainees it becomes apparent easily when another man is on ACDT plan. There is a potential risk, they felt, of the plan to 'name and shame' specific individuals.

## **Service use**

Some detainees were positive about the services they received in Morton Hall. They singled out ease of access and quality of services. Among the services that some detainees reported as regularly used were relaxation classes, psychologists, mental health team. Other activities like gym and religious services were also reported as very helpful in terms of coping with detention. A number of detainees reported being upset and not having accessed any of the mental health services.

There was a discrepancy between the perceived abilities of mental health services to deal with the needs of detainees. Staff were more positive about the institution's abilities to deal with the number of detainees in need of help, whereas detainees more negative. Detainees who believed that the mental health services were overwhelmed reported that as a reason for not seeking help in the first place. Even those who were satisfied with mental health staff reported being turned away by the services on certain occasions due to the limited capacities of the services.

Most detainees were willing to accept medication with the exception of a few who were concerned about losing control over their capacities if they took medication for their mental health. Some complained about timing of receiving medication. One detainee reported not



receiving his mental health medication at a regular time and a few instances where he became agitated and felt that he needed to ask staff repeatedly to address the delay. Similarly, a staff member reported an incident where delays in mental health medication of someone who was on ACDT caused considerable distress to the individual and to the staff who had to support him.

A few detainees reported being denied medication by mental health staff. This was the case even for a detainee who had received the same medication outside detention. He explained that he would not challenge the mental health team decision on medication because he did not want to be perceived as trouble maker. Another man did not believe the medication provided was good enough or appropriate for him.

### **Detainee perspectives on Mental Health services in Morton Hall**

Some detainees were positive about quality of care inside immigration detention with a minority believing it is better than services in the community. Others reported that services were only reactive because of the large number of detainees with mental health problems. Mental health staff, they alleged, concentrated on serious issues like suicides or harm to self and threat of harm to others, leaving more common, but less serious problems, such as anxiety and depression untreated.

Whilst several detainees recognised the professional qualifications of the onsite mental staff, they generally mistrusted the health services. According to them, all the services could achieve was to 'prolong the agony' of the experience of detention. Part of the inefficiency of the mental health services, they claimed, arose from their location within the institution that is causing distress. Their distress, they felt, was too great to be addressed by talking therapy. The detainees suggested the importance of incorporating immigration case support within mental health services.

### **Mental health and ACDT procedures**

Staff believed the current procedures were good and that they understood how to apply them. The staff had received training on ACDT procedures but the refresher training had not always been provided at the required frequency. This was not an issue for some staff members because often they relied on their experience from long-term service, but it was an issue for others. There were some suggestions from those who were currently conducting ACDT assessments that mental health trained staff would be more suitable to make complex assessment and decisions on observations like they do in prisons. Most staff reported that they would find more in-depth training on ACDTs as beneficial.

In Morton Hall, one of the issues with implementing the ACDT procedures was concern about safety. For example, staff reported instances when, faced with an emergency, they hesitated, because they could not ensure safe procedures. This was directly related to the number of officers available in units at the time and the layout of Morton Hall, which is spread across a wide geographic area making it more difficult for staff to access quickly remote areas. Despite this, overall some staff were very confident in their skills of being able to negotiate and de-escalate potentially harmful situations.

One detainee who had experienced ACDT review meetings found that he could engage with the staff and discuss mental health concerns. He appreciated the formal structure of the process which allowed for more in-depth engagement.

On the other hand, centre staff did not feel competent in assessing and dealing with mental health issues. Many were worried that they did not know if they were causing any unintended harm or were missing important signs. Given that detainees suggested they would talk to members of staff on the wing (DCOs) if mental health staff were busy or unavailable about their mental health concerns, such gaps in officer knowledge could be problematic. Informal discussions with detainees are vital to identifying people in need of help and in assisting with signposting. Although it is not the role of DCOs to provide specialised health care, they are being approached by detainees about such issues and have to make decisions regarding referral.

Mental health provisions at weekends are currently limited which can impact on reviews of ACDT cases as the presence of a mental health professional is required.

Staff used interpreters to conduct assessments with non-English speakers. Whilst this was mostly perceived as beneficial, staff reported that at times quality of translation was not at an acceptable level.

## **The role of centre staff on service access and perceptions of quality of care.**

### **Relationships between detainees and staff**

A few detainees and most staff reported good relationships between the two groups in Morton Hall. They described positive and caring communications, respectful staff and assistance in dealing with distressing situations. For instance, a few detainees reported being able to find a staff member they could talk to and trust when they were upset.

Most of those who were positive about the relationships with staff, however, did not believe interaction with staff would bring positive outcomes in their mental health. They did not believe that staff had any practical means of supporting them or were trained to deal with mental health. They also worried they might be prejudiced about mental health, which discouraged interactions on such issues.

