Health and Wellbeing Health Needs Assessment Programme: Immigration Removal Centres and Residential Short Term Holding Facilities

National Summary Report
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Health and Wellbeing Needs Assessment Programme

Immigration Removal Centres and Residential Short Term Holding Facilities

National Summary Report

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2 Equality Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- *Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and*
- *Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.*

3 Introduction

This report is intended to provide a national summary of the key issues identified in the programme of Health and Wellbeing Needs Assessments across the IRC estate in 2013/14. The report is based on individual health and wellbeing needs assessments (HWBNA) in the following Immigration Removal Centres (IRCs) and residential Short Term Holding Facilities (STHFs) for which NHS England has commissioning responsibilities:

- Brook House (London Gatwick Airport)
- Tinsley House (London, Gatwick Airport)
- Cedars (Pease Pottage, Crawley)
- Campsfield (Killington, Oxon)
- Dover (Western Heights, Dover)
- Dungavel (Strathaven, South Lanarkshire, Scotland)
- Harmondsworth (Harmondsworth West Drayton)
- Colnbrook (Harmondsworth West Drayton)
- Larne House STHF (Larne, Antrim, NI)
- Morton Hall (Swinderby, Lincolnshire)
- Pennine House STHF (Manchester Airport)
- Yarl's Wood (Clapham, Bedfordshire)
- Haslar (Haslar, Hampshire)

The Harmondsworth and Colnbrook Health Needs Assessment was completed separately in 2013 and undertaken by North West London NHS Foundation Trust.

The purpose of this report is to provide a national baseline of health and wellbeing needs assessment that can be used by NHS England and the Home Office to inform future service commissioning for healthcare in IRCs.

Immigration Removal Centres (IRCs) are used for temporary detention, in situations where people have no legal right to be in the UK but have refused to leave

voluntarily. Those detained in IRCs can leave at any time to return to their home country. Some detainees are foreign national prisoners who have completed prison terms for serious crimes, but who then refuse to comply with the law by leaving the UK.

The national operating standard for healthcare in IRCs states that "All detainees must have available to them the same range and quality of services as the general public receives from the National Health Service". In addition, the operating standard states that IRCs must:

"…develop needs based health services in partnership with their local Primary Care Trust and NHS providers. This should be done through Health Needs Analysis and a Health Improvement Plan, which is time based and which identifies who is responsible for delivery. This must be reviewed annually."

The National Institute for Health and Clinical Excellence (NICE) defines a Health Needs Assessment as:

"A systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities"[1]

In order to better reflect current drivers on integration for health and social care, including the establishment of Health and Wellbeing Boards as part of the local commissioning structures the term Health and Wellbeing Needs Assessment (HWBNA) has been adopted (Department of Health. 2012. HWBNA toolkit).

HWBNAs are conducted so that Commissioners and Providers can make plans for healthcare and related services based on a sound understanding of current service provision and people's health and wellbeing needs.

The World Health Organisation defines health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

The HWBNA reports health refers to both physical and emotional/mental health, and to the impact of substance misuse. There is also a focus on wellbeing. For vulnerable adults and young people wellbeing is about strengthening the protective factors in their life and improving their resilience to the risk factors and setbacks that feature in their lives and may have a continuing adverse impact on their long-term development.

The Government is seeking to increase local accountability, public engagement and value for money in the commissioning and delivery of services. Accordingly, the Government has introduced a series of reforms and new structures across the health, social care and criminal justice sectors, including via the Health and Social Care Act 2012. The Government believes that the new structures and systems will give local areas more control over how they commission and deliver services, allowing them to focus on the needs and priorities of their local population.

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[1] [1] Health needs assessment: a practical guide (2005) NICE

In regards to the commissioning of healthcare in a custodial setting, from April 2013 NHS England has taken over responsibility for overseeing the commissioning of all health services delivered in prisons and other forms of prescribed detention. This makes it an appropriate time to use a health needs assessment process to collate baseline information.

4 Aims

The aim of the IRC HWBNA Programme is to provide a sound understanding of current service provision and detainees' health and wellbeing needs as part of establishing a national baseline for meeting health needs in these services.

The specific benefits expected to come from this approach are:

- more informed and improved identification of the full range of health and wellbeing needs of detainees;
- improved understanding about the ways in which integrated pathways between the immigration removal system and the wider health and social care agencies impact on the delivery of safe and effective health care services;
- information that can inform staff learning and development;
- better understanding about the equality impacts of meeting health needs;
- increased understanding about current service configurations and areas for improvement;
- in meeting health and wellbeing needs and also identification of areas of good practice.

5 Methods

5.1 Data sources and evidence

This report uses the findings from each of the individual health and wellbeing needs assessments to present a national picture of health need and activity. A variety of data sources have been used in the individual HWBNAs including: previous health needs assessments; Her Majesty's Inspectorate of Prisons (HMIP) Reports; Independent Monitoring Board Reports and healthcare monitoring data from the individual IRCs and STHFs. In addition, each HWBNA involved interviews with staff, focus groups with detainees and the use of a Detainee Health Needs Questionnaire.

The collective responses include:

- Semi-structured interviews with 73 Healthcare and IRC staff around strengths, weaknesses and suggestions for change;
- 19 focus groups involving 92 detainees.
- A Health Needs Questionnaire with responses were obtained from 403 detainees

This report also draws on the Health Needs Assessment undertaken for Harmondsworth and Colnbrook IRCs by Central and North West London NHS

Foundation Trust, which involved at least 179 staff questionnaires and interviews and 120 questionnaires with detainees in addition to various focus groups.

The individual HWBNAs were carried out using the three main methods of epidemiological, corporate and comparative health needs assessment that will be familiar to NHS commissioners:

- The epidemiological needs assessment - this includes of a review of clinical activity and services and a literature review for evidence of effectiveness.

- The corporate needs assessment - this consists of consultations with key stakeholders, healthcare staff, other service providers and detainees[2]

- The comparative needs assessment - this includes comparing existing services and need against current healthcare standards and priorities.

The Terms of Reference for the individual HWBNAs can be found at Appendix A. The staff interview schedule can be found at Appendix B. The detainee focus group schedule can be found at Appendix C. The Detainee Health Needs Questionnaire can be found at Appendix D.

Resource constraints for the HWBNA meant that only detainees with sufficient command of English were able to participate in focus group and completing questionnaires.

6 Activity and demand

Each of the IRCs and the STHFs has a primary healthcare service provided on site. These mostly consist of general medical and nursing services although there is variety in staffing configurations, physical resources and types of service available. (The medical and qualified nursing configurations at the time of the HWBNAs are listed in the table below).

- All figures are over a 12 month period (2013 - 2014)

The range of healthcare provision typically available includes:

- Initial health screening and risk assessment, including an induction to healthcare. (Written information on a variety of healthcare issues is also provided in a range of languages)

- Routine treatment of disease and infection
- Immunisation services
- Sexual health screening if indicated by the initial assessment
- Care management and support for of physical disabilities

[2] Resource constraints for the HWBNA meant that only detainees with sufficient command of English could participate in focus group and completing questionnaires.

- Treatment of injuries
- Management of long-term conditions, such as asthma
- Dental diagnosis and treatment
- Optician
- Identification and management of mental health conditions
- Support for substance misuse dependency
- Pharmacy services

The exact configurations of the above differ across IRCs depending on the individual circumstances and commissioning history.

Nursing and medical configurations

IRC	Provider	Medical cover	Nursing staff	Certified Normal Accommodation
Haslar	Central and North West London NHS Foundation Trust	4 GPs	5 RGNs 1 RMN	170
Morton Hall	G4S Forensic and Medical Services (UK) Ltd	2 GPs	10 RGNs 2 RMN	392
Brook, Tinsley and Cedars	G4S Forensic and Medical Services (UK) Ltd	7 GPs	14 RGNs 2 RMNs	Brook – 385 Tinsley – 111 Cedars - 18
Dover	IC24	1 GP	5 RGNs	300
Campsfield	The Practice PLC	2 GPs	6 RGNs	276
Dungavel	Primecare	3 GPs	6 RGN 2 RMN	249
Yarl's Wood	Serco Health	7 GPs	12 RGN/RMNs	406
Colnbrook	Serco	3 GPs	9 RGNs 5 RMNs	409
Harmonds-worth	Primecare	3 GPs	8 RGN 2 RMN	615
Pennine House	Tascor Medical Services	1 GP	4 RGN 2 RMN	32
Larne House	Tascor Medical Services	1 GP	3 RGN	19

The medical cover for GPs is sessional and does not reflect actual sessional time allocated in each establishment. The nursing posts include both full and part time staff.

In addition to the core GP cover there are separate arrangements for out of hours.

The table above also does not include managers, many of whom are qualified nurses. In addition to the above each of the IRCs has a variety of health care

assistants, assistant nurse practitioners, technicians including pharmacy and emergency medical, counsellors, administration staff and bank staff.

Activity and demand for general medical and nursing healthcare

The following table shows the differences in activity and demand for general medical and nursing healthcare across each of the Centres.

IRC	GP Appointments		Nursing Appointments		Population for period
	Booked	Seen	Booked	Seen	
Haslar (5 months)	411	337	296	264	870
Morton Hall	4,512	3,888	5,621	4,345	4,817
Brook	7,586	6,483	-	3,914	7,966
Tinsley	1,837	1,477	-	894	1,746
Campsfield	5,284	4,164	23,834	477	3,000
Dungavel (10 months)	1,976	1,682	10,743	10,157	2,109
Yarl's Wood	10,400	8,882	Data not available		5,8,808
Harmondsworth	11,700	9,360	6,552	4,325	6,429

This data was not available for Dover, Colnbrook, Cedars, Pennine and Larne House.

There are some significant differences between the IRCs in activity and demand for general medical and primary nursing services. For example:

- activity and demand at IRC Haslar appears significantly lower for both GPs and nurses. However, it should be noted that these data are based on 5 months;
- demand for and access to GPs is significantly higher for IRC Campsfield, Yarl's Wood and Harmondsworth but this also reflects different recording approaches e.g. including drop-ins;
- demand for and access to nurses at IRC Dungavel is significantly higher than any other IRC.

The did not attend (DNA) rates and attendance for appointments differ across IRCs and between GP and Nursing services:

6.1 DNA rates

IRC	GP DNA rate	Nursing DNA rate
Haslar (5 months)	18%	11%
Morton Hall	14%	23%
Brook	15%	-
Tinsley	20%	-
Campsfield	27%	-

Dungavel (10 months)	15%	5%
Yarl's Wood	15%	-
Harmondsworth	20%	34%

The DNA rate for GPs varies from 14% to 27% while the DNA rate for nurse appointments varies from 5% to 34%. These wide variations in DNA rates represent potential capacity in the system. Learning from the best could enable those IRCs with much higher DNA rates to better manage demand and improve access to both GP and primary nursing services.

7 Initial health screening and assessment

IRCs currently operate under the Detention Service Order (DSO) targets for initial healthcare screening and assessment:

- to be seen by a nurse for an initial health assessment within 2 hours of admission;
- to be seen by a GP within 24 hours of admission.

As this is one of the main historical performance targets for healthcare services it is mostly met. However, not all detainees need to see a GP and a thorough and competent nursing assessment would determine this.

The target for being seen by a GP may also be creating unnecessary demand for GP appointments and restricting access for detainees with more urgent needs. There are no standard health screening and assessment tools for detainee populations. Most healthcare services in IRCs are using their own assessment templates. Some include validated screening tools such as the PHQ 9 for assessing depression and some use a two-step assessment process whereby a fuller health needs assessment is undertaken on a follow-up appointment.

The lack of a standard assessment tool for all IRCs creates challenges in determining common health needs across the population. Over time we would want to consider solutions over how this can be resolved. The volume of admissions can be seen in the table below:

IRC	Admissions 2012/13
Haslar	1,740
Morton Hall	4,796
Brook	7,693
Tinsley	2,309
Cedars	153
Dover	3,360
Campsfield	2,896
Dungavel	2,531
Yarl's Wood	5,004

Harmondsworth	5,856
Colnbrook	10,224
Pennine House	3,857
Larne House	485
TOTAL	50,904

A standard assessment tool would also be useful for transfer as many detainees move frequently between different IRCs and undergo a new assessment each time. For example, the actual number of people entering detention in 2013 was 30,423 (Source: Home Office, Immigration Statistics October to December 2013).

Assuming the above figures for admissions represent an average annual turnover there are approximately 20,000 detainees moving round the IRC system (40% of all admissions).

When detainees are transferred within the IRC system their health notes travel with them. The use of standard assessment and screening tools would greatly help IRC healthcare staff identify health needs at the point of entry and enable more effective continuity of care if this is required.

8 Access to secondary care services

Detainees are able to access secondary care hospital services e.g. Accident and Emergency and specialist clinics:

IRC	A&E	Other clinic		Total hospital	% Pop
Haslar	1	24	5.5%	25	2.8%
Morton Hall	21	144	3%	165	3.4%
Brook	47	559	7%	606	7.6%
Tinsley	21	206	9%	227	13%
Cedars	1	0	0	1	0.7%
Dover	Data not available				
Campsfield	23	50	2%	73	2.4%
Dungavel				161	7.6%
Yarl's Wood	-	73	6%	84	1.4%
Colnbrook	Data not available				
Harmondsworth	8	244	4%	280	4.3%
Pennine	Data not available				
Larne	Data not available				
TOTAL	123	1,300		1, 622	5%

Rates of access and transfer to local hospital services vary significantly across IRCS from less than 3% of the detainee population to more than 10%.

There are some significant data gaps and it is also likely that some IRCs combine data on specific specialties e.g. A&E and/or X-ray referrals may be included in other clinic reporting.

The average referral and use rate for secondary hospital services is approximately 5% of the total detainee population.

Detainees are escorted to hospital appointments, commonly under restraints. These has been raised as an issue in several HMIP reports:

> *"Detainees were handcuffed routinely on escorts to external appointments regardless of the risk they presented, and some had been accompanied into consultation rooms during external appointments for dental treatment and optician appointments."* (HMIP Unannounced Inspection Report IRC Haslar. February 2014. 1.35. Page 24.)

> *"Nominal risk assessments were carried out for every detainee being escorted to outside appointments, mainly to hospitals. However, they were all handcuffed unless there was evidence to suggest that this was unnecessary, rather than handcuffed only if there was good reason to do so. The outcome was that almost all detainees were handcuffed during such visits".* (HMIP Unannounced Inspection Report IRC Morton Hall. March 2013. 1.6. Page 17.)

> *"Handcuffs were routinely applied during escorts to external appointments, irrespective of risk, sometimes with weak justifications".* (HMIP Unannounced Inspection Report IRC Brook House. June 2013.1.5. Page 19)

> *Nominal risk assessments were carried out for every detainee being escorted to hospital but there was an inappropriate presumption that all should be handcuffed unless there was evidence to the contrary, which meant that almost all detainees were handcuffed at these times".* (HMIP Unannounced Inspection Report IRC Dover. June 2013. 1.62. Page 26)

Anecdotal evidence from healthcare staff for the HWBNAs suggests that detainees may refuse hospital treatment because they do not want to attend under restraints:

> *"Detainees have to attend hospital appointments in handcuffs, some refuse to go on this basis."* (Healthcare staff member, IRC Haslar)

> *"Some detainees will refuse hospital care rather than go in handcuffs."* (Healthcare staff member, IRC Morton Hall)

The IRCs undertake a risk assessment for each detainee due to attend an outside hospital appointment. This is an independent assessment and provides the basis on whether or not to use restraints for the hospital visit.

