

# Decision-making capacity of detainees in immigration removal centres (IRCs)



Position Statement PS03/17  
November 2017

Royal College of Psychiatrists  
London

Approved by Policy and Public Affairs Committee and Council: October 2017

Due for review: October 2020

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# Introduction

## THE PURPOSE OF THIS DOCUMENT

- To set out the view of the Royal College of Psychiatrists on current processes for assessing decision-making capacity of detainees in immigration removal centres (IRCs).
- To make recommendations on how progress might be made in ensuring that the problems identified in this document are addressed.

## THE PROBLEM

Assessing decision-making capacity in relation to healthcare decisions or legal decisions in an IRC detainee who has a mental disorder is complex and difficult. Individuals experiencing symptoms of a mood disorder (e.g. anxiety, depression, post-traumatic stress disorder) or of a psychotic disorder can experience distorted cognitions (due, for example, to high levels of anxiety or delusional beliefs) and these may affect their ability to appropriately weigh and balance information given to them. Such deficits may be difficult to ascertain. Cognitive deficits relating to intellectual disability and dementia are more likely to affect an individual's ability to understand information and express a consistent opinion. This type of decision-making deficit may be easier to ascertain than the test of weighing/balancing, but only if the deficit has been correctly identified. Behaviour relating to such cognitive deficits and other mental disorders can be misconstrued as attention-seeking behaviour.<sup>1</sup>

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1 Jeremy Johnson QC makes this point in his sub-review for the Shaw Report (Johnson, 2016: point 62).

# Background and key evidence

## THE IMPACT OF IMMIGRATION DETENTION

During 2016, 28900 people were detained in IRCs (Migration Observatory, 2017). Between 2500 and 3500 are held at any one time, and although the average length of stay is 2 months (Shaw, 2016), nearly 4% of detainees are detained for longer than 6 months (Silverman, 2017).

In 2015, Professor Mary Bosworth conducted a comprehensive review of the academic literature pertaining to the impact of immigration detention on the mental health of detainees. She concluded that 'literature from across all the different bodies of work and jurisdictions consistently finds evidence of a negative impact of detention on the mental health of detainees' and that 'the negative impact of detention on the mental health of detainees increases the longer detention persists' (Bosworth, 2016: p. 305).

## PROVISION OF MENTAL HEALTHCARE IN IRCs

Concerns have been expressed regarding the provision of mental healthcare in IRCs (Grant-Peterkin *et al*, 2014; Sen *et al*, 2017). These concerns have arisen in part from six cases<sup>2</sup> in which it was found that the detention and treatment of mentally ill detainees amounted to inhuman and/or degrading treatment to an extent that breached Article 3 of the European Convention on Human Rights. Jeremy Johnson QC reviewed all six cases and concluded that 'the nature and pattern of findings are such that they are more likely to be a reflection of a systemic problem (ie insufficient medical – particularly psychiatric – provision) rather than individual failings' (Johnson, 2016: point 56).

The government-commissioned review of mental health in IRCs conducted by the Tavistock Institute (the 'Tavistock Report') found that 'Home Office staff, who are not medically qualified, are required to make extremely difficult decisions', adding that the 'Home Office accepts that it has not always got decisions right on the detention of those with mental health conditions'. The Report also highlighted system-wide issues insofar as 'a complex casework process [...] results in the processes not being robust enough for the consideration of mental health issues at key decision points' (Lawlor *et al*, 2015: points 1.5, 1.6 and 4.10).

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2 One case was set aside by consent.

## ASSESSMENT OF DECISION-MAKING CAPACITY

The Home Office does not currently keep records of the frequency or outcome of capacity assessments in IRCs, so the full extent of this problem is unknown. Assessment of decision-making capacity is not a routine part of the initial or subsequent medical assessments conducted in IRCs.

The report of the Shaw review into the welfare of vulnerable people in detention, commissioned by HM Government, made two references to capacity assessments and one recommendation. The first reference was in relation to cases of refusal of food and fluids. Although by their very nature these would be expected to warrant repeated assessments of decision-making capacity by appropriately trained healthcare professionals, 'proper mental capacity assessments are rarely carried out' (Shaw, 2016: para. 6.29). The second reference was to note the recommendation by non-governmental organisations (NGOs) that IRC staff needed 'training on the Mental Health Act 1983 and the Mental Capacity Act 2005, including the differences between them, so that staff understand how the two statutory regimes relate to each other and can recognise when a detainee's capacity needs to be assessed' (Shaw, 2016: para. 1.40).

## EXISTING RECOMMENDATIONS

Recent research has found psychiatric morbidity rates among immigration detainees similar to those found in prisons (Sen *et al*, 2017). The College has existing guidelines for the provision of mental healthcare in prisons (Royal College of Psychiatrists, 2007) that could act as a starting point when considering the level of care required.