Indeed, some detainees were particularly concerned about the impact of such conversations on their case. They did not want staff to pass on information to other parties. For example, one detainee was very upset that the mental health worker had spoken to an officer about his mental health status in an incident where he had asked for help but was turned away. Concerns with confidentiality, impact on their case and stigmatization could have implications given that mental health services rely on centre staff to identify those in need of help or follow-up.

DCOs relied on good relations with detainees to identify potential mental health issues because of language barriers, high number of detainees in units and turnover of population. Some staff reported they could only really get to know the long-term residents.

The recent deaths in custody shaped people's perceptions of staff-detainee relationships. Thus, while some detainees recognised that staff had been psychologically affected by the deaths, others believed staff only reacted to them from an administrative perspective.

### **Negative psychological impact of working inside immigration detention**

Staff reported high levels of stress. A number described the impact of responding to serious self-harm or other stressful situations. They expressed concerns about a general lack of support following these incidents. There were reports of beneficial interviews following distressing incidents but they would have preferred to have additional support or counselling in the aftermath and opportunity to take some time off. The care team is a potential source of additional support, but staff were not confident the team was specialised (with up to date training) or positioned to provide the support required.

In addition to psychological distress, staff reported concerns about the responses to serious self-harm. Low staffing levels, they claimed, made it difficult to respond rapidly and raised potential safety issues. Similarly, some officers reported feeling unsafe especially at night due to low staff levels, aggressive behaviour of some detainees and the layout of Morton Hall. Issues of safety, they noted, contributed to their stress levels. Such matters were compounded by requests to cover additional shifts and the low levels of control they had over their time off. All of these matters they traced back to staff levels.

Staff were demoralised by the change in their role from prison to detainee officers. In their new role they felt unable to help detainees. They believed their roles had been reduced to keeping order whereas when working as prison officers they could help towards rehabilitation. Some staff had doubts about the purpose and usefulness of immigration detention which was a further source of distress. At the time of the study some of the staff could not see potential, positive ways for improving the current situation of their jobs.

Despite the above, most of the staff felt very committed to support detainees during the distresses of incarceration which is reflected in the positive view of staff from detainees.

### **Staff training**

Staff reported that training on recognising signs and dealing with mental illness would be useful. Most currently lack such training and reported not being confident to discuss such issues with detainees and decisions they regularly had to make. Staff reported they were often guided by their instincts or experiences prior to their work in IRCs when making decisions on how to interact and identify mental health issues because they had not received any formal training.

Staff involved as assessors as well as other officers complained that ACDT training occurred irregularly and infrequently. Nonetheless, they were confident and satisfied with the current procedures in place except the need for a health professional to conduct complex ACDT assessments.

## **Additional vulnerability factors**

### **The impact of the recent deaths in custody**

The recent deaths in custody were well-known and had been widely discussed among staff and detainees. Most detainees knew the men who had died, and some of the staff had responded to the incidents first hand. These deaths had distressed everyone.

Some of the detainees believed more strongly that the deaths were perceived by the Home Office as an administrative issue. Many feared that they themselves might take up the same actions given their heightened distress and potential loss of their mental ability to cope with detention. A number of staff expressed concerns about the decisions in relation to self-harm given the issues of language, mental illness, trust, volume and fluidity of the population.

### **The severely mentally ill**

Many of the detainees and staff were aware of other detainees with severe mental health problems currently residing in Morton Hall. They expressed concern for the wellbeing of these people and the capacity of the centre to deal with them. They were also concerned about potential harm to themselves.

Detainees and most staff believed Morton Hall did not have facilitates and capacities to deal with the severely mentally ill or those who have severe episodes of mental distress. In addition, staff did not feel they were trained to recognise and deal with such detainees, which had consequences for safety. Detainees believed that vulnerability of such individuals highlights weakness in the system since they are unable to comply with immigration request which would prolong their detention.

### **Drugs**

Both staff and detainees highlighted drug problems in the centre. This was an additional source of safety concern for most staff and some detainees. Detainees believed staff showed care towards those who became vulnerable and incapacitated because of the drug problems but staff expressed concerns towards vulnerabilities that drug use brought to detainees (e.g. getting in debt).

### **Language barriers**

Both staff and detainees recognised the challenges faced by non-English speakers. Some detainees had witnessed very positive attempts by staff to find ways of communicating with non-English speakers, but this relied on non-formal sources like other detainees or language line. Staff believed there were challenges to using both of these sources; ethical in the first one and loss of sensitivity in the second. Staff often relied on other detainees to help translate even when following up mental health concerns believing that detainees would be more willing to trust other detainees with such issues rather than an interpreter.

Those participants who had limited English language were not able to communicate clearly what services they were seeing, and the roles of the professionals. They reported that most of the communications would not happen in the presence of an interpreter.

### **Torture survivors**

Two of the detainee participants reported to have experienced torture in their countries of origin but neither could explain what support they were receiving. There was no mention of any trauma related interventions. Their English was limited and they reported that meetings with health professionals take place mostly in English.

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Keywords: depression, self-harm, suicidal thoughts, immigration detention, service access.



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