> *"A number of factors may contribute to the decision to use handcuffs and healthcare staff may not always be aware of the intelligence available to security staff that would inform these decisions".* (Centre Management, IRC Morton Hall Report)

Some IRCs have managed to greatly reduce the use of handcuffs for escorts:

> "*At the time of the HWBNA this situation had greatly improved with less than 25% of escorts involving the use of handcuffs. In February 2014 there were nine appointments and only 2 resulted in the use of handcuffs. In March 2014 out of 13 appointments handcuffs were used only three times".* (HWBNA Report, IRC Haslar)

9 Related healthcare clinics

9.1 Dentistry

Provisions of dentistry services varies across the IRC estate with most Centres holding a sub- contract with a local dentistry service which detainees can visit under escort. IRC Morton Hall and IRC Dungavel have their own fully equipped dentistry suites. Some IRCs including the STHFs only offer emergency dental services while others are able to offer a wider range of services e.g. routine dental care and hygiene.

IRC	No booked for dentist	% Population booked	No seen	% Population seen
Haslar	33	4.5%	28	4%
Morton Hall	1,314	27%	1,090	23%
Brook	383	5%	271	3.5%
Tinsley	44	2%	37	1.6%
Cedars	0	-	0	-
Dover	Data not available		Data not available	
Campsfield	88	4%	Data not available	-
Dungavel	Data not available	-	503	20%
Yarl's Wood	Data not available	-	108	2%
Harmondsworth	116	7%	82	5%
Colnbrook	199	2%	179	1.7%
Pennine House	Data not available		Data not available	
Larne House	Data not available		Data not available	

The average demand for dentistry excluding IRC Morton Hall and Dungavel is between 2% and 7% of detainees. IRC Morton Hall (27%) and IRC Dungavel (20% seen) have significantly higher use of dentistry. This is most likely due to IRC Morton Hall and IRC Dungavel both having their own dental suite and thus providing a wider range of dental services.

9.2 Opticians

Optician's services are provided under sub-contract with some IRCs having a visiting optician and others requiring detainees to visit and outside service under escort.

IRC	No booked for optician	% Population booked	No seen	% Population seen
Haslar	9	1.2%	9	1.2%
Morton Hall	170	3.5%	147	3%
Brook	172	2.2%	137	1.8%
Tinsley	17	0.7%	17	0.7%
Cedars	0	-	0	-
Dover	Data not available		Data not available	
Campsfield	44	2%	Data not available	-
Dungavel	80	3%	72	2.8%
Yarl's Wood	Data not available	-	108	2%
Harmondsworth	46	1.4%	39	1.2%
Colnbrook	63	1%	30	0.5%
Pennine House	Data not available	-	Data not available	-
Larne House	Data not available	-	Data not available	-

Demand for opticians is fairly consistent varying from 1% to 3.5% with rates of those seen from 0.5% to 3% of the population. There are some significant differences in DNA rates e.g. none at IRC Haslar compared to 54% at Colnbrook.

9.3 Podiatry

There is very little data available on the provision of podiatry services:

IRC	No booked for podiatry	% Population booked	No seen	% Population seen
Haslar	0	-	0	-
Morton Hall	60	1%	56	1%
Dungavel	Data not available	-	45	1.7%
Harmondsworth	Data not available		7	0.1%

9.4 Physiotherapy

IRC Dungavel is the only IRC able to report on numbers of detainees seen by a physiotherapist (4 detainees, 0.1% of population)

10 Physical healthcare needs

Most detainees responding to the Detainee Health Needs Questionnaire perceive their physical health to be OK, Good or Very Good (85%). 62 detainees (15%) perceived their physical health to be bad or very bad:

Physical Health (N = 403)					
Rating	1 Very good	2 Good	3 OK	4 Bad	5 Very bad
Number of Detainees	86 (21.5%)	116 (29%)	139 (34.5%)	37 (9%)	25 (6%)

The majority of detainees report being asked about their physical health when they first entered the IRC:

When you first entered this IRC did anyone ask you about your Physical Health? (N = 403)		
Yes	340	84.5%
No	59	14.5%
Not answered	4	1%

A little over half of detainees reported having seen a doctor at the IRC about a physical health problem:

Since being at this IRC have you seen a Doctor about any Physical Health problems? (N = 403)		
Yes	220	55%
No	177	44%
Not answered	6	1%

Amongst those who said that they had seen the doctor 151 detainees (67%) answered the question about waiting times. Most (73%) report having to wait a short time e.g. less than two days to see the doctor:

How long did you have to wait to see the doctor? (N = 151)		
Less than 24 hours	63	(42%)
Between 1 and 2 days	47	(31%)
Between 3 and 7 days	28	(18.5%)
2 weeks or more	10	(6.5%)
More than 1 month	3	(2%)

228 detainees (57%) report having seen a nurse about a physical problem:

Since being at this IRC have you seen a Nurse about any Physical Health problems? (N = 403)		
Yes	228	(57%)
No	166	(41%)

Not answered	9	(2%)

155 detainees (68%) responded to the question about waiting times to see the nurse. The majority (83%) report the waiting times was less than two days:

How long did you have to wait to see the nurse? (N = 155)		
Less than 24 hours	96	(62%)
Between 1 and 2 days	33	(21%)
Between 3 and 7 days	24	(15%)
2 weeks or more	2	(1%)
More than 1 month	0	0

Detainees were asked a variety of questions about their physical healthcare:

Since being at this IRC have you had any of the following? (N = 403)	
Someone to check if you have problems with your eyes	69 (17%)
Someone to check if you have problems with your ears	33 (8%)
Someone to check if you have problems with your teeth	88 (22%)
Someone to check if you have problems with your feet	29 (7%)
Someone to check if you have problems with your muscles	36 (9%)

These answers are encouraging as the rates are generally higher than the percentage population assumptions from actual booked and seen appointments with dentistry, opticians and podiatry. However, this may also indicate that there is unmet need amongst the detainee population for these types of service.

11 Long-term health conditions

There is no national data on the prevalence of long-term health conditions amongst detainees. The detainee population is a relatively healthy and young population, however, some ethic groups are known to have higher prevalence rates of certain chronic conditions e.g. Diabetes.

Diabetes Mellitus is found twice as often amongst Caribbean and South Asian communities in the UK compared to the British population as a whole (Cruickshank, 1989). Also some ethnic groups are known to have higher rates of cardiovascular disease e.g. people from South Asia are more susceptible to coronary heart disease (McKeigue et al, 1993; McKeigue and Sevak, 1994).

In the UK data on stroke incidence has shown ethnic variations e.g. significantly higher rates of stroke are shown amongst people of Caribbean origin (Balajaran, 1991). 70 detainees (17%) report having used a nurse clinic e.g. for diabetes or asthma.

Have you used any nurse clinics for example, for Asthma or Diabetes? (N = 403)		
Yes	70	(17%)
No	327	(81.5%)
Not answered	6	(1.5%)

Each of the health and wellbeing assessments asked for data on long-term health conditions. The quality of these data varies as not all IRC operate a long-term health conditions register, however based on the data gathered the following assumptions about prevalence have been made.

LTC	Estimated detainee prevalence	No of detainees based on population entering system in 2013	National UK prevalence
Diabetes	1% - 3%	304 – 912 detainees	4.6%4
Asthma	1% - 2%	304 - 608	5.9%5
CVD	0.5% - 1%	152 – 304	3% - 5%6
Epilepsy	0.5% - 1%	152 – 304	1%7
Hypertension	2% - 4%	608 – 1,217	28% - 31%8
Hyperthyroidism	0.3%	91	1% - 2%9
Stroke	0.5%	152	2% - 3%10
Cancer	0.2%	61	1 in 3 lifetime11
Kidney disease	1%	304	4%

Caution must be exercised when making comparisons with general population data on prevalence for long-term health conditions because the detainee population has a number of factors that would influence this.

Factors that will impact on differential prevalence figures amongst detainees include

- Age – the detainee population is on average younger i.e. under 30 years of age.
- Gender – the detainee population is mostly male.
- Ethnicity – the detainee population is widely divergent by ethnicity with the largest population groups being South Asian and Black African.

However, even given these differential factors it is likely that the incidence of long-term conditions amongst the detainee population is being underestimated:

> *"Local data accessed indicates that the actual numbers of detainees diagnosed with specific health conditions (including Asthma, Diabetes, Epilepsy and Learning Disabilities) is well below that of the community based*

population and the rates picked up are below estimated prevalence figures highlighted in national research projects. This may indicate that health conditions are not being picked up at reception and may lead to health deteriorating while in detention". (Harmondsworth and Colnbrook HNA. Page 6)

For example, it is known that there is much higher prevalence of diabetes amongst South Asian and Afro-Caribbean populations:

> *"The UK prevalence of diabetes is approximately 4%[3]. There are no figures for the prevalence of diabetes within the IRC populations. It is known that diabetes is more prevalent amongst Asian and Afro-Caribbean populations and given that there are significant numbers of detainees from this group, it is likely that diabetes would be over-represented in the detainee population.*

Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common among people of African and African-Caribbean origin4[4]. Among women, diabetes is more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women, compared with women in the general population"[5] [6]. (Harmondsworth and Colnbrook HNA. Page 109)

The management and care of detainees with long-term health conditions in IRCs differs considerably. For example, some IRCs have lead nurses and clinics for specific conditions while others lack these specific skills and competencies.

Most IRCs have care plan procedures in place but there are a number of factors that can compromise continuity of care for detainees with long-term health conditions:

- rapid turnover of detainees means that care plans may be interrupted;
- detainees may be returning to countries that have very poor or no healthcare provisions for specific conditions;
- if detainees need to access secondary healthcare services this is usually done under escort and may involve the use of restraints. There are anecdotal reports of some detainees refusing this level of care as a result of being required to go under restraints.

The lack of consistent recording of long-term health conditions across IRCs means that there is insufficient data extrapolated across the population for commissioners to assess health need and determine appropriate resources. A national template for

[3] http://www.diabetes.org.uk/Documents/Reports/Diabetes-in-the-UK-2012.pdf
[4] Department of Health (2001). National service framework for diabetes www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4096591
[5] The Information Centre (2006). Health Survey for England 2004: health of ethnic minorities: www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-surveyforengland/health-survey-for-england-2004:-health-of-ethnic-minorities--full-report
[6] Health Protection Agency. Migrant Health: Infectious diseases in non-UK born populations in the UK. An update to the baseline report – 2011

use by all IRCs could be introduced to ensure greater consistency and accuracy in reporting.

12 Communicable diseases

Detainee populations are more likely to be susceptible to certain outbreaks of infectious diseases due to lack of immunisation in their home countries when children. Outbreaks of infectious diseases, such as chicken pox, do sometimes occur. Guidance from the Health Protection Agency in 2012 points out the higher susceptibility of prisoner and other detainee populations to chicken pox:

> *"Higher susceptibility to chickenpox among foreign-born prisoners and detainee populations because:*
>
> 1. *Persons from rural tropical and subtropical regions are less likely than those from temperate zones to be infected as children, resulting in susceptibility in adulthood (6-fold higher susceptibility than Western European adults4);*
> 2. *Infants and children, the group most likely to be infected with chickenpox, are located in some prisons and places of detention;*
> 3. *Increased prevalence of vulnerability to serious illness resulting from chickenpox in some detention populations (e.g. people living with HIV or AIDS, pregnant women, immuno-suppressed people)"* (DH HPA, 2012)

In common with prisons and other places of prescribed detention IRCs can be vulnerable to outbreaks of infectious diseases. Some of the particular risks that can result in the transmission of infections include:

- the nature of the environment e.g. many IRCs were previously prisons and they vary in their age, design, construction and healthcare facilities. It is also common for detainees to share rooms and there are varying levels of staff awareness and skills in identifying and managing infectious diseases;
- the nature of the population e.g. about 2,500 people are detained in IRCs at any one time. Throughput and turnover are very high and involve large numbers of detainees rapidly moving from one Centre to another. Some of the detainee population come directly from police cells or the community and may have entered the country illegally or through hazardous and clandestine routes. Also, many detainees have a poor record of engagement with health services due to their illegal status and fear of contact with authorities;
- the prevalence of disease: detainees come from very mixed ethnic and national groups many of whom are known to be vulnerable to particular diseases either through prevalence in their home countries and/or lack of childhood immunisations in their home countries.

Doctors are required to notify the local Consultant in Communicable Disease Control (CCDC) of any case of a serious infectious disease. The CCDC is responsible for managing infectious disease incidents including those occurring in prisons and other detention settings. The benefits to an IRC in involving the local CCDC includes

expert advice on infection prevention and control and facilitating outside laboratory testing and hospitalisation, where necessary.

The Public Health in Prisons (PHiPs) team is part of the national Health and Justice team within Public Health England (PHE). Previously part of the HPA, the PHiPs team's original title was Prison Infection Prevention (PIP) team but this has been updated to reflect the extension of the team's remit relating to public health work in prisons and other places of detention. However, it is unclear to what degree IRCs are complying fully with the PHiPs team's operating procedures.

The standard operating procedure for Health Protection Teams reporting to the Public Health in Prisons Team (Health & Justice, December 2013) includes templates for minimum dataset reporting. This includes outbreaks in addition to single infections. The minimum reporting on outbreaks should include:

- Acute respiratory infection (viral, including influenza, and bacterial agents)
- Gastrointestinal infection (GI), i.e. diarrhoea and/or vomiting, including norovirus and other viral, bacterial, preformed bacterial toxin and parasitic agents and non-biological substances;
- Unexplained skin rashes

Gastrointestinal complaints and skin rashes are common amongst detainees and in some cases account for more than 15% of all presentations to the GPs. However, these are not classified as outbreaks and do not form part of the health protection reporting.

The full list of reportable single Infections for prisons includes:

- Escherichia coli of serogroup known to be toxin-producing, e.g. E. coli 0157
- Food poisoning
- Hepatitis A (acute)
- Hepatitis B (acute and chronic)
- Hepatitis C (acute and chronic)
- Herpes zoster
- Infectious bloody diarrhoea (shigellosis)
- Invasive group A streptococcus disease (IGAS)
- Legionnaires' disease (Legionella sp.)
- Listeriosis (Listeria monocytogenes)
- Measles (measles virus)
- Meningitis (bacterial, viral and other)
- Meningococcal septicaemia (without meningitis)
- Mumps (mumps virus)
- Pertussis/whooping cough (Bordetella pertussis)
- Salmonellosis (Salmonella enterica)
- Scarlet fever
- Staphylococcus aureus, Panton-Valentine leukocidin (PVL)-producing
- Tuberculosis (Mycobacterium tuberculosis complex)
- Typhoid (Salmonella Typhi and Salmonella Paratyphi, causing paratyphoid)
- Varicella (chickenpox)

Any other major infectious diseases:

- Acute encephalitis
- Acute poliomyelitis
- Acute infectious gastroenteritis/food poisoning
- Anthrax
- Botulism (Clostridium botulinum)
- Brucellosis
- Cholera (Vibrio cholerae)
- Diphtheria (Corynebacterium diphtheriae)
- Haemolytic uraemic syndrome (HUS)
- Leprosy
- Malaria (Plasmodium falciparum, vivax, ovale, malariae)
- Plague (Yersinia pestis)
- Rabies (rabies virus)
- Rubella (rubella virus)
- Severe Acute Respiratory Syndrome (SARS-associated coronavirus and
- Middle East respiratory syndrome coronavirus virus, MERS-CoV)
- Smallpox (variola virus)
- Tetanus (Clostridium tetani)
- Typhus (Rickettsia prowazekii)
- Viral haemorrhagic fevers (Lassa virus, Marburg virus, Ebola virus, Crimean-Congo haemorrhagic fever virus)
- Yellow fever (yellow fever virus)

It is important that IRCs are given clear instructions nationally on reporting for communicable diseases. These data should be managed and collated separately to prisons to enable a clear national picture of incidence of infectious diseases and outbreaks in the IRC system.

