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Alison Harvey
General Secretary
Immigration Law Practitioners' Association

(via email – **Elizabeth.White@ilpa.org.uk**)

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Dear Alison

Thank you for your letter of 11 October, which you e-mailed to Dee Bourke, then Director of Central Operations and Performance. I am responding as Chapter 55 of the Enforcement Instructions and Guidance (EIG) comes under my responsibility. I am sorry for the delay in replying.

You are concerned that changes made to Chapter 55.10 of the EIG in August did not go out to consultation and that there was no advance notice of the changes. You seek answers to a number of questions. Taking them in turn, our response is as follows.

Reason for change/consultation

The earlier version of Chapter 55.10 failed to recognise that our immigration removal centres (IRCs) have the capacity to provide or arrange access to a wide range of healthcare services, including those relating to mental health issues, and general care provision. That they are capable of doing so has been the case for some considerable time; it is for this reason that we did not consider the matter to be a change in policy, rather it reflected a more explicit statement of our existing policy. It follows that we did not consider it necessary to consult on the issue and that it was not necessary to prepare an equality impact assessment. That remains our position; but on the basis that the original policy has never been subject of an EIA (as it preceded the introduction of the requirement to do so) we will undertake an EIA when we are in a position to do so.

It became clear that the earlier guidance in 55.10 was capable of being interpreted to mean that a person who, for example, had a serious medical condition or any mental illness would not be detained other than in very exceptional circumstances. This was not intended to be the case, nor has it been UK Border Agency policy. To give an example: a person who has been diagnosed as being HIV+ plainly has a serious medical condition. But it is also the case that the care and treatment required by that person is capable of being provided in detention: this is what is meant by "satisfactorily managed". As a consequence, the detention of such a person would not be exceptional, nor would it require exceptional circumstances to exist in order for detention to be

authorised. Conversely, if a person's medical condition was such that it could not, for whatever reason, be satisfactorily managed in detention then he or she would normally be regarded as unsuitable for detention unless there were exceptional circumstances arguing the contrary. The same principle would apply in the case of persons suffering from serious mental illness, have serious disabilities or those who, as a result of their advanced age, require constant or significant supervision. That has always been our position. However, the earlier guidance in 55.10 did not make it explicit. The revised guidance does so.

It is not accepted that the case of MC provides authority regarding the level of mental illness required to engage the policy; rather it considered the type of mental illness covered by the policy.

That we have widened the policy

You are concerned that the impact of the changes to 55.10 is to widen the Secretary of State's detention policy to the detriment of those categories of people the policy was designed to protect. We do not accept this. As already stated, the purpose of the amendments to 55.10 was to clarify the existing position. In reflecting that position, we consider that part of the changes made also requires UKBA officials to take into account whether the needs of individuals can be met within the detention estate. In doing so, the policy seeks to protect those whose needs cannot be met in the detention estate; as such the effect of the policy is narrowed. The clarification of the guidance in 55.10 will not lead to individuals being detained who would not have been detained under the earlier guidance.

What is meant by "satisfactorily managed"?

This is not defined, nor do we consider it necessary to do so. However, as stated above, the phrase is intended to cover the broad basis on which a person's healthcare, mental health or physical needs might need to be met if they were to be detained, with the expectation being that where these needs cannot be met the persons concerned would not normally be suitable for detention. We regard the term as making it implicit that the particular needs of the detainees concerned would have to be capable of being met within the detention setting, whether through the provision of on-site healthcare services or by access to community-based healthcare services, if they are to be considered suitable for detention. It may be the case that the individual concerned is not satisfied with his/her management but that is not to say that their needs are not capable of being met satisfactorily.

When considering whether detention is appropriate and whether a health related issue can be satisfactorily managed within detention (in those cases where detention is deemed an otherwise proportionate decision) particular note will be made of the treatment required for the management of the condition, the method by which any medication should be administered and whether this can be successfully delivered or arranged by the healthcare team of an IRC. Thought will also be given to where any medical appointments will need to take place and the practical implications for this. Following this, caseworkers will contact colleagues in the Detainee Escorting and Population Management Unit (DEPMU) who will in turn contact the relevant healthcare team at a centre to discuss the information that has been made available and to check if the needs of the person concerned can be met in the detention setting.

If at any stage during detention it becomes apparent that a person's needs can no longer be met it would be a matter for the IRC doctor to ensure that arrangements are made for this to be brought

to the attention of the relevant UKBA caseworker to consider whether continued detention would be appropriate. This can be done direct or via the UKBA team at the centre. There is an escalation process available to IRC doctors where they are not satisfied with the caseworker's initial response to such concerns.

Healthcare services in IRCs are provided either under the NHS (in the directly managed centres) or by private healthcare suppliers (in the contracted-out centres). In both cases, standards of healthcare will comply with all relevant standards and guidelines, including the NICE guidelines, and with the Care Quality Commission's standards for the quality and safety of care. In such circumstances, there is no reason to believe that a detained person would receive a lesser standard of care in detention than would be the case if their care was provided in the community.

Guidance on Mental Health Act transfers

IRC contractors and those operating our directly managed centres are obliged to implement the joint Department of Health/Home Office guidance (to which you refer) for referring and sectioning a detainee under the Mental Health Act. Such matters are, quite appropriately, ones for the healthcare team in the relevant removal centre to instigate as part of normal healthcare procedures; it is not an area in which UKBA caseworkers take the lead.

Caseworkers may seek advice from the Mentally Disordered Offenders (MDO) team within Criminal Casework Directorate (CCD) about the best way to manage a case, including liaison with the Mental Health Casework Unit in the Ministry of Justice. This will include reviewing the appropriateness of detention.