The Tavistock Report recommended that: 'appropriate levels of training in mental health awareness and appreciation of when specialist treatment is required should be extended to all staff who have contact with, or make decisions in relation to, people who are detained' and that 'psychiatric advice should be available to the team in order to provide a stronger basis for decision-making' (Lawlor *et al*, 2015: recommendations 1 and 7).

The Shaw Report focused on the impact of deficiencies in the provision of care by staff in IRCs on a detainee's ability to engage in the legal process. In its recommendations, the report stated that 'those that are most vulnerable should not languish in detention because they lack the capacity to make a bail application' (Shaw, 2016: para. 10.26).

# The College's position

There are specific difficulties relating to the assessment of decision-making capacity in people with mental disorders in IRCs. The first is the problem of individuals who lack capacity but speak no or very little English, rendering their lack of capacity less obvious to staff. The second is the fact that capacity can fluctuate in people with mental disorders. The third is that the frequent movement of detainees from one IRC to another reduces the possibility for the sustained therapeutic relationship and for eliciting the consistent, sufficiently detailed psychiatric history that should inform any capacity assessment. Fourth, capacity is time and decision specific and depends on the nature and complexity of the decision in question. Specialist support would be required for individuals with complex needs and problems (including those arising from sociocultural factors) and/or multiple mental and physical conditions.

The College's view is that:

- existing evidence (medical, legal and government reports) provides grounds for serious concerns that both pre-existing mental disorders (which are likely to be aggravated by detention) and those arising during detention may result in detainees losing decision-making capacity with regard to healthcare and legal matters;<sup>3</sup>
- the processes in place within IRCs to address these concerns are not sufficiently robust;
- to begin to make progress in addressing these issues, the recommendations made in this Position Statement need to be implemented.

## RECOMMENDATIONS FOR ACTION

- The Home Office should keep and regularly disclose accurate figures regarding the number of immigration detainees who are assessed for decision-making capacity and the number found not to have capacity.
- IRC healthcare providers should investigate the possibility of an appropriate tool for screening for likely impairment in capacity and for

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<sup>3</sup> In relation to healthcare, these would include acceptance of treatment; in relation to legal matters, these would include the ability to instruct a lawyer, the ability to engage with the asylum or immigration process, and accepting or challenging detention.

reassessing such capacity at significant junctures during an individual's detention (e.g. if a new treatment is initiated, if the detainee refuses food or fluids, or if there is a significant change in the detainee's immigration status). Such a screening tool would need to be sufficiently sensitive and specific and to be administrable by detention centre or healthcare staff. The tool would also need to take account of language and cultural barriers, and provision should be in place for multiple assessments to confirm the presence or absence of decision-making capacity. Implementation of a screening tool would only be worthwhile alongside a robust and reliable pathway for taking action if a detainee were found to lack capacity or to need support to make decisions or access remedies, and for keeping capacity under review. In this context it is noteworthy that NHS England, which is responsible for the provision of healthcare within the IRCs in England,<sup>4</sup> is currently undertaking research into the feasibility of screening for intellectual disability as part of the induction process for new detainees. The College welcomes this initiative.

- There should be regular training for all Home Office and healthcare staff on the circumstances in which capacity assessments should be triggered; this should be linked to safeguarding training. Experienced and appropriately trained professionals are needed to assess capacity – to follow the individual's cognitions and ascertain whether a mental disorder directly affects, and to the required degree, the decision in question.
- Assessment of decision-making capacity in IRCs should be of at least the same standard as best practice in NHS psychiatric hospitals (NHS England, 2014: pp. 6–7) and capacity should be reviewed regularly in detainees with known mental disorders, as well as in detainees who are displaying changes in behaviour. See Appendix 1 for an example of circumstances in which capacity would be assessed in a NHS hospital.
- NHS England service specifications should require named mental capacity leads in each IRC healthcare unit; the 'named person' should not be the institution as a whole or the overall provider.

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4 There are no IRCs in Wales or Northern Ireland. Scotland's one IRC remains the responsibility of the Home Office.



# Appendix 1 When to conduct a capacity assessment

The following extract is from East London NHS Foundation Trust's policy in respect of the Mental Capacity Act 2005 (East London NHS Foundation Trust, 2016: para 3.2):

'Assessments of capacity are a continuous and on-going process throughout an episode of care. It is not possible to list all eventualities when a capacity assessment should be carried out; however, as a minimum, a capacity assessment must be completed in the following circumstances:

- Informal admission to hospital
- When a detained patient becomes subject to compulsory powers under a community treatment order
- To comply with the requirements of section 58, 58A and part 4A of the Mental Health Act 1983
- Serious medical treatment
- Significant change in mental state
- Significant change of accommodation
- A necessary breach of confidentiality
- Any situation where there is a consideration that the person may be being deprived of their liberty
- Other important decisions which may involve finances, personal affairs, property etc.'

# References

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