12.1 Tuberculosis

While the rate of TB infections across the detention estate is not known a number of countries in the European Union have reported rises in TB infections as a result of migration. For example, Denmark reported a rise in foreign-born cases of TB from 18% in 1986 to 60% in 1996 (Prinsze, 1997).

The last national survey of Tuberculosis for England and Wales estimated that 40% of all TB cases occur amongst people arriving from the Indian sub-continent (Karmi, 1997). Similar research from other European countries showed that migrants were between three and six times more likely to diagnosed with TB than non-migrants (Huismann et al, 1997; Gliber 1997). Research from Canada in the early 1990s showed that Tuberculosis and Hepatitis B were becoming more important from an epidemiological perspective as a result in shifting migration patterns (Statistics Canada, 1993).

The reported incidence of TB in the detainee population is quite low:

IRC	Number of detainees suspected of having TB	No of detainees receiving TB immunisation
Haslar	0	0
Morton Hall	8	2
Brook	12	0
Tinsley	0	0
Cedars	0	0
Dover	Data not available	Data not available
Campsfield	4	0
Dungavel	21	0
Yarl's Wood	2	0
Harmondsworth	11	0
Colnbrook	Data not available	Data not available
Pennine House	Data not available	Data not available
Larne House	Data not available	Data not available
TOTAL	58	2

Although there are significant data gaps it is highly likely that there are much lower numbers of detainees receiving immunisation for TB than those suspected as having the disease. However, data on the exact number of positive results from screening was not routinely monitored.

12.2 Hepatitis B

The common policy in IRCs regarding Hepatitis B is that if a detainee enters the Centre part way through a course of vaccination for Hepatitis B this will be continued but healthcare staff will not initiate this type of vaccination.

The rapid turnover and short duration of detainees in the IRC system can make the provision of immunisations and vaccinations challenging. For example, Hepatitis B immunisations involve a course of treatment over a period of time and this can inhibit healthcare staff from wanting to initiate this kind of immunisation.

IRC	No of detainees testing positive	% Pop	Numbers of detainees provided with Hepatitis B immunisation	% of detainees testing positive given immunisation
Haslar	1	0.1%	0	0
Morton Hall	37	0.8%	11	30%
Cedars	2	1.3%	0	0
Dungavel	9	0.3%	0	0
Harmondsworth	11	0.32%	0	0

12.3 Flu vaccination

The Department of Health target for uptake of the Flu vaccination in 2013/14 was 75% in the community. The key months for Flu vaccinations are from September to January. The number of detainees in IRCs aged over 65 years is very low, less than 1% at any given time. Most IRCs offer the Flu vaccination to detainees aged over 55 years of age alongside any detainees with at risk conditions.

It is challenging to determine the population rates for older detainees and those at risk due to particular conditions but it likely to be between 2% and 5% of the detainee population. Data on flu vaccinations was only available for three IRCs:

IRC	Numbers of detainees provided with Flu vaccination	Coverage using 2% at risk estimates	Coverage using 5% at risk estimates
Haslar	9	62%	25%
Morton Hall	28	72%	28.5%
Dungavel	16	76%	30%

As can be seen from the above three examples even using the low estimate of 2% population at risk there are between one quarter and one third of detainees at risk not receiving the Flu vaccination.

13 Blood Borne Viruses

13.1 HIV/AIDS

There is mixed evidence on the prevalence rates of HIV amongst migrant populations compared to the host population with some research showing lower prevalence rates amongst migrant groups (Muynck, 1997; Carchedi & Picciolini, 1997). However, some European countries have identified significantly higher rates of HIV infection and AIDs amongst migrant populations.

For example, in Germany 14% of all AIDS cases were from migrants (Huismann et al, 1997) and in Sweden rates of HIV and other sexually transmitted diseases exceeded national rates, especially from African migrants (Janson et al, 1997). Following anecdotal reports that people living with HIV were not receiving the quality of care they needed while in immigration detention, the National Aids Trust (NAT) surveyed IRC healthcare teams in 2005 about the HIV treatment and care they were providing [7].

The survey revealed a number of gaps and pressure points in IRC healthcare processes, which were leading to treatment interruption and poor continuity of care

[7] http:// www.nat.org.uk/Media%20library/Files/PDF%20documents/Immigration-Removal-Centre-Discussion-Paper-(May-2007)-FINAL.pdf

for people living with HIV who were taken into immigration detention and/or removed from the UK.

The survey focused on finding out how many people living with HIV were in IRCs and what policies IRCs had in place to ensure care was provided to a quality equivalent to community NHS services.

In 2011-12, NAT conducted a second survey of HIV care in IRCs. This time data was sought both from IRC healthcare teams and from the NHS HIV clinics that see patients from their local IRC[8]. 95 cases of detainees with HIV were identified in the 10 IRCs during the 12 month period. As there is movement between IRCs, this represents fewer than 95 individual detainees.

Based on the number of transferred patients reported by IRCs, NAT estimates that there were between 60 and 70 individual patients moving through the detention estate during this time period. 67% of the reported cases were in the three largest IRCs (Harmondsworth, Yarl's Wood and Colnbrook).

The health and wellbeing assessments for the national programme reveal low levels of detected HIV infection:

IRC	Number of detainees HIV+	% of population	No of detainees on treatment
Haslar	4	0.5%	0
Morton Hall	19	0.4%	12
Brook	26	0.3%	0
Tinsley	0	-	0
Cedars	0	-	0
Dover	Data not available		
Campsfield	Data not available		
Dungavel	11	0.4%	0
Yarl's Wood	14	1%	0
Harmondsworth	13	0.2%	0
Colnbrook	Data not available		
Pennine House	Data not available		
Larne House	Data not available		

Where data has been made available it is fairly consistent with rates of identified HIV infection varying between 0.2% and 0.5%. Yarl's Wood has the highest rate at 1% and as this is a women only Centre this much higher rate may be indicative of higher rates of infection amongst women from certain ethnic and national groups. These data are also broadly consistent with the NAT survey estimates that there are between 60 and 70 individuals in the IRC estate at any one time who are known to be HIV+.

[8] http://www.nat.org.uk/media/Files/Publications/Dec_13_IRC%20report_final.pdf

The very low numbers of detainees who are on medication e.g. 14% of those known to be HIV+ may be a cause for concern. NAT identified a number of issues for detainees on medication:

- Interruption in supply of medication during transfer to an IRC from the community
- Speed of response in providing medication when there has been an interruption;
- Lack of clear protocols and suitable arrangements with local HIV/AIDS services;
- Detainees not being able to manage or hold their medication (http://www.nat.org.uk/media/Files/Publications/Dec_13_IRC%20report_final.pdf)

In approximately 10% of cases the patient arrived at the IRC without a supply of their antiretroviral medication. Of this group, only one patient was reported to have received a supply of the necessary medication within 24 hours, as recommended in the NAT/BHIVA advice.

The NAT/BHIVA advice makes clear that a protocol should be in place between the IRC and their local clinic to ensure this prompt access to Anti-Retroviral Therapy (ART). Eight of the IRCs reported that they had a protocol for the management of newly arrived patients with HIV (in two cases, the IRC stated they used the NAT/BHIVA advice as their protocol).

Around 5% of patients were diagnosed in the IRC. Seven of the IRCs reported they had a protocol for HIV testing. In one case this protocol was to not routinely offer tests. Another reported that they used NICE testing guidance for their protocol.

Most IRCs reported that patients were able to hold their own medication, as is recommended in the NAT/ BHIVA advice. There were only three cases reported where the detainee had been given their medication dose by dose. The survey did not ask the reason for this approach, but it may have been following an individual risk assessment.

> *"Tudor Wing Clinic (Harmondsworth/ Colnbrook) and The Gate Clinic (Dover) reported that they instruct IRC healthcare teams to allow patients to hold their medication themselves to reduce the likelihood of treatment interruption. Although the clinic reports represent only six IRCs (excluding one of the largest, Yarl's Wood), their responses indicate that more than four patients experienced interruption".* (NAT. 2013. HIV care in Immigration Removal Centres. Survey Report December 2013.)

There are also reported incidents from the HWBNAs of detainees' HIV status being written on the front of IS91 forms. This may not accord with the detainees' rights to confidentiality and may also feed resistance amongst detainees to being identified or screened for HIV.

13.2 Hepatitis C

Liver disease is the only major cause of mortality and morbidity which is rising in England whilst decreasing in Europe [9].

> *"There was a 25% increase in liver disease deaths between 2001 and 2009[10]. The most recent national estimates suggest that around 216,000 individuals are chronically infected with the hepatitis C virus (HCV) in the UK, but only approximately 3% are treated each year [11].*
>
> (Hepatitis C Trust. May 2013. Addressing hepatitis C in prisons and other places of detention: Recommendations to NHS England).

The Hepatitis C Trust goes on to estimate that by the year 2020, over 15,000 people in England are expected to be living with cirrhosis or liver cancer caused by hepatitis C, unless they are diagnosed and treated.

> *"The most seriously affected will require liver transplants[12]. Direct healthcare costs of hepatitis C are currently in excess of £0.5bn per annum and rising by 10% per year. Both hospital admissions and deaths from HCV-related end stage liver disease (ESLD) and hepato-cellular carcinoma (HCC) are continuing to rise in the UK. Hepatitis C is the only cause of liver disease amendable to intervention. It is also preventable1"[13].* (Ibid)

The numbers of detainees at risk of Hepatitis C is not known. Nationally, there are very few reported cases of Hepatitis C in IRCs.

IRC	Numbers of detainees Hepatitis C	% Population
Haslar	1	0.1%
Morton Hall	8	0.2%
Dungavel	10	0.4%
Harmondsworth	1	0.1%

[9] Department of Health, Annual Report of the Chief Medical Officer 2011: Volume One 'On the state of the public's health', November 2012: https://www.gov.uk/government/publications/cmo-annual-report-2011-volume-one-on-the- state-of-the public-s-health

[10] National End of Life Care Intelligence Network, Deaths from liver disease: Implications for end of life care in England, March 2012: http://www.endoflifecare-intelligence.org.uk/resources/publications/deaths_from_liver_disease

[11] National End of Life Care Intelligence Network, Deaths from liver disease: Implications for end of life care in England, March 2012: http://www.endoflifecare-intelligence.org.uk/resources/publications/deaths_from_liver_disease

[12] Health Protection Agency, Press Release: 'Four thousand people in England may need liver transplants by 2020 due to hepatitis C, HPA warns', July 2011: http://www.hpa.org.uk/NewsCentre/NationalPressReleases/2011PressReleases/110728HepCmayleadtotransplantneeds/

[13] Office for National Statistics, Avoidable Mortality in England and Wales, 2010 Reference Table 3, May 2012: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-262418

> *"In 2010, 162,199 individuals, over one year of age, were tested by a first-line service for antiHCV, of whom 2.5% tested positive. These individuals had a similar demographic profile to that described in previous reports. Slightly more males were tested than females and overall males were nearly twice as likely to test positive. However, in prison settings females were 2.5 times more likely to test positive for anti-HCV compared to males. Nearly half of all individuals tested and 56% of those testing positive were aged between 25 and 44 years. Using ethnicity classification from multiple data sources, 80% of individuals were classified as being of White or White British origin (100,144/125,537), a further 14% were classified as Asian or Asian British origin, 4% were classified as other and/or mixed ethnic origin, and 2% were classified as Black or Black British origin. Individuals of White or White British origin were most likely to test positive".* (Health Protection Agency Colindale, Sentinel Surveillance of Hepatitis Testing in England Hepatitis C testing 2010 Report Analyses of HCV testing data between 2007 and 2010, July 2011)

Some IRCs have reported problems accessing appropriate treatment for detainees with Hepatitis C due to the rapid turnover resulting in detainees having to leave treatment courses uncompleted.

In February 2013, The Hepatitis C Trust convened an expert group of doctors, nurses, consultants, commissioners and public health specialists to develop recommendations for how hepatitis C healthcare in prisons could be improved through the new commissioning arrangements. [14]

Although the IRC population is very different to that of prisons and there is much less reported drug use, there may be scope for considering the recommendations for prisons and their applicability in the IRC environment.

14 Health promotion

14.1 Smoking cessation

Smoking is the greatest cause of preventable illness and premature death in the UK. Smoking hits poorer people harder, widening inequalities in health among social groups.

Some form of smoking cessation support exists in most of the IRCs but reporting on the throughput and outcomes from these services varies significantly.

[14] Second to drug dependency services, a higher proportion of individuals test positive for hepatitis C in prisons than in other health settings in the community. Health Protection Agency Colindale, Sentinel Surveillance of Hepatitis Testing in England Hepatitis C testing 2010 Report Analyses of HCV testing data between 2007 and 2010, July 2011:
http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1313155286634

IRC	Smoking cessation support No of detainees seen	Outcomes i.e. No of 4 week quitters
Haslar	153	0
Morton Hall	126	Unknown
Campsfield	21	2
Dungavel	17	1

Nearly half of the detainees responding to the Detainee Health Needs Questionnaire report being smokers (193 detainees, 48%). Amongst these half smoke less than ten a day and 4% smoke more than 30 a day. Only 11% report having asked for help at the IRC to stop smoking.

Do you smoke cigarettes? (N = 403)		
Yes	193 (48%)	
No	202 (50%)	
Not answered	8 (2%)	-

Amongst those who smoke most (49.5%) report smoking less than 10 a day:

If yes, how many cigarettes did you smoke in a day? (N = 193)		
Less than 10	95	49.5%
Between 10 20	66	34%
Between 20 – 30	24	12.5%
Between 30 40	6	3%
More than 40	2	1%

Amongst the smokers 82 detainees (42.5%) report that smoking causes them cough or feel short of breath:

Does smoking cause you to cough or feel short of breath? (N = 193)		
Yes	82	42.5%
No	108	56%
Not answered	3	1.5%-

33 of the detainees who smoke have asked for help at the IRC to stop smoking:

Have you asked for help at this IRC to stop smoking? (N = 193)		
Yes	33	17%
No	155	80%

Not answered	5	3%-

It can be seen from the Detainee Health Needs Questionnaire data that there are significant numbers of detainees at risk from smoking but actual numbers seeking or receiving help to stop smoking are relatively small.

