

Mental Welfare Commission for Scotland

Report on announced visit to: Dungavel House Immigration Removal Centre, Muirkirk Road, Strathaven, South Lanarkshire ML10 6RF

Date of visit: 25 January 2018

Where we visited

Dungavel House opened as an immigration removal centre in 2001. It is the only immigration and removal centre (IRC) in Scotland and maintains close links with similar centres in England. It holds people being detained under immigration powers, pending their deportation from the UK. The centre has capacity for 249 detainees, a maximum of 14 of which are female. There were 130 detainees in the centre at the time of our visit. Of these 130, only two were currently receiving care and treatment from the mental health team under a vulnerable adults care plan.

The centre is inspected by Her Majesty's Inspectorate of Prisons (HMIP). In 2016 the Home Office announced plans to close Dungavel, but those plans were abandoned in February 2017. Dungavel is operated on behalf of the Home Office and managed by the GEO Group UK Ltd. Nursing with general medical provision and counselling is provided by Med-Co Secure Healthcare Services Ltd, with the visiting psychiatry input contracted from NHS Lanarkshire. The health centre has close links to NHS Scotland and is supported by NHS England.

Detainees have access to an education centre, a library, several lounge areas, a gymnasium, outdoor recreational facilities and multi-faith centres, as well as two small onsite shops. Bedrooms are a mixture of dormitory, double and single rooms. There is access to satellite television and the internet.

We last visited the centre in July 2014. On this occasion we were keen to hear more about the mental health care in the centre and about how, when required, transfers to mental health hospital are managed.

Who we met with

We met with and reviewed the care and treatment of two detainees who are currently under the care of the mental health team.

We spoke with the general manager, the health centre manager, the compliance manager, immigration managers and the visiting consultant psychiatrist.

Commission visitors

Colin McKay, Chief Executive

Margo Fyfe, Nursing Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We are conscious that the experience of detention is a traumatic one for many people. The report into the welfare in detention of vulnerable persons by Stephen Shaw in 2016 (Cm 9186) cited a study showing four out of five respondents in immigration detention met clinical criteria for depression, and made a large number of recommendations which are being taken forward in the IRC estate, including Dungavel. The primary focus of our visit was the specialist care and treatment provided for the smaller number who are particularly vulnerable and experiencing significant mental health difficulties.

We were pleased to hear that detainees are seen by a member of the health care team within two hours of arrival, and that referrals to the mental health team from any source, will be seen within 48 hours. Telephone interpreters are available, but in full mental health assessments interpreters are there in person. Care plans are put in place around vulnerability, and individuals who require this are closely monitored to ensure their wider needs are being met.

We spoke with two individuals who are currently being cared for by the mental health team. They praised the support of the team and were fully aware of their treatment.

The visiting psychiatrist is formally contracted for a half session (approximately two hours) every fortnight, but we heard that he was very accessible and supportive. He is in the centre most weeks and is available by telephone out with his visits. The mental health nurses work closely with the psychiatrist to deliver appropriate care and treatment to the benefit of the detainees they care for. There is also daily access to GP services. We heard that although medication is one form of treatment available to individuals, the focus is on talking therapies and minimal medication where at all possible.

There is a counsellor on site who provides a range of counselling to the detainees which incorporates individual and group sessions. In addition, nursing staff also provide group work and individual support to the detainees. The centre has not accessed specialist clinical psychology input, but the mental health team has training in a variety of interventions, including trauma based work.

Care Plans

The care files we examined contained clear risk assessments and needs assessments. The care plans covered both physical and mental health care needs and had a good focus on individuals' rights. However, we were concerned that a template is used for the care plan rather than each care plan being written specifically for the individual. We discussed this with the health centre manager and pointed out the benefit of a more person-centred care plan that identified specific interventions for the individuals involved. We recommended that the use of templates is reviewed.

Recommendation 1:

The health centre manager should review the use of templates in care plans to ensure care plans are fully person centred and individualised.