Once a person subject to deportation proceedings as an ex-foreign national prisoner is transferred to a mental health facility the case is then managed by the MDO team. Once the detainee is transferred any decision to detain under immigration powers will be taken by this specialist team who will ensure that there is a detailed care plan in place in case of release from the hospital order.

I can also confirm that, once transferred to a mental health facility, the person concerned is not contacted directly during initial communication and most notices/decisions are relayed via the responsible clinician. Contact is also made with the patient's social worker and any other external agency interested in the case.

The MDO case owner will establish a close working relationship with the various professionals involved in the management and care of the person's individual needs. This level of cooperation between the UKBA case owner and mental health practitioners in particular ensures that the case owner is fully aware of the medical diagnoses made by the trained mental health practitioners and that they tailor their approach, within the confines of the relevant policies, to each case to ensure that decisions are served at a point at which they will be understood by the recipient and it is not viewed to constitute a significant risk to their improved mental health.

Additional resources

You asked what additional resources and/or facilities have been made available in IRCs for the care and treatment of the groups covered by the changes to the guidance. I have outlined the basis on which healthcare services in IRCs are provided and regulated. As stated above, the

changes to the guidance will not lead to individuals being detained who would not have been detained under the earlier guidance. Existing healthcare services available in IRCs are generally able to provide appropriate levels of care and treatment for such individuals, and are able to access community-based, specialist healthcare services if necessary.

The UKBA detention estate has in-patient facilities at both Colnbrook and Harmondsworth IRCs. Detainees with mental health problems present significant issues across the immigration detention estate. It is for this reason that we are working closely with the Department of Health and relevant NHS Primary Care Trusts to find ways to improve systems and processes. For example, through discussions with Hillingdon PCT we have secured an agreement whereby transfers of detainees to mental health beds will take place within 14 days. We are also considering options for increasing the number of in-patient bed spaces available in IRCs; however, this will require significant funding, which is not presently available.

Guidance/effective communication

All cases are considered on an individual basis against the guidance in the EIG, which seeks to provide a framework for caseworkers and those authorising or reviewing detention. However, because of the large number of combinations of factors that might be present in individual cases, it is not possible for this guidance to provide specific advice on all situations.

In enforcement cases all available information about the mental and general health of the person concerned would form part of the risk assessment prepared prior to the operation to arrest and detain that person. New medical or mental health issues discovered at the time of arrest and detention would be considered as part of the initial decision to detain and, if detention was maintained, the issues would be reported to Detention Services via the IS91RA risk assessment form. This issue is covered in Chapter 55, which is available to all enforcement staff.

CCD caseworkers are supported by a team of senior caseworkers who provide support and advice on the application of the guidance; an operational policy and process unit specifically for criminal casework; and an enforcement policy unit with responsibility for a broader spectrum of policy advice.

All decisions to detain an individual under immigration powers on completion of a prison sentence, or to re-detain to facilitate their removal are considered in line with the EIG. As part of the decision process checks are made to establish whether there are any known mental health issues which would require a level of successful treatment that could not reasonably be administered within an IRC.

In addition, when dealing with the detention of those who may have mental health issues and who are subject to deportation action, CCD case owners also consult their Mentally Disordered Offender team for advice specifically relating to those individuals who may be subject to restriction orders, restriction directions or hospital directions. Whilst the Mentally Disordered Offender team are not qualified medical practitioners, they are trained to consider the weight which should be given to mental health issues, working closely with the Mental Health Casework Unit in the Ministry of Justice and with mental health practitioners across the UK. UKBA Detention Services will also provide advice regarding the ability of IRC healthcare teams to provide specific care plans.

It is already the case that as a result of recent Court cases (details of which were also highlighted in your letter) CCD has re-emphasised the need to pay particular attention to all medical issues, including mental health concerns, as part of the considerative process of whether it would be appropriate not to release an individual. Such issues will of course be balanced against the risk of harm the individual poses to the public and their risk of re-offending (as determined by their offender manager), including the issue of a Multi-Agency Public Protection Arrangements (MAPPA) rating; any concerns about their likelihood of complying with any restrictions, especially where the use of electronic monitoring is contra-indicative; the potential length of detention; and, when considering medical issues, the availability of appropriate accommodation in relation to a health authority willing to provide treatment.

It is certainly not the case that caseworkers are being asked to make clinical judgments. When considering whether any health related issue can be successfully managed within detention, the views of a range of clinical staff are, by their nature, the foremost consideration. Particular note will be made of the treatment required for the management of the condition, the method by which any medication should be administered and whether this can be successfully delivered or arranged by the healthcare teams of individual IRCs, as well as taking account of any other medical evidence presented. On occasions it may also be that an independent report is commissioned where there is contradictory medical opinion.

Where detention is deemed to be an appropriate measure the case owner will continue to consult with the relevant IRC, including the health care unit, on a regular basis determined by the circumstances of the case but at least monthly. Any information shared by the health care unit will be restricted to a level dictated by the individual in question having provided authority (on request) for records to be disclosed.

There is, of course, a further safeguard under the terms of Rule 35 of the Detention Centre Rules 2001, which requires the doctor at the centre to bring to our attention those cases where there is concern that a detainee's health is likely to be injuriously affected by continued detention. The caseworker is required to consider the appropriateness of detention in the light of such reports.

Detention pending assessment or transfer under the Mental Health Act

You are concerned that the wording of chapter 55.10 is such that it leads caseworkers to reach decisions to maintain detention. I disagree; the wording is quite clear in that it states that "*In exceptional cases it may be necessary for detention at a removal centre or prison to continue….".* The wording clearly recognises that there may be instances where the person concerned may be temporarily admitted or released. Moreover, caseworkers are required to justify their decisions.

Yours sincerely

ALAN KITTLE