14.2 Sexual health

Most IRCs will offer Chlamydia screening to males aged under 25 but the take up for this appears to be very low:

	No screened for Chlamydia	% Eligible population
Haslar	3	0.7%
Morton Hall	11	0.5%
Campsfield	4	0.4%
Dungavel	11	1%

Detainees were asked if they had received a sexual health screening test since being at the IRC. Less than 3% reported that they had received a test but significant numbers of detainees refused to answer this question (42%), which may indicate cultural barriers to questions about sexual health:

Have you had a sexual health-screening test in this IRC? (N = 403)			
Answer	Yes	No	Not answered
Number of Detainees	11 (2.7%)	219 (55.3%)	168 (42%)

Condoms are made available for detainees but in some Centres these have to requested, which may inhibit some detainees from taking condoms. Relationships with local GUM clinics vary across the IRC estate and many Centres report that sexual health promotion and screening and could be improved if the GUM was able to provide a confidential service on site. This would also prevent the need for detainees to be escorted to the GUM clinic thus improving confidentiality and likely compliance.

14.3 Weight, diet and exercise

Apart from the STHFs most IRCs have good facilities for gymnasium and sports activities. In some Centres there is a good relationship between healthcare staff and Physical Education Instructors/ Security staff to promote healthy activities and fitness. In the STHFs space is at a premium and the very short duration of detainees' stays means that it would be very challenging to provide more space or facilities for physical activity. Detainees were asked about their physical activity and fitness before entering the IRC and since coming in to the IRC:

Do you take part in sport and fitness activities? (N = 403)		
Yes	No	Not answered

In this IRC	248 (61%)	137 (34%)	18 (4%)
Before entering this IRC	261 (65%)	128 (32%)	14 (3%)

As can be seen from the above table there is a slight increase (4%) in the number of detainees who have been active in sports or fitness since entering the IRC.

On the whole good attempts are made to provide detainees with a varied and healthy diet. However, this is often complicated by the wide variety of cultural tastes and diets that is being catered for. To assist with this some IRCs provide 'cultural kitchens' whereby different national groups are able to cook their own food in line with their particular cultural tastes and requirements.

Despite these efforts detainee feedback consistently shows lack of satisfaction with the diet on offer. For example, in the detainee Health Needs Questionnaire 51% (205 detainees) report being worried about the food that they can eat and 34% (135 detainees) report being worried about their weight.

Do you worry about the food at this IRC and what you can eat? (N = 403)		
Yes	No	Not answered
205 (51%)	185 (46%)	13 (3%)

Do you have problems with your weight? (N = 403)		
Yes	No	Not answered
135 (33%)	253 (63%)	15 (4%)

15 Mental health

There are no known prevalence figures for mental health problems amongst detainee populations. However, certain common mental health conditions, especially those that are stress related and depression would be expected to be high due to a variety of factors that are pertinent to these populations e.g. experience of trauma, stress related to immigration status and likely return to a home country where conditions and circumstances may be challenging.

Other factors likely to have an impact on mental health amongst detainees include emotional problems as a result of being in detention and the consequent negative impact on immigration status, deprivation of liberty and separation from friends and family, boredom and isolation, living in close proximity to others with whom there may be regional or inter-country conflicts. (Amaral, P 2010; Cleveland, J, 2013; Mueller et al, 2010).

For those who are Gay or Lesbian there may be additional problems associated with homophobia, which is higher amongst certain national groups, especially those from Africa. There are also known differential rates of mental illness diagnosis amongst certain ethnic populations.

Stress related health problems are known to be more common for example, Moroccan immigrants in Belgium were found to be five times more likely to develop

peptic ulcers (Muynck, 1997) and stress related ulcers were a frequent source of morbidity amongst migrants in Germany (Huismann et al, 1997).

Other stress related disorders and symptoms reported as being higher amongst migrant populations include frequent and severe headaches, anxiety attacks, skin problems and sleeping disorders (Carballo et al, 1996). For detainee populations there is a very wide range of cultural diversity and this can exacerbate the ability to assess and meet mental healthcare:

> *"There is a shortfall in transcultural care, everything is set up on a UK cultural basis which is realistic but there is a need for greater understanding of the different mental health presentations amongst different ethnic and national groups, for example, reporting of somatic symptoms in place of emotional ones and over reliance on the medical model of care."* (Healthcare staff member, IRC Morton Hall)

The provision of mental health support services differs across IRCs. For example, some have a dedicated primary mental health care team and some have no RMNs on the staffing establishment. The following IRCs were able to provide data on mental health support:

IRC	Mental health booked appts	No seen
Haslar	Data not available	23
Morton Hall	1,640	1,245
Campsfield	Data not available	65
Dungavel	Data not available	97
Yarl's Wood	608	Data not available
Harmondsworth	295 (active case load)	Data not available
Colnbrook	1,080	918

As can be seen from the above table reporting on primary mental health support is inconsistent, apart from IRC Morton Hall, which produces monthly detailed activity reports on mental health support including data on presenting mental health conditions.

Despite the lack of consistency in reporting healthcare staff members across the IRCs identify mental health issues as a priority for healthcare:

> *"The RMNs could do more to support detainees with stress and sleeping problems for example relaxation therapies."* (Healthcare staff member, IRC Campsfield)

"We do an emotional health check when detainees first come in, it is a very anxious time for them, it's like they are grieving, they can be angry too and emotions can run very high." (Healthcare staff member, IRC Dungavel)

"I wouldn't say mental health is the biggest challenge, but we probably need a stronger screening process for this." (Healthcare staff member, IRC Haslar)

"It would be good to have more facility for one to one care in the person's own language, this can be very important for mental health issues." (Healthcare staff member, IRC Morton Hall)

Perceptions about emotional health are less positive than physical health amongst the respondents to the Detainee Health Needs Questionnaire e.g. 155 detainees (39%) perceive their emotional health to be bad or very bad. 241 detainees (61%) perceive their emotional health to be OK, good or very good:

Emotional Health (N = 403)					
Rating	1 Very good	2 Good	3 OK	4 Bad	5 Very bad
Number of Detainees	41 (10.5%)	77 (19.5%)	123 (31%)	99 (25%)	56 (14%)

One of the factors related to perceptions about health and wellbeing is how comfortable detainees would feel talking to others about health problems. Significant numbers of detainees do not feel comfortable telling others if they were worried about their health e.g. 167 detainees (42.5%) would be unhappy or very unhappy telling others:

If you were worried about your health, how comfortable would you feel telling others? (1= Very unhappy and 5 = Very happy) N = 393 (10 detainees did not reply to this question)					
Rating	Very unhappy	Unhappy	OK	Happy	Very happy
Number of Detainees	68 (17.5%)	99 (25%)	149 (38%)	56 (14%)	21 (5.5%)

Less detainees report having been asked about their emotional health than their physical health e.g. 163 detainees (41%) report that they were not asked about their emotional health:

When you first entered this IRC did anyone ask you about your Emotional or Mental Health? (N = 403)		
Yes	230	57%
No	163	40.5%
Not answered	10	2.5%

More than one third of detainees report having asked for help at the IRC because they felt unhappy, stressed or worried:

Have you asked for help at this IRC because you felt unhappy, stressed or worried? (N = 403)

Yes	146	36%
No	243	60%
Not answered	14	4%

20% report having seen a doctor at the IRC about an emotional or mental health problem:

Since being at this IRC have you seen a Doctor about any Emotional or Mental Health problems? (N = 403)		
Yes	79	20%
No	313	78%
Not answered	11	2%

Amongst those reporting they saw a doctor 48 (61%) responded to the question about waiting times. 24 detainees (50%) report that the waiting time was less than two days:

How long did you have to wait to see the Doctor? (N = 48)		
Less than 24 hours	13	27%
Between 1 and 2 days	11	23%
Between 3 and 7 days	18	37.5%
2 weeks or more	6	12.5%
More than 1 month	0	-

A quarter of detainees report having seen a nurse about an emotional or mental health problem:

Since being at this IRC have you seen a Nurse about any Emotional or Mental Health problems? (N = 403)		
Yes	96	24%
No	290	72%
Not answered	17	4%

58 of those saying they saw a nurse (60%) replied to the question about waiting times. Amongst these:

How long did you have to wait to see the nurse? (N = 58)		
Less than 24 hours	30	(52%)
Between 1 and 2 days	9	(15.5%)
Between 3 and 7 days	13	(22.5%)
2 weeks or more	4	(7%)

More than 1 month	2	(3%)

One of the factors associated with poor emotional or mental health is being unable to sleep. 51% of detainees report having problems sleeping:

Do you have trouble sleeping? (N = 403)		
Yes	202	51%
No	157	39%
Not answered	44	10%

15.1 Serious mental illness

Incidents of serious mental illness are reportedly very low e.g. less than 6% of mental health cases. There are also very low numbers of detainees reported as having been transferred to hospital under the Mental Health Act e.g. one or two a year at most.

However, not all IRCs report on the classification of illness or condition for those presenting for mental health support. Amongst those that do the following have been identified:

IRC	Depressive disorder	Psychotic disorder	Only classified as SMI
Haslar	23		
Morton Hall	81	61	
Campsfield	6		
Dungavel	125	13	
Yarl's Wood	112		42

As can be seen from the above table the reporting of serious mental illness lacks clarity on diagnostic classifications. The majority of presentations are for depression but this may also include common depression as opposed to clinical depression as these are not distinguished in the reports.

16 Allegations of torture

An issue that correlates strongly with mental health is that of alleged torture or abuse. The response to allegations of torture in IRCs is governed by Rule 35 of the Detention Centre Rules 2001 under Special illnesses and conditions (including torture claims) which states:

1. The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.
2. The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained

person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.

3. The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.
4. The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.
5. The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care.

(Detention Centre Rule, Statutory Instrument, 2001: 238. Part II Health Care, Rule 35) Section 55.8A of the Enforcement Instructions and Guidance states the Rule's purpose:

> *"The purpose of Rule 35 is to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention. The information contained in the report needs to be considered in deciding whether continued detention is appropriate in each case."*

The definition of torture is based on case law:

> *"Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based upon discrimination of any kind."* (EO and Others v SoS HO (2001) EWHC 1236 (Admin).

The actions and considerations required by the medical officer at the IRC after receipt of an allegation of torture are intended to ensure timely and accurate responses. These responses are mandatory and include: Review the report on receipt:

- If the medical practitioner clearly states that the report reflects a repeated claim or assertion rather than a reasoned medical concern (the practitioner is entitled to do this), the report must be considered, although it will likely carry less weight as a consequence);
- If the report states that it raises a medical concern, but contains insufficient content to understand the medical concern, meaningful consideration of the report will not be possible (such a view must not be reached lightly). In such cases, telephone the Home Office contact management team in the IRC immediately and ask them to obtain sufficient information from the IRC medical practitioner for meaningful consideration, and to repeat the issuing process.

(Enforcement Instructions and Guidance, Section 2)

- An assessment under Rule 35 should trigger an immediate review of detention:
- Consider the issues raised, and conduct a detention review in line with published detention policy;
- Take prompt action to release the detainee if appropriate (which will include if the report amounts to independent evidence of torture and if no very exceptional circumstances apply);
- Where there are additional unit or directorate specific requirements as regards obtaining management approval for releases, or for notifying releases, these must be followed (Ibid)

Under the Enforcement Instructions and Guidance detention where there is independent evidence of torture will only be justified in exceptional circumstances e.g. there is a high risk of the detainee absconding and/or poses a risk to public safety (EIG Ch. 55.10).

Not all IRCs had robust arrangements in place for ensuring healthcare staff including both GPs and nurses received adequate training in recognising symptoms of torture and using the correct reporting procedures.

These assessments are complex and need to be handled with care and sensitivity. It is possible that medical staff and mental health team members on the healthcare team will be dealing with people who do not meet the classification for torture but have nevertheless been subject to violent abuse, including sexual abuse.

> *"People from certain geopolitical situations are much more likely than others to have experienced torture. In contrast to the estimated 5 per cent of Australians who develop PTSD following trauma, studies on overseas populations exposed to high rates of torture have found rates of PTSD in excess of 30 per cent, often accompanied by elevated levels of anxiety, social dysfunction and severe depression".* (DIAC. 2007. Detention Health Framework: A policy framework for health care for people in immigration detention. Department of Immigration and Citizenship. Australia. Page 44)

Medical officers undertaking the Rule 35 assessment do not have to be trained in standards relating to allegations of torture but this should not detract from the relevance or validity of the report.

However, determining whether or not there is independent evidence of torture can be challenging, the guidance provides the following pointers for staff undertaking the assessment:

- A report which simply repeats an allegation of torture will not be independent evidence of torture;

- A report which raises a concern of torture with little reasoning or support or which mentions nothing more than common injuries or scarring for which there are other obvious causes is unlikely to constitute independent evidence of torture;

- A report which details clear physical or mental evidence of injuries which would normally only arise as a result of torture (e.g., numerous scars with the appearance of cigarette burns to legs; marks with the appearance of whipping scars), and which records a credible account of torture, is likely to constitute independent evidence of torture. (EIG, Part 3 i)

Diagnosis and identification of Post Traumatic Stress Disorder (PTSD) is poorly recorded across all IRCs. This is potentially an important mental health classification for assessment of mental health need amongst this population:

> *"People with acute stress disorder and PTSD will not necessarily mention the fact that they have had a traumatic experience when they first see a doctor or another health professional. They may present with any of a range of problems, including anger, relationship problems, poor sleep or physical health complaints such as fatigue, headaches or gastrointestinal problems. The distress and stigma associated with mental health problems or traumatic events may prevent some people from talking about their experience"*[15]. (DIAC. 2007. Detention Health Framework: A policy framework for health care for people in immigration detention. Department of Immigration and Citizenship. Australia. Page 44)

17 Substance Misuse

17.1 Illegal drug use

The European Union has seen increasing numbers of problematic drug users migrating e.g. this has been reported in the UK (Lipsedge and Turner, 1990) and in Holland half of all methadone bus programme users were foreign born (de Jong, 1994).

Drug use has also become an increasing problem in prisons. Nationally, research shows that 81% of prisoners said they had used illicit drugs at some point prior to entering prison, including almost two-thirds (64%) within the month before entering prison.[16] Over half have used cannabis and a third had used heroin and /or crack cocaine.[17] Around 6% reported that they had developed a drug problem since their arrival[18].

However, although some detainees do come from prison environments there is reportedly very low use of drugs amongst detainee populations in IRCs.

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[15] Australian Centre for Post traumatic Mental Health (2007). Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Post-traumatic Stress Disorder: Practitioner Guide, Australian Centre for Posttraumatic Mental Health, Melbourne. www.nhmrc.gov.au/publications/synopses/mh13syn.htm

[16] Surveying prisoner crime reductions (SPCR) in the 2010 compendium of reoffending statistics and analysis, MOJ statistical bulletin www.justice.gov.uk/publications/compendium-reoffending)

[17] Stewart, D. (2008) The problems and needs of newly sentenced prisoners: results from a national survey. London: Ministry of Justice

[18] HM Chief Inspector of Prisons for England and Wales Annual Report (July 2013) London: The Stationary Office

IRC	Substance Misuse No of detainees seen	% Population	No of detainees treated for withdrawal
Haslar	0	0	0
Morton Hall	37		Data not available
Brook	7		Data not available
Tinsley	2		2
Cedars	0		0
Dover	Data not available		Data not available
Campsfield	17		Data not available
Dungavel	Data not available		4
Yarl's Wood	20		0
Harmondsworth	45		Data not available

It is reported that six appointments are made to the Substance Misuse clinic a week at Colnbrook (312 a year) but actual data and attendance rates were not available.