Access to Advocacy

We were told that advocacy services are available on referral from The Advocacy Project based in Glasgow. However, to date this has not been used as there is a long wait between referral and advocacy availability. This is problematic as the average stay in the facility is only around 30 days. In our experience, independent advocacy can be enormously helpful in supporting vulnerable people and has a positive impact in establishments where it is well used. We suggest that there is further discussion with the advocacy service to consider how a service can be developed, which is timely and effective in this particular context.

Recommendation 2:

The health centre manager should discuss with the advocacy service how to ensure that detainees have meaningful access to independent advocacy services.

Rights and restrictions

On the day of the visit we had informative discussions with senior managers regarding rights and restrictions of detainees. We were pleased to hear that any use of seclusion is as a last resort. At the moment, if this is required to support someone safely, and protect their dignity, they will adapt areas of the centre to use, allowing the person space rather than confining them to a small room. We were informed that on the rare occasions that seclusion has to be used, it will be for the minimum amount of time possible and the visiting psychiatrist will be fully involved along with the mental health nurses.

There is building work about to begin to develop two dedicated care suites to provide care to people who require intensive support for a period of time. This reflects one of the key recommendations of the Shaw review. We look forward to seeing this change in future visits.

We noted that in situations that require a high level of observation, this is carried out in the area the detainee wishes to be. Doors within the communal areas and bedroom doors are not locked.

There is a strong presumption that a person who is seriously mentally ill should not be admitted to an IRC or, if they become unwell while at an IRC, they should be promptly moved to an appropriate healthcare setting. This presumption is detailed in the following documents:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/594770/DSO_Adults_at_risk_.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/57389/5/2016-11-30_Joint_mental_health_action_plan.pdf

If removal to hospital is required, this is carried out under the procedure set out in s136 of the Mental Health (Care and Treatment) (Scotland) Act 2003. The transfer usually takes place within five days. Transferred detainees have the status of restricted patients and must go to locked wards. The wards accessed to date have been in NHS Lanarkshire, NHS Greater Glasgow and Clyde and NHS Lothian.

Although the time period for transfer is usually short, this can be a very difficult and challenging time for the detainee and for staff. The development of two care suites should greatly improve the ability to provide safe and appropriate care pending transfer.

We asked about the techniques used to ensure someone who may be very distressed is safe during transfer. We were informed that Dungavel cannot administer medication without consent to calm individuals prior to the transfer journey, either orally or as intramuscular medication. There is no current legislation that would allow them to do so. This has been an issue in the past, and has meant that more intensive restraint has had to be used, which can cause a great deal of distress to the individual and those caring for them. This is a matter which the Scottish Government may wish to consider, and which reinforces the need for skilled and well planned management of transfers to hospital.

Where at all possible, the nursing staff will accompany the individual being transferred to hospital and, in the great majority of cases, the use of restraint is not required. Should someone require restraint for transportation, this is provided by another company who will supervise the transport and are trained in the use of a specialist restraint belt that restricts movement but does not incapacitate the individual.

Activity and occupation

We found a recognition of how important it is to provide meaningful activity for detainees to participate in, and to help occupy their days and maintain their mental health. We heard that there are multiple jobs made available, from gardening to duties within the centre, and that detainees are paid to carry out these jobs.

On our tour around the facility, we saw a variety of activity options on offer to the detainees both inside and outside. We also saw photographs of events and witnessed individuals accessing activities.

There is a polytunnel that detainees grow vegetables in and have entered the produce into local competitions.

It was clear from our visit that the staff are culturally aware and try to meet the cultural needs of the detainees as far as possible. There is a multi-faith room and several

prayer spaces available. Dietary needs are accommodated and detainees are encouraged to cook for themselves and others.

We were pleased to hear about the focus on meaningful activity and that detainees are encouraged to engage in work activities which they are paid for.

The physical environment

The main part of the centre is the original country house. There have been extensions made to accommodate the population. Rooms are large and detainees are encouraged to personalise their bed areas. There is a bright, well-furnished family area for visitors. Visitors can have a meal with the detainee. Private rooms