The above numbers are equivalent to less than 0.5% of the total detainees for the previous year Assuming Colnbrook had a 50% DNA rate the figure would be 1%.

Amongst respondents to the Detainee Health Needs Questionnaire 9% (35 detainees report having used illegal drugs before entering the IRC. Amongst these 51% (18 detainees) report having used more than one substance 57% (20 detainees) report being worried about their drug use and 43% (15 detainees) report having asked for help at the IRC with their drug use. If these figures were carried over into the total detainee population it would equate to 2,738 having used illegal drugs with a potential demand for help of 1,177 detainees.

Less than 10% of detainees report having used illegal drugs:

Before entering IRC Morton Hall had you used illegal drugs? (N = 403)		
Yes	35	9%
No	356	88%
Not answered	12	3%

Amongst those who reported using drugs nearly half (48.5%) report having used more than one drug:

Had you regularly used more than one drug? (N = 35)		
Yes	17	48.5%
No	18	51.5%
Not answered	0	-

13 of those who had used drugs (37%) report being worried about their drug use:

Are you worried about your drug use? (N = 35)		
Yes	13	37%
No	22	63%
Not answered	0	-

9 detainees who reported having used drugs had asked for help since being at the IRC:

Have you asked for help about your drug use at this IRC? (N = 35)		
Yes	9	26%
No	25	71%
Not answered	1	3%

The Detainee Health Needs Questionnaire data suggest much higher rates of problematic drug use than is being identified or responded to in the IRCs. This may be a result of variances in training and staff competency amongst IRC healthcare staff e.g. not all are trained to RCGP Level 1 or 2. This would also impact on healthcare staff competency in using validated assessment tools such as COWS in assessing detainees on entry to the IRC.

Other factors that would mitigate detainees willingness to come forward and admit to having a drug problem would include cultural and religious taboos regarding illegal drug use and fear of recriminations e.g. it could be perceived as something that would go against their case for seeking asylum.

17.2 Alcohol use

There is some evidence that rates of alcohol problems are lower amongst migrant communities but that when alcohol problems do occur they are often more severe (Greenslade et al, 1995; Mullen at al, 1996).

There is very little reporting of alcohol use problems amongst the detainee population though Yarl's Wood reported treating 10 detainees for alcohol withdrawal.

Contrary to what might be expected there are larger numbers of detainees reporting alcohol, some at problematic levels amongst respondents to the Detainee health Needs Questionnaire:

Drinking frequency	No detainee	% of respondents
2 – 3 times a month	92	23%
2 – 3 times a week	25	6%
More than 4 times a week	12	3%
Every day	22	5%

Those drinking between 4 times a day and every day is 8% (34 detainees). Amongst the total number reporting having drunk alcohol:

Before entering this IRC how often did you drink alcohol? (N = 403)		
Never	229	57%
2-3 times a month	92	23%
2 – 3 times a week	25	6%
More than 4 times a week	12	3%
I drank alcohol every day	22	5%
Not answered	23	6%

If these rates were carried over to the total detainee population it would equate to 2, 434 detainees potentially having an alcohol problem with approximately 1,125 seeking help.

Amongst those admitting to consuming alcohol 12 detainees (8%) report having asked for help at the IRC:

Have you asked for help at this IRC with your drinking? (N = 150)		
Yes	12	8%
No	126	84%
Not answered	12	8%

Similarly to illegal drug use it is likely that cultural barriers and fears of recrimination on asylum cases would inhibit detainees from coming forward about alcohol problems. As can be seen, even amongst a population with strong cultural and religious prohibitions against drinking alcohol 37% do admit to drinking alcohol and 5% report having drunk every day.

There are also variances in staff competencies and knowledge on identifying and addressing alcohol problems.

18 Social vulnerability factors

18.1 Bullying and harassment

This data has been compiled from HMIP reports.

IRC	Feeling threatened or intimidated		Sample size	Inspection dates
	By other detainees	By staff		
Haslar	10%	6%	92	February 2014
Morton Hall	14%	15%	142	March 2013
Brook	11%	12%	216	June 2013

Tinsley	9%	4%	86	October 2012
Cedars	Survey data not published			January 2014
Dover	8%	13%	148	March 2014
Campsfield	Survey data not published			May 2011
Dungavel	11%	1%	129	June 2010
Yarl's Wood	9%	10%	203	June2013
Harmondsworth	7%	11%	229	August 2013
Colnbrook	20%	21%	194	February 2013
Pennine House	Survey data not published			May 2013
Larne House	Survey data not published			November 2013

The IRC comparators are 19% for feeling threatened by other detainees and 15% for feeling threatened by staff.

The only significant outlier is Colnbrook for detainees felling threatened by staff (19% compared to IRC comparator of 15%):

> *"Most detainees reported feeling insecure and unsafe, but perceptions of safety had substantially improved since the previous inspection. The number of violent incidents had decreased and the atmosphere in the centre was calmer, despite the many vulnerable and frustrated detainees held".* (HMIP Unannounced Inspection Report IRC Colnbrook 2013. Page 19. 1.20)

Most of the HMIP Inspection reports found that detainees felt safe:

> *"Detainees reported feeling safe in the centre. Levels of violence, bullying and antisocial behaviour were very low. The centre carried out some analysis of the low number of reported incidents, but had no improvement plan for safer custody. The policy document was comprehensive but not written in plain English. The behaviour improvement policy was not used consistently and could*
> *be punitive. Investigations into incidents of bullying were not always carried out and we were not assured that victims were offered adequate support."* (HMIP Unannounced Inspection Report IRC Haslar. 2014. Page 21. 1.13)
>
> *"Most detainees reported positively on levels of safety in the centre. The collection of data relating to violent incidents was improving but the violence reduction strategy was not fully informed by an analysis of the patterns of violence in the centre. The safer detention meeting was not a sufficiently effective forum, but weekly order and control meetings discussed violent incidents, and the security department was fully engaged in monitoring and coordinating interventions to minimise violence".* (HMIP Announced Inspection Report IRC Morton Hall. 2013. Page 19. 1.20)
>
> *"In our survey, most detainees were positive about safety. The number of physical assaults and bullying incidents was low and there were no identifiable trends or patterns of behaviour. Investigations into incidents were thorough but anti-bullying records were of variable quality. A well-attended safer*

community group meeting considered detailed violence reduction data. A safer community orderly performed a valued role". (HMIP Announced Inspection Report IRC Tinsley House. 2012. Page 18. 1.19)

"We were told that bullying of detainees had not occurred in the centre and we did not find any evidence that it had. High levels of supervision and low occupancy contributed to providing a safe environment". (HMIP Unannounced Inspection Report IRC Cedars 2014. Page 22. 1.19)

"The anti-bullying policy had recently been revised and staff we spoke to had a basic understanding of it but not enough had been done to publicise the changes. The revised policy had been distributed and all staff were expected to sign to confirm they had read it but few had actually done so. Entries in bully monitoring logs recorded the mood of the alleged bully rather than any interactions. We repeat the recommendation". (HMIP Unannounced Inspection Report IRC Campsfield House 2011. Page 19. 2.42)

"Dungavel remained a safe and respectful centre, with good activities to engage detainees. With the exception of preparing detainees for release, the centre had not rested on its laurels but had actively worked to improving outcomes for detainees. Improvements in reception, health care, teaching and work places were particularly welcome, as was the introduction of a first night centre and interventions to help detainees overcome the frustrations of detention". (HMIP Unannounced Inspection Report IRC Dungavel 2012. Page 6)

"Detainees felt safe and there was little evidence of any victimisation, although there had been insufficient attempts to explore what appeared to be under-reporting of intimidation. A new, more individualised approach was being taken to investigate and monitor such behaviour, but this was not yet expressed in an up-to-date published policy". (HMIP Unannounced Inspection Report IRC Yarl's Wood 2013. Page 21. 1.26)

"Safer detention meetings were productive but poorly attended. Monitoring of trends was good. Our survey results on safety had improved since the previous inspection. The number of fights and assaults was fairly low and they were of a relatively minor nature. Investigations into bullying and violent incidents were good". (HMIP Unannounced Inspection Report IRC Harmondsworth 2013. Page 23. 1.19)

"Most detainees told us they felt safe. There was a cooperative atmosphere and staff were available along the main corridor, in the dining or TV rooms at most times. There had been no recorded incidents of bullying in the centre since our last inspection. However, women could not lock their doors and felt more vulnerable". (HMIP Unannounced Inspection Report Pennine House STHF 2013. Page 11. 1.20)
"There was little evidence of bullying and victimisation; however, both men and women were held at the facility and neither could lock their bedroom doors. CCTV in the corridor did not address the risk to women of men entering

their rooms. Detainees we spoke to felt safe". (HMIP Unannounced Inspection Report Larne House STHF 2013. Page 7. S3)

Detainees were reported to be concerned about levels of personal safety in IRC Brook House and IRC Dover:

> *"In our survey, about a third of detainees said that they currently felt unsafe, which was similar to the proportion at other centres. The number of violent incidents was similar to that at other centres, and bullying was rare. Victims received reasonably good support. Structures to identify bullying and violence were sound. A wide range of data was collated and analysed for trends at monthly meetings. A safer detention survey had not been conducted since 2012 and the violence reduction policy was out of date".* (HMIP Unannounced Inspection Report IRC Dover 2014. Page 19. 1.21)

> *"In our survey, a third of detainees said they did not feel safe and significantly fewer than the comparator said they had been victimised, intimidated or threatened. However, there was evidence of under-reporting of incidents. Analysis of data was limited but a recently introduced violence survey provided a good source of intelligence. Investigations were adequate but there was no constructive intervention to change behaviour".* (HMIP Unannounced Inspection Report IRC Brook House. 2013. Page 21. 1.22)

18.2 Safeguarding

While most of the IRCs have some form of safeguarding policy there are reportedly variances in staff understanding and training on this area:

> *"Staff were less clear on whether there was a safeguarding lead within each centre and on external reporting arrangements. Staff were unclear on the role and function of the Local Area Designated Officer (LADO), and on the roll of the Local Safeguarding Board (LSB)".* (Harmondsworth and Colnbrook HNA. Page 67)

> *"It was reported that Healthcare staff attend as many ACDT reviews as possible, although not all staff had received training around safeguarding".* (HWBNA Report IRC Dover. Page 57)

Some good practices were identified:

> *"There are appropriate adult safeguarding and children's safeguarding strategies/policies in place. There is a particularly strong child-centred ethos and approach in Cedars, and appropriate safeguarding and child protection procedures. Safeguarding meetings, both adult and children are held across all three centres, as appropriate. The manager responsible for safeguarding children met Gatwick Children's Services each quarter and a memorandum of understanding had been established between the IRCs and Children's Services. A Home Office regional manager attended the West Sussex Local Safeguarding Children Board. Notices around the centres reminded staff of their duty to safeguard and promote the welfare of children. The safeguarding*

children manager delivered comprehensive safeguarding training to all staff and some staff also took the NSPCC 'Child protection: staying aware' course. Resource packs on safeguarding had also been produced for all managers". (HWBNA Report IRC Brook, Tinsley and Cedars. Page 80)

However, most IRCs have underdeveloped arrangements for notifying the Local safeguarding Board and/or relevant officers when a detainee who may be vulnerable has been released into the community.

19 Equality and Diversity

Equality and diversity monitoring is normally managed by the IRC staff and there are variances in the degree to which healthcare services utilise these data as part of their own service monitoring and planning.

19.1 Age

Some IRCs have developed nurse led older person's clinics but the percentage of detainees over the age of 55 is low:

Age of Detainees										
	Morton Hall		Haslar		Brook		Tinsley		Dover	
AGE	No	%	No	%	No	%	No	%	No	%
18 – 21	26	7%	18	13.8%	44	11.4%	12	10.81%	13	4.6%
22-29	144	40%	61	47.1%	156	40.5%	46	41.44%	135	48.2%
30-39	122	34%	36	27.6%	107	27.8%	27	24.33%	87	31.0%
40-49	48	13%	10	7.7%	60	15.9%	12	10.81%	29	10.4%
50-59	18	5%	5	3.8%	15	3.9%	13	11.71%	9	3.2%
60 69	4	1%	0	-	3	0.8%	1	0.9%	4	1.4%
70 and over	-	-	0	-	0	0%	0	0%	1	0.3%
TOTAL	362	100%	130	100%	385	100%	111	100%	280	100%

Age of Detainees								
	Campsfield		Dungavel		Yarl's Wood		Harmondsworth	
AGE	No	%	No	%	No	%	No	%
18 – 21	8	9%	11	5%	10	3%	59	10
22-29	41	46%	90	40%	97	34%	237	40
30-39	24	27%	76	34%	87	34%	181	30
40-49	9	10%	34	15%	43	17%	94	16
50-59	6	7%	10	5%	26	9%	18	3
60 69	0	-	2	1%	8	3%	6	1
70 and over	1	1%	0	-	1	0.3%	0	0
TOTAL	89	100%	223	100%	272	100%	595	100

Pennine House			Larne House		
18 25 years	991	25.69%	18 25 years	117	24.12%
26 35 years	1766	45.79%	26 35 years	203	41.86%
36-45 years	695	18.02%	36-45 years	113	23.30%
46 55 years	295	7.65%	46 55 years	37	7.63%
56 65 years	91	2.36%	56 65 years	12	2.47%
66 75 years	19	0.49%	66 75 years	3	0.62%
TOTAL	3,857	100%		485	100%

Data on age of detainees was not available for Cedars and Colnbrook. Age data for Pennine and Larne is recorded in different categories to the other IRCs. As can be seen from the above tables the majority of detainees are young e.g. amongst the total sample of 2,447 detainees (excluding Pennine and Larne):

- 1,183 (48%) are below the age of 30
- 150 (6%) are over the age of 50

There is very little evidence of healthcare services being targeted at the younger age range of detainees.

19.2 Ethnicity and national origin

The ethnicity and nationalities of detainees are immensely diverse. Most equality monitoring tends to be focused on nationality rather than ethnic group but the following table shows which IRCs have identified ethnic groups:

Ethnic group of detainees										
	Morton Hall		Haslar		Campsfield		Dungavel		Colnbrook	
AGE	No	%	No	%	No	%	No	%	No	%
Asian Indian	42	11%	14	10.8%	13	14.6%	29	14%	43	12%
Asian Pakistani	38	10%	20	15.4%	8	9%	53	25%	85	24%
Asian Bangladeshi	25	6%	18	14%	24	27%	25	12%	32	9%
Asian – Other Asian	40	10%	7	5.4%	12	14%	12	6%	15	4.2%
Black Caribbean	18	4.5%	2	1.5%	1	1%			16	4.5%
Black African	63	16%	25	19.2%	13	15%	53	25%	58	16%
Black – Other Black	7	2%	1	0.8%	2	2.4%	-	-	24	6.7%
Asian Chinese	16	4%	8	6%	3	3%	18	8%	11	3%
Other Arab	22	6%			-	-	12	6%		
White – Other White	66	17%	11	8.5%	4	4.5%	9	4%	16	4.5%
Mixed – White and Black African	2	0.5%	7	5.4%	3	3%	-	-		
Mixed – White and Black Caribbean	2	0.5%	2	1.5%	0	-	-	-		

Mixed – White and Asian	2	0.5%	1	0.8%	0	-	-	-		
Mixed – Other Mixed	11	3%	2	1.5%	5	5.5%	-	-	4	1%
Any other ethnic group	29	7.5%	7	5.4%	-	-	-	-	51	14.3%
Prefer not to say	6	1.5%	5	3.8%	1	1%			1	0.2%
TOTAL	389		130		89		211		356	

The remaining IRCs record nationalities:

Nationality of Detainees – Brook, Tinsley, Dover, Yarl's Wood, Harmondsworth		
NATIONALITY	No	%
Afghanistan	127	7.6%
Albania	48	3%
Algeria	43	2.5%
Bangladesh	183	11%
China	105	6%
Eritrea	16	1%
Gambia	23	1.4%
Ghana	36	2%
India	186	11%
Iran	18	1.4%
Iraq	11	0.5%
Jamaica	40	2.4%
Nigeria	123	7.5%
Pakistan	291	17.5%
Sierra Leone	26	1.5%
Sri Lanka	22	1.3%
Sudan	14	1%
Turkey	9	0.5%
Vietnam	23	1.4%
Other	314	19.5%
TOTAL	1,662	

The data was not available in table format for Cedars but it is reported: "during 2013 there were 18 different nationalities and the top four nationalities were Albania, followed by Nigeria, Pakistan and China, respectively". (HWBNA Report IRCs Gatwick – Brook House, Tinsley House and Cedars. Page 25).

The data for Pennine House and Larne House is for the full year so this is shown separately below:

Pennine House	Larne House

Nationality	No	%	Nationality	No	%
China	258	6.69	China	93	19.18
Pakistan	1607	41.66	Pakistan	43	8.87
Nigeria	188	4.87	Nigeria	42	8.66
India	404	10.47	Albania	24	4.95
Bangladesh	400	10.37	Bangladesh	36	7.42
Other Australasia	73		Other Australasia		
Other Indian Subcontinent	315		Other Indian Subcontinent		
Middle East	95	2.46	Middle East	28	5.77
Other Africa	298	7.73	Other Africa	97	20.00
S America & Caribbean	22		S America & Caribbean		
Europe	138	3.58	Europe	19	3.92
Refugees	7	0.18	Refugees	12	2.47
North America	52	1.35	North America	7	1.44
TOTAL	3,857	100%		485	100%

Approximate numbers of the most dominant ethnic groups in the IRCs shows that:

South Asian = 44%
Black Afro-Caribbean = 22% Other Arab = 15%
Chinese = 13%

With respect to health services there is little evidence of targeted health planning or interventions using ethnicity data and known health issues e.g. although each IRC provides support, care planning and treatment for diabetes this is not assessed in terms of ethnic groups known to be more susceptible such as South Asian.

Some of the healthcare services, such as Morton Hall monitors activity by ethnicity but most do not. This may also have implications for providers and commissioners in demonstrating compliance with the Public Sector Equality Duty of the Equality Act 2010.

The different ways in which ethnicity and nationality are recorded may also provide problems in assessing national activity and health needs. This would be improved if each IRC used the same template based on the standard ONS categories for ethnic groups in addition to monitoring of nationality.

The latter may be important from the perspective of understanding patterns of disease and ill health in the detainee's home country. This may also be significant

with respect to discharge and understanding the health context and prohibitions that detainees may face on return to their home country.

19.3 Gender

The only IRCs to take women detainees are IRC Dungavel, IRC Yarl's Wood, IRC Colnbrook and both Pennine and Larne STHFs.

Some of the IRCs operate Well Man Clinics in which detainees are encouraged to take better care of their health and can have a variety of heath tests undertaken e.g. blood pressure, weight etc. There is less evidence of specific health clinics for women:

> *"Female detainees are asked if they have had a recent smear test but there are no health clinics for women. Healthcare staff members also report that the female detainees are very reluctant to discuss issues of sexual health. Women detainees are also thought to miss out on smear tests in the community due to their illegal status:*
>
> *"Women avoid getting smear tests because of their illegal immigration status, they avoid most health checks." (Healthcare staff member)* (HWBNA Report IRC Dungavel. Page 20).

Other health issues known to effect women from certain ethnic groups includes diabetes:

> *"Among women, diabetes is more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women, compared with women in the general population[19]."* (HNA Report Harmondsworth and Colnbrook. 2013. Page 109).

Some concerns have been raised by the Independent Monitoring Board and HMIP about the detention of women at Yarl's Wood without adequate health screening taking place beforehand:

> *"It is important to remember that Yarl's Wood IRC has become the main removal centre for women. This means that women detained at airports, for example, will be brought directly to Yarl's Wood without, it appears, any kind of health assessment. This has resulted in Healthcare staff having to deal with residents with more complex issues."* In 2012, the Independent Monitoring Board [20] raised this issue and commented:
>
> *"The Board is still concerned at the detention of those with mental health problems. We fail to understand the justification of detaining people with mental health problems and believe detention can only cause a deterioration,*

[19] The Information Centre (2006). Health Survey for England 2004: health of ethnic minorities : www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles-related-surveys/health-surveyforengland/ health-survey-for-england-2004:-health-of-ethnic-minorities--full-rep

[20] Annual Report 2012 Independent Monitoring Board Yarl's Wood Immigration Removal Centre

and we monitored several instances where this was the outcome of a detention."

More recently, the HMIP Inspection Report of October 2013 stated that:

"Several mentally ill women had recently been detained by the Home Office before being sectioned and released from the centre. It was unclear why detention was considered justified at all, given their obvious health needs." (HWBNA Report IRC Yarl's Wood. Page 53).

19.4 Pregnant women

People with darker skins and those whose mothers lacked adequate nutrition during pregnancy and breast-feeding are known to be at risk of Vitamin D deficiency. Asylum seeking women are seven times more likely to develop complications during childbirth than the general population [21], and women's health within this population must also consider other issues such as genital mutilation and higher incidence of rape.

Within Yarl's Wood IRC, Healthcare staff reported that there were 10 pregnant women detained at the time of the HWBNA.

"At Yarl's Wood IRC, the Midwife will attend the IRC on a weekly basis, if required and women are taken to Bedford Hospital for routine scans and any additional medical appointments.

There are clear pathways on how to deal with pregnant women in the IRC for Healthcare staff. However, some Healthcare staff commented that they were concerned about their lack of knowledge in addressing the needs of pregnant women. This is particularly a concern for staff when women are admitted to the IRC unaware that they are pregnant, which may be the result of a rape. Unsurprisingly, these residents can become distressed and will need time to adjust to their pregnancy. Options around the pregnancy, including termination are discussed with the resident, as and when appropriate". (HWBNA Report IRC Yarl's Wood. Page 50).

19.5 Disability

There is limited provision for detainees with disabilities, in particular mobility restrictions in the IRC estate. For example, Pennine House cannot take anyone with mobility restrictions as the accommodation floor can only be accessed by a staircase.

As with other equality monitoring recording of detainees with disabilities is managed by the Centre staff. This is usually done through some form of diversity office or team. There is little evidence of healthcare teams operating their own monitoring system for uptake and use of health services by disability.

[21] Confidential Enquiry in Maternal and Child Health (2004). Why Mothers Die 2000–2002. The Sixth Report of the Confidential Enquiry into Maternal Deaths in the UK. London: Royal College of Obstetricians and Gynaecologists.

There is very little data on learning disabilities amongst the detainee population and screening and assessment tools such as the Learning Disability Screening Questionnaire (LDSQ) have not been tested for use with migrant populations and those with little or no command of English.

Some of the key issues regarding disability include:

Accommodation restrictions:

> *"Morton Hall IRC can cater for detainees with a disability and there is a disabled suite on site to be used where necessary. The Centre's buildings are all on one level, apart from Windsor and Fry Units first floor rooms, which would not be used for anyone with mobility or sight problems".* (HWBNA Report Morton Hall. Page 46)

Lack of data:

> *"There was no current data available on the numbers or types of disability in Colnbrook IRC. Disability does not appear to have been measured as part of recent government report. Learning Difficulty and learning disability are not screened for as a part of the reception screen. Disability is included in local Equality and Diversity policy. Healthcare has wheelchair access via a lift and with clinic room doorways wide enough for wheelchair access".* (HNA Report Harmondsworth and Colnbrook. 2013. Page 18).

> *"In terms of physical disabilities, although there was a clear procedure to identify disability on admission to the centres to address individual needs, none of the centres had a disability register/ log and so no data was available on the number of disable detainees".* (HWBNA Report Gatwick IRCs – Brook, Tinsley House and Cedars. Page 29)

Understanding about appropriate use of assessment questions for disability:

> *"Information provided for this report indicates significantly fewer disabled detainees were identified in 2012 than in 2011. The reduction may be down to a difficulty with perception and defining disabilities. Each new arrival completes a disability questionnaire at reception and this will trigger the opening of a Support Plan (including a Personal Emergency Evacuation Plan if required) for Operational Staff. Previous surveys have picked up more positive responses to the question 'Do you have a disability?' than have been recorded during initial Healthcare Screening. This very issue was discussed at the Centre Managers' meeting in May 2013 and appears to be an estate wide phenomenon. From an operational perspective, it is not clear whether there has been a significant increase or decrease in the proportion of residents with a disability. The management of disabled detainees is currently on the agenda for the Home Office at a strategic level".* (HNA Report Harmondsworth and Colnbrook. 2013. Page 19).

Staff experience and competencies:

"There are no healthcare staff members with learning disability experience. However, there is a process in place for providing vulnerable adults with care planning". (HNA Report IRC Campsfield. 2013. Page 35).

19.6 Religion

More than half the detainee population are Muslim (52%) followed by a wide variety of Christian denominations (21%); Sikh (8%); Hindu (6%) and Buddhist (3.5%). Far less detainees are atheist or agnostic compared to the general population of the UK e.g. 5% of detainees compared to 25% of the UK general population according to the 2011 Census.

Religion of Detainees – Dover, Campsfield, Dungavel, Haslar, Colnbrook, Harmondsworth, Morton Hall, Brook House, Tinsley House		
RELIGION	NO. OF MEN	PERCENTAGE
Muslim	1,314	52%
All Christian	532	21%
Sikh	209	8%
Hindu	149	6%
Buddhist	73	3.5%
Atheist/Agnostic	125	5%
Other	28	1%
Not known	71	3.5%
TOTAL	2,501	100%

The data was not available for Cedars, Pennine House and Larne House, however, it is not thought that the pattern of religious denominations is different.

Religion and faith are important factors in wellbeing and healthcare staff members need to be able to understand religious implications for healthcare treatment. It is also important from the perspective of demonstrating compliance with the Public Sector Equality Duty.

19.7 Sexuality

Estimates of the numbers of people in the UK who are Gay, Lesbian or Bi-sexual vary. The Office for National Statistics (ONS) found that 480,000 (1%) consider themselves Gay or Lesbian, and 245,000 (0.5%) Bisexual (ONS 2008-9). Much less is known about migrant populations and those from other countries.

There is generally much less information about sexual orientation amongst detainees, as questions about sexuality are not routinely asked. Similarly, sexual orientation generally remains the least well-protected characteristic in prisons under the Equality Act 2010[22].

[22] HM Chief Inspector of Prisons for England and Wales Annual Report 2011-12 (17 October 2012) London: The Stationary Office

19.8 Trans-gender

Trans-gender is addressed through the Detention Services Order 11/2012: Care and management of transsexual detainees. This states:

> *"Immigration removal centres (IRCs), short-term holding facilities (STHFs), holding rooms and escorting officers must aim to treat transsexual detainees as members of the gender in which they live. Detainees who consider themselves transsexual, and who have undergone, are beginning to undergo, or wish to begin gender reassignment, must be permitted to live permanently in their acquired gender." (1.2 p3)*

19.9 Marriage and civil partnership

Data on marriage and civil partnership is not collected for detainees and it is not generally thought to be relevant.

20 Access to friends and family

Cedars is the pre-departure accommodation for children and families, which opened in 2011. The operational capacity is 44 bed spaces. For a family to be eligible to be admitted to Cedars, one of the children must under 18 years of age. Families will stay for up to 72 hours before being removed. This can be extended to one week with express ministerial authority.

The charity Barnardo's provides welfare and social care services to the families and children in the Centre. There are permanent operational staff based at the Centre, regardless of whether families are resident at the Centre or not. However, if there are no families at the Centre the Healthcare staff are redeployed to work at either Tinsley House or Brook House.

For other detainees access to family and friends is regarded as very important and this can be challenging due to the rapid churn of detainees across the IRC estate and travel times involved for family and friends to visit detainees.

Feedback from detainees in the HWBNA process highlights greater access to friends and family as the most significant factor that would improve their health and wellbeing.

112 respondents to the Detainee health Needs Questionnaire identified factors that they believed would help improve their health. More than a third identified more access to friends and family:

- More access to friends and family (35%)
- More access to the gym (28%)
- Better food and improved diet (21%)
- More and improved access to professional help (15%)
- Other including release, improved sleep, access to outside spaces and medication (10%)

21 Healthcare services and engagement with detainees

There are various arrangements by which IRC healthcare staff members engage formally with detainees about healthcare. A number of services have tried specific healthcare forums but generally these have not been well attended and most have opted to use the standard detainee consultative forums. The problem with the latter is that healthcare is one of a number of agenda items and there may not always be scope to explore detainee issues in detail.

Formal engagement with detainees beyond the clinical encounter is important in order to ensure that:

- detainees remain aware of the health services available and how to access them;
- detainees receive updated information about health promotion and the control of communicable diseases;
- detainees are able to express their views as to what is important to them in terms of healthcare and have the opportunity to share their views on healthcare services and their development in a formalised way providing feedback on any issues raised.
- Some IRC health services operate their own periodic customer satisfaction surveys and some have separate systems by which detainees may make complaints about healthcare. However, feedback from detainees in focus groups shows that understanding about how to make complaints about healthcare are not always well understood:

  > *"I don't know how to complain, I wouldn't know what to do."* (Detainee, Focus Group)
  >
  > *"You have to complain through someone else, can't do it yourself*." (Detainee, Focus Group)
  >
  > *"We have no power to talk about complaints, if you raise something then you are removed, shipped out to another IRC." (*Detainee, Focus Group)
  >
  > *"Complaining doesn't make a difference, we need solutions."* (Detainee, Focus Group)

Healthcare staff members are aware of the issues and different teams have been developing responses to try and make the complaints process easier and more transparent:

> *"The team at Colnbrook suggested that they would welcome a dedicated pigeonhole for the receipt of complaints, and the use of a more robust tracking and audit process (use of email to send/ receive complaints). The development of a service directory and/or information leaflet (in multiple languages) could assist detainee understanding of the processes, in managing the expectations of healthcare, and in detailing timeframes that healthcare operate within".* (HNA Harmondsworth and Colnbrook. Page 66)

As a general rule of thumb those IRCs with good detainee engagement e.g. regular dedicated healthcare forums and other means by which detainees can provide feedback produced more engagement in terms of questionnaires returned and focus group attendance for the HWBNA process.

Good service user involvement is vital and it is important that an effective way to obtain the views of detainees is found on an ongoing basis if accurate data gathering on health needs is to be obtained over time.

Therefore, other ways of obtaining detainees views needs to be found, for example, regular annual surveys, in a variety of languages, using independent or voluntary sector organisations to capture the view of detainees may be more successful.

22 Conclusions

The detainee population is unique and presents particular challenges for commissioners and providers in identifying and meeting health and wellbeing needs. These challenges are particularly important in the current context as NHS England completes the transfer of responsibility for healthcare commissioning for IRCs and STHFs across England.

The picture of health needs that emerges from the individual Health and Wellbeing Needs Assessments is of a population that is highly stressed due to their particular circumstances and the fact of being in detention. These circumstances and stresses alongside known variances in health need and disease prevalence for particular ethnic and national groups means that there are a variety of health and wellbeing needs that require sensitive and appropriate responses. These include:

- the potential for communicable diseases to spread or go unchecked due to the likelihood of detainees not having received childhood immunisations;
- aggravation of long term conditions e.g. diabetes due to detainees having avoided contact with formal healthcare services prior to being detained and/or the lack of access to appropriate health services in their home country;
- high levels of stress resulting in poor mental health and associated physical problems e.g. skin disorders, lack of sleep etc.;
- risk factors associated with poor health including smoking, alcohol and drug use;
- cultural and religious barriers making early identification and treatment of sexual and blood borne viruses problematic in particular HIV/AIDS;

Although all detainees have access to primary care services while in detention including GP and Nursing assessments and clinics that are provided within the detention centres there are a number of systemic problems that provide particular challenges to the process of accurately identifying and meeting the health and wellbeing needs of detainees. These include:

- the lack of a national template for initial health screening and assessment;

- reliance on manual data systems that makes compiling health need and service activity data problematic and time consuming;
- inconsistent use of health need recoding systems e.g. not all IRCs and STHFs have a long term condition register and many do not record diagnostic classifications such as READ codes for presenting health problems;
- the range of providers and historical commissioning arrangements means that there are variances in the type of service configurations across IRCs and STHFs;
- the short length of staff for detainees and numbers transferring internally within the system inhibits continuity of care;

Appendix A: Terms of Reference for the HWBNA

1. Introduction

1.1. The National Institute for Health and Clinical Excellence (NICE) defines a health needs assessment (or a health and well-being needs assessment (HWBNA)) as 'a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities' (Health needs assessment: a practical guide, NICE, 2005.)

1.2. The HWBNA to be carried out in this IRC will provide an opportunity to make the health services better able to respond to appropriate health and well being needs of detainees; to identify any newly-emerging needs and to take account of the increasing knowledge base about effective healthcare interventions and implications for the IRC environment

2. Scope of the Health and Wellbeing Needs Assessment

2.1. This HWNA will consider a range of issues, including:

- The characteristics and demographics of detainees;
- The physical health needs of this population;
- The mental health needs of this population;
- The needs of detainees with learning disabilities;
- The needs of detainees with substance misuse problems e.g. drugs, alcohol and prescription medications;
- The needs of groups with protected characteristics as defined by the Equality Act 2010;
- Current health referral and delivery pathways and service provision;
- Identification of any gaps in current health service provision;
- The working surroundings, facilities and workforce requirements for healthcare;
- The quality of data, including gaps, and the IT systems used;
- Clinical governance;
- Safeguarding issues;
- Liaison between IRC staff and healthcare staff;
- Liaison with other agencies.

2.2. Community Innovations Enterprise (CIE) have been commissioned to deliver this HWBNA. CIE will provide a series of recommendations, based on analysis of the findings from the above with the aim of suggesting areas for improvements to healthcare service provision and ways of better meeting the health needs of detainees. The final report will aim to cover the following areas:

- The purpose of the HWBNA, an outline of the methods used and the main policy drivers;

- A description of the IRC, including the facilities, a description of the detainees (age, gender, ethnicity), legal status and length of detention, movement in and out of the IRC and so forth.
- Review of current healthcare service provision and gaps, including the current response to health needs, workforce issues, working surrounding/facilities, processes for promoting health such as information sharing, integrated working, safeguarding issues and implications of meeting health needs in an IRC environment e.g. continuity of care;
- The assessment of health and wellbeing needs, including physical health needs, emotional and mental health needs, substance misuse needs and health needs related to other vulnerability factors;
- Outline of the stakeholder consultation process, the detainees' consultation process and the
- analysis carried out and the final recommendations.

3. Methods to be used in the Health and Well-Being Needs Assessment

3.1. This work programme will be carried out using the three main methods of epidemiological, corporate and comparative health needs assessment that will be familiar within the NHS:

- The epidemiological needs assessment this includes of a review of various medical records, a review of clinical activity and services and a literature review for evidence of effectiveness.
- The corporate needs assessment this consists of consultations with key stakeholders, including healthcare staff and the views of detainees.
- The comparative needs assessment this will include comparing existing services and need against current healthcare standards and targets.

3.2 A range of tools will be used to collect the best possible information, including

- National and local intelligence gathering, including:
    - Review and analysis of national and local policy statements, national and local research studies, inspection reports and any previous needs assessments conducted within the IRC.
    - Review and analysis of variables such as age, gender, ethnicity, reason for referral to healthcare services, the nature and duration of interventions provided, and outcomes/results.

- Stakeholder Consultations will be carried out using individual interviews and/ or group discussions. The particular methods chosen will be those that are most appropriate for consulting with the different people that need to be involved in this HWBNA, including healthcare staff, NHS commissioners, etc. The staff interviews will include people from different strands of the service and at different levels of seniority, as appropriate.
- Focus group/questionnaires with detainees – The views of detainees are considered important for completion of the HWBNA. Only CIE staff with the appropriate security clearance will have access to detainees. IRC Healthcare

staff can be present at these interviews/focus groups. Use of a self completion questionnaire will also be considered where appropriate.

- Service Mapping – This will be used to map the referral and delivery pathways, the custodial environment and current service provision for the various populations.
- Case studies – These may be used, if appropriate, to help describe and comment on the experiences of different groups of detainees to bring to life the impact of their needs and circumstances.

4. Timescales

4.1. The proposed timescale outlined below is based on the availability of data sources and access to staff/stakeholders to carry out interviews and access to detainees via focus groups or questionnaires. With this caveat, we propose the following timeframe for the completion of this HWNA.

- Phase 1 – 2 months: Setting up staff/stakeholder interviews and detainee focus groups, and beginning data collection.
- Phase 2 – 2 months: Carrying out staff/stakeholder interviews and detainee focus groups.

Further data collection.

- Phase 3 – 1 month: Completing data collection, final staff/stakeholder interviews and carrying out analysis. Commence production of report.
- Phase 4 – 1 month: Production of final report completed.

5. Delivery of the IRC HWBNA Work Programme

5.1. The work programme will be led by Dr Jon Bashford from CIE who will be assisted by appropriate staff from CIE with clinical backgrounds and experience of HWNAs, and in carrying out stakeholder interviews and detainee focus groups. All CIE staff have undergone an appropriate DBS check. Dr Bashford and Sherife Hasan will have the additional Home Office security clearance required for access to IRC detainees prior to any contact with detainees.

Appendix B: Healthcare staff interview schedule

Background Information

Community Innovations Enterprise has been commissioned by the Home Office and NHS Commissioners to conduct a Health and Wellbeing Needs Assessment (HWBNA). This HWBNA is being carried out so that commissioners can make plans for healthcare and other services, based on a sound understanding of current service provision and people's needs.

Definitions of Health and Wellbeing

In this context, health refers to both physical and mental health, and to the impact of substance misuse.

Confidentiality

The information you share with us will be anonymous and confidential, and will be used to develop an action plan to improve services

QUESTIONS

1. Background Information

1.1 Name:
1.2 Job title/Length of time in post:
1.3 Please give us an outline of your current role and position.

2. Overview of General Service Delivery

2.1 Are healthcare services available 24 hours a day, seven days a week and 365 days of the year? If not, what are the hours of cover across the week?
2.2 Do people with disabilities and/or learning difficulties have specific help to enable them to gain full access to healthcare services?
2.3 How effectively do the healthcare services respond to people where English is not the first language?
2.4 Are healthcare services delivered in conjunction with other agencies including UKBA, NOMS, community services, other healthcare providers, the Health Protection Agency (for communicable disease control issues), and education services?
2.5 Are there emergency plans e.g. flu pandemic plan, outbreak plans, and provision for infection prevention and control programmes?

3. Referrals and Assessments

3.1 Generally, how healthy do you think the people you assess are in terms of their: Physical Health; Emotional Health?
3.2 What tool do you use for carrying out screening for health needs?
3.3 Are assessments and screening tools used to identify people at risk of:
- Mental health problems
- Infectious and/or including blood-borne viruses such as Hepatitis B and C
- Long term conditions e.g. asthma, diabetes, epilepsy
- Sexual transmitted infections including HIV and Chlamydia
- Substance misuse (drug and alcohol) problems

3.4 Do you believe the assessment process is effective for screening for these health needs?
3.5 Do staff undertaking assessments have appropriate training in relevant areas such as mental health and substance misuse (drugs and alcohol)?
3.6 Are communication difficulties and language needs, learning disabilities or learning difficulties identified at this stage?
3.7 Are people given information on the healthcare services and on how to access these services at this stage? Is the information available in different languages

and formats suitable for the population, which takes into account the low literacy levels?

3.8 Is planning for discharge at the time of assessment to ensure continuity of care carried out?

HEALTHCARE SERVICES

4. Healthcare Services Primary Care

Immunisations and vaccinations

4.1 Is there an immunisation policy?
4.2 Are people routinely asked whether they are up to date with childhood immunisations?
4.3 Are people routinely asked about their Hepatitis B infection status?
4.4 Is there a designated nurse lead for immunisations?
4.5 Which immunisations are currently provided e.g. Hepatitis B, measles, mumps rubella (MMR).
4.6 4. How it this information recorded (e.g. SystmOne or manually?)
4.7 Do staff record whether first or second vaccines have been provided?

Oral health

4.8 Is there is dental clinic, and if so, what hours is it open and are there waiting times?
4.9 Are all people offered a dental assessment after entry to the Centre?
4.10 Do people have access to an oral health educator or a professional who delivers oral health education as part of wider health education sessions?

Sight, and hearing

4.11 Is data on the prevalence of visual and auditory impairment recorded?

Speech and Language Communication Therapy

4.12 Is there a process is in place to provide appropriate speech and language communication therapy?

Weight, diet and exercise

4.13 Is the weight of people recorded to monitor both risks of obesity and those who are underweight as a result of neglect?
4.14 What links are there between healthcare professional and catering staff?
4.15 Does the current health promotion activity cover healthy eating?

Long-term health conditions

4.16 Are long-term medical conditions recorded and can data be provided specifically on:

- asthma

- diabetes
- epilepsy
- cardiovascular system (sickle cell disease, heart problem)
- allergies (hay fever, food)
- gastrointestinal system (inflammatory bowel disease (IBD) Crohn's disease or colitis)
- endocrine system (thyroid dysfunction, general development other than diabetes)
- nervous system (orientation, memory, headaches, unsteady gait or fits or faint)
- musculoskeletal system (posture/gait, trauma, breaks and fractures).

Physical disability

4.17 Are the number of people with a physical disability recorded and the type of disability?

4.18 What specific adaptations have been made for people with a physical disability – e.g. are there any adapted rooms for wheelchair users?

Other issues

4.19 What is the process for recording the number of people who have experience an accident or injury during the last 12 months? Can you provide information on the range of injuries sustained?

5. Healthcare Services Sexual Health

5.1 Is there a range of sexual health services are available, including:

- Healthcare advice on sexual health.
- Sexual health screening and risk assessment.
- Contraceptive information and services.
- Chlamydia screening on an opt-out basis.
- HIV testing and counselling.
- Access to a GUM and HIV specialist.

5.2 Is there blood borne viruses (BVV) provision, including:

- BBV immunisation programmes and clinics, appropriate to age range of the young people.
- Hepatitis B immunisation and access to specialist treatment and Hepatitis C testing and access to specialist treatment, as appropriate.

6. Healthcare Services Out of Hours GP

6.1 Is there access to good quality of out-of-hours care?

6.2 Is an out of hours GP service is available?

7. Healthcare Services Nurse Led Services

7.1 Are there nurse led services that provide healthcare services in a range of areas, including:

- Health assessments reception screening, identification and ongoing care planning.
- Health monitoring e.g. blood pressure, blood sugar, weight, peak flows, maintenance of disease registers, specimen collection, wound care, care planning, health advocacy and coordination of care.
- Screening, testing, vaccination, treatment and referral in accordance with NHS Blood Borne Virus policy.
- An immunisation programme including MMR, Hepatitis B and influenza, as well as any other vaccination in response to an outbreak situation (such as meningitis vaccination).
- Health protection/infection control infection control programmes, sterilisation of equipment, infections outbreak management plans, education of staff and prisoners, counselling and appropriate isolation and referral of infected or potentially infected young people.

7.2 Are there nurse led clinics are available, for example for:
Long term conditions e.g. diabetes, asthma, epilepsy or sexual health services

- Minor injuries clinic, including wound dressing, suturing, etc.
- Phlebotomy clinic
- Stop smoking clinic

8. **Health Education and Health Promotion, including Smoking**

8.1 Do people have access to health education, prevention and other health promotion interventions to meet their assessed needs, including mental health promotion and wellbeing; smoking; healthy eating and nutrition; healthy lifestyles, including sex and relationship education, and active living; and, drugs, alcohol and other substance misuse interventions and support.

8.2 What is the level of need for stop smoking services?
8.3 Are there services in place to ensure that people who smoke are encouraged and supported to quit?

9. Family/Carer Involvement

9.1 Is there active engagement with the families/carers?

10. Access to a range of reintegration, resettlement and recovery support services

10.1 If someone is being released into the community how do healthcare services at the IRC liaise with local health services and ensure appropriate care pathways are maintained?

11. Healthcare Services Mental Health

11.2 Is medication and other treatment provided in accordance with a documented care plan and ongoing monitoring of symptoms and regular reviews of progress?
11.3 Are crisis intervention and resolution policy and procedures in place, including the transfer out to a secondary mental health inpatient facility?
11.4 Is access to psychological interventions (such as Clinical Psychology, Occupational Therapy) available?
11.5 How are ACDT (Assessment, Care in Detention, Team working) procedures managed? Is there close liaison with the safer detention/suicide prevention team around the identification, monitoring and management of people at risk of self harm/suicide?

12. Healthcare Services Substance Misuse (Drugs and Alcohol)

12.1 Are there a range of clinical and non-clinical substance misuse (drug and alcohol) services are available?
12.2 Do substance misuse (drug and alcohol) interventions target the main drug(s) of choice, including cannabis and alcohol?
12.3 Are there services for people with dual diagnosis i.e. with a mental health and a substance misuse problem?
12.4 Are people provided with advice and up-to-date information on a range of substance misuse related issues, including:

- Information about different drugs and alcohol, and their effects.
- Advice about stopping drug and alcohol misuse.
- Information on how to reduce the potential harm from drug misuse (e.g. safer injecting and reducing overdose risks).
- How and where to access help for substance misuse problems on release.

12.5 Does treatment include:

- Effective psychosocial interventions
- Stabilisation on substitute opioids (followed by detoxification or maintenance prescribing).
- Prescribing for withdrawal from opioids.
- Stabilisation and withdrawal from sedatives, e.g. benzodiazepines.
- Prescribing for assisted withdrawal from alcohol.
- Treatment for stimulant users, which may include symptomatic prescribing.
- Interventions for alcohol users with pathways from access to discharge, to assist them to remain healthy and be alcohol free.

RISKS AND VULNERABILITIES

13a) Allegations of torture (AOT)

- Is there a specific healthcare policy on handling AOTs? How is this managed? Are there any particular issues that arise from this?
- How common is it for detainees to make allegations of torture? Is there a discreet recording system for these and can outcomes be identified over time?

- Are staff trained in dealing with AOTs? How? Is this reviewed and/or updated regularly?

13. Risk and Vulnerabilities – Self harm and Suicide Prevention

13.1 If there is an incident of self harm, is this appropriately recorded and a team review carried out?

14. Risk and Vulnerabilities – Incidents and Serious Events

- Are policies and procedures in place for the management of all serious and significant incidents?
- Is there a policy that details the procedures that should be followed in the event of a death?
- Are all incidents are reported, recorded and managed in line with NHS guidance?

15. Risk and Vulnerabilities – Learning Disabilities

15.1 Do staff have the knowledge, skills, attitudes and abilities to work with people with learning disabilities?
15.2 If needs around learning disabilities are identified, do staff draw up care plans appropriate to the individual's needs, for their time within the establishment and upon their release into the community?
15.3 Has the healthcare service made:

- Reasonable adjustments including physical barriers to accessing health services?
- Whatever alterations are necessary to policies, procedures, staff training and service delivery?

16. Risk and Vulnerabilities – Complaints

16.1 Are all healthcare complaints dealt with in line with NHS complaints procedures – i.e. complaints are dealt with at the right level and responses are taken seriously and answered as soon as possible?
16.2 Has information be made available to service users and carers as to how to access NHS complaints procedures?
16.3 Is there a system in place to monitor and quality assure the complaints system, which will include the ability to identify common issues; themes and concerns and address these accordingly; timelines for responses; the actual response; and, the overall quality of the resolution?

17. Risk and Vulnerabilities – Equalities

The healthcare service must take positive action to combat discrimination, therefore:
17.1 Is there a suitable equalities policy for the service and have staff been made aware of the necessary procedures and requirements?
17.2 Is there a plan for implementing the policy, detailing what actions are to be taken?

17.3 Have staff received equalities training?
17.4 Are victimisation, discrimination and harassment disciplinary offences?
17.5 Are staff supported if they are discriminated against by a service user or another member of staff?
17.6 Is there a system for monitoring and reviewing the policy?

QUALITY AND GOVERNANCE

Is there a clinical governance framework to ensure patient safety and clinical effectiveness?

18. Quality and Governance Medicines Management

Can the healthcare service demonstrate compliance and provide evidence of the following:

18.1 Clinical Governance

- Reports against complaints, and concerns and incidents.
- Clinical audits in relation to the service provided and details of the completed audit findings and associated action plan.
- Compliance with the Mental Health Act and the Mental Health Capacity Act and any subsequent guidance.
- All treatment is underpinned by research evidence and complies with NICE guidelines and other best practice requirements.
- Written policies, protocols and guidance to support the delivery of all clinical services.
- Regular audit infection control and complies with the national specification for clean NHS premises and the relevant requirements of the Health Act 2006 code of practice for the prevention and control of healthcare associated infections.

18.2 Medicines Governance

- Are medicines management activities provided in accordance with Department of Health guidelines and comply with the Care Quality Commission Outcome 9 Management of medicines?
- Are medicines managed in a safe, legal and cost-effective manner and are there formal medicines management governance arrangements, including the production, review and implementation of policies and Standard Operating procedures to meet the needs of the service, including:
    - Medicines Management within the STC o The safe use and disposal of medicines o The use of any unlicensed medicines
    - Dealing with the pharmaceutical industry
    - Pharmaceutical services including clinical pharmacy services
    - Management of controlled drugs
    - Medicines waste
    - Arrangements for discharge medication and on-going pharmaceutical care post
    - discharge
    - Monitoring and audit of drugs
- Is prescribing in line with the NHS Local Formulary and NICE guidelines?

- Are risk assessments conducted and audits undertaken for medicines management (prescribing and supply processes) to demonstrate compliance with current national and local standards and/or take action to ensure non-compliance is addressed?
- Are all staff engaged in the use of medicines educated/trained to meet the required competencies to fulfil their responsibilities and is this is recorded?
- Are all medicines incidents, complaints or concerns are investigated, reported to the commissioner and action taken to address these?
- Are systems in place in accordance with current medicines legislation, guidance and agreed policies and procedures?
- Are detailed and accurate records of medicines administration and dispensing of medications maintained?
- Are links established with other healthcare providers to ensure pharmaceutical needs of the people are met on discharge?

18.3 Prescribing, administration and supply

- Is there evidence of:
  - Compliance with relevant guidance e.g. Department of Health Clinical Guidelines [23] .
  - Adherence to prescribing formularies and any locally agreed care pathways or protocols.
  - Compliance with any guidance issued by the NHS to secure best value for money from prescribing resources.
  - Issue/administer medicines and treatment only against a prescription from a medical or independent non-medical prescriber or by appropriate health professionals.

18.4 Controlled drugs

- It is essential that an individual person obtains their correct medicine safely and within the various current legal constraints [24]. Therefore, does the healthcare service provide for a standard of provision[25], which encompasses the changes in the Controlled Drugs regulations and Medicines Act requirement and Department of Health policy, the guidance for the safe and secure management of controlled drugs [26] and the regulations under the Misuse of Drugs Regulations 2001[27]?
- Is there a Controlled Drug Register (CDR) and a secure location where Controlled Drugs are stored and administered?
- Are all drugs liable to misuse administered under supervised conditions by at least one registered healthcare professional with a competent person to witness the administration?

[23] Drug Misuse and Dependence: UK Guidelines on Clinical Management (2007) Department of Health
[24] http://www.rpsgb.org/pdfs/MEP32s1-2a.pdf
[25] http://www.rpsgb.org.uk/pdfs/safsechandmeds.pdf
[26] http://www.dh.gov.uk/en/Healthcare/Medicinespharmacyandindustry/Prescriptions/ControlledDrugs/index.htm
[27] http://www.opsi.gov.uk/si/si2001/20013998.htm

- Is there is a designate a lead person to oversee the management of Controlled Drugs and ensure all incidents and concerns are investigated and reported?

19. Quality and Governance Information Governance

19.1 Is SystmOne used for all electronic record keeping and reporting?
19.2 Is there compliance with all information governance legislation i.e. is there a policy for handling personal data and the sharing of patient information, in line with the Data Protection Act and to ensure the following:
- Consent from people is routinely sought for the sharing of information.
- To allow the sharing of information for public protection services, the healthcare service abides by MAPPA and DPA policies/guidance.
- There is an information consent form and policy and all staff have guidance on information sharing relevant to people in line with legislation and local safeguarding procedures.
- Electronic records are maintained and appropriate training is provided to staff as required.

19.3 Are people granted access to their medical records, if requested, in line with NHS service guidelines and in compliance with the Data Protection Act?

20. **Quality and Governance Workforce**

20.1 Is the healthcare service provided by suitably trained, qualified and registered staff?
20.2 Do all healthcare staff have a job description outlining their role, responsibilities and the competencies needed to carry out the requirements of their post?
20,3 Do the clinical staff have an induction programme, receive statutory training, and access ongoing training as determined by their role and competency?
20.4 Is Continuous Professional Development including participation in peer review and audit for all clinical staff facilitated by the service?
20.5 Is there a performance development and review process is in place and documented for all staff, including a training needs analysis?
20.6 Are all clinical staff appropriately supervised?

Appendix C: Detainee Focus group Schedule

Aim

The aim of holding interviews and/or focus groups with detainees is to ensure that their voices are included as part of the Health and Wellbeing Needs Assessment (HWBNA). This is important as detainees may identify issues and health and wellbeing needs that do not show up in common data sets. For example, whether detainees feel able to be honest about health needs in assessments.

Selection process The interviews and/or focus groups with detainees are an additional source of information for the HWBNA and are not intended to as research. CIE recognise the limitations of the environment and that it is necessary to fit in with

the daily routines and requirements of the IRC. We therefore prefer to let the IRC Healthcare staff identify detainees for interview and/or focus groups.

Please note that participation in the focus groups/interviews is totally voluntary and detainees can refuse to participate. Detainees who do agree to take part in the focus groups/interviews will not be asked about any confidential or personal information but only about their experiences of health services in this IRC in general terms.

We would normally expect there to be between two and four focus groups with approximately 8 –15 people in each one. One-to-one interviews may be conducted if the IRC Healthcare staff feel that this is more appropriate e.g. due to language barriers or issues of confidentiality. The number of people for one-to-one interviews is to be agreed with the healthcare staff lead manager.

Methods

The focus groups/interviews are conducted using a topic schedule (see below). This consists of general questions about the full range of health care experiences. Some may be more relevant than others depending on the nature of service provision at the IRC.

The focus groups/interviews are conducted by CIE staff with the appropriate level of security clearance. IIRC Healthcare staff can be present during the focus groups/interviews to observe though they would not be expected to lead the discussion.

The focus groups/interviews should be conducted in a suitable room e.g. with the ability to close the door for privacy, appropriate seating, as little external noise distraction as possible etc.

The focus groups/interviews will start with introductions explaining who the CIE staff are and the purpose of the focus group/interview and HWBNA.

Detainees will be asked to confirm verbally that they consent to take part in the focus group/interview.

The explanation of the focus group/interview will include assurance that it is confidential and that no one will be identified by name. Reassurance will also be given that participation in the focus group/interview will not form part of any procedure related to their detention or any related application to the Home Office or other official body related to their immigration status.

The focus groups/interviews will normally last no more than one hour.

Health and Well Being Needs Assessment Focus Group/Interview topic schedule for IRC Detainees

Background Information for Detainees

The NHS Commissioners are interested find out more about the health of detainees in this IRC and the health services provided.

The questions you will be asked will allow them to improve the help they can give people in Immigration Removal Centres. The information you give us will not have your name on it and will only be used for this project. Participation in this focus group/interview is voluntary and in no way influences or has any impact on your current legal status or any applications you may have with respect to the Home Office or other official bodies.

Participants asked to verbally consent to taking part.

Questions

1. How good do you think your overall physical health is? By physical health, we mean things like how fit you think you are, how often you get ill, any on-going health issues you might have, etc.
2. When you first came to this IRC did anyone ask you about your physical health?
3. Was a plan set up to help you with any physical health problems – for example:
   - Was an appointment made for you to see a doctor?
   - Did you have your eyes tested?
   - Did you have your hearing tested?
   - Did you go to the dentist?
4. Do you ever worry about your diet and what you eat?
5. Do you every worry about smoking or drinking too much?
6. Did anyone offer you any help with your diet, or to help you stop smoking or with your drinking?
7. How helpful did you find the staff or the service e.g. stop smoking service or substance misuse nurse?
8. Do you have questions or problems around sexual health? If you were worried about this and wanted to get some advice and information, where would you be most likely to get this information from?
9. How good do you think you overall emotional health is? By emotional health, we mean things like how often you feel unhappy, are you able to think through problems you might have, how happy you are with your appearance etc.
10. When you first came to this IRC did anyone ask you about your emotional health?
11. Was a plan set up to help with any emotional health problems – for example, as an appointment made for you to see a doctor?
12. If you have worries and concerns about your health, how good are you at discussing this with others?
13. If you were worried about your health and wanted to get some advice and information, where would you be most likely to get this information from?
14. Which aspects of your health would you appreciate more help and information on?
15. In terms of health services, which services or staff in this IRC do you think are good and which do you think are not so good? For example, do you feel that

staff in this IRC listened to your concerns about your health needs? Did you feel safe to talk to them about your health needs?

16. Can you tell us 3 things that would make the health services at this IRC better?

Appendix D: Detainee health Needs Questionnaire

1. On a scale of 1 – 5 (1= Very good and 5= Very bad) how is your physical and emotional health?
2. If you were worried about your health, how happy would you feel telling others? (1= very unhappy and 5= very happy)
3. When you first entered this IRC did anyone ask you about your physical health?
4. Since being at this IRC have you seen a doctor about any physical health problems?
5. If yes, how long did you have to wait to see a doctor?
6. Since being at this IRC have you seen a nurse about any physical health problems?
7. If yes, how long did you have to wait to see a nurse?
8. Have you used any nurse clinics, for example, for asthma or diabetes?
9. Have you had a sexual health screening test in this IRC?
10. If yes, how long did you have to wait for the test?
11. Since being at this IRC have you had any of the following? (please tick as many as appropriate)
    - Someone to check if I have any problems with my eyes
    - Someone to check if I have any problems with my ears
    - Someone to check if I have any problems with my teeth
    - Someone to check if I have any problems with my feet
    - Someone to check if I have any problems with my muscles
12. Do you take part in sport and fitness activities at this IRC?
13. Did you take part in sport and fitness activities before you came to this IRC?
14. Do you worry about the food at this IRC and what you can eat?
15. Do you have problems with your weight?
16. Do you have trouble sleeping?
17. When you first entered this IRC did anyone ask you about your emotional or mental health?
18. Have you asked for help in this IRC because you have felt unhappy, stressed or worried?
19. Since being at this IRC have you seen a doctor about any emotional or mental health problems?
20. If yes, how long did you have to wait to see a mental health doctor?
21. Since being at this IRC have you seen a nurse about any emotional or mental health problems?
22. If yes, how long did you have to wait to see a mental health nurse?
23. Do you smoke cigarettes?
24. If yes, how many did you smoke in a day?
25. Did smoking cause you to cough or feel short of breath?
26. Have you asked for help in this IRC to stop smoking?
27. Before entering this IRC how often did you drink alcohol? (please tick) Never

- 2-3 times a month
- 2-3 times a week
- More than 4 times a week
- I drank alcohol every day

28. Have you asked for help at this IRC with your drinking?
29. Before entering this IRC had you used illegal drugs?
30. Had you regularly used more than one drug?
31. Are you worried about your drug use?
32. Have you asked for help about your drug use at this IRC?
33. What do you think would help to improve your health?

Demographics of respondents

Age

Age of respondents (n = 403)		
18 24	64	16%
25 – 34	171	43%
35 44	61	15%
45 – 54	26	6.5%
55 64	2	.5%
65 and over	0	-
Not answered	79	19%

Ethnicity

Ethnicity of respondents (N = 403)		
ETHNICITY	NUMBER	PERCENTAGE
White – Other White	35	9%
Mixed – White and Black African	7	2%
Mixed – White and Black Caribbean	6	1.5%
Mixed – White and Asian	4	1%
Mixed – Other Mixed	9	2%
Asian Indian	47	11.5%
Asian Pakistani	86	21%
Asian Bangladeshi	35	9%
Asian – Other Asian	35	9%
Black Caribbean	1	0.2%
Black African	42	10%
Black – Other Black	16	4%
Asian Chinese	21	5%
Any other ethnic group	1	0.2%
Not recorded	58	14.6%
TOTAL	403	100%

This report has been compiled by Dr Jon Bashford, Sherife Hasan and Professor Lord Patel of Bradford OBE on behalf of the Home Office Immigration Enforcement and NHS England.

Data is taken from the individual health and wellbeing needs assessments as part of the national programme. These data were reported as accurate at the time the individual health and wellbeing needs assessment reports were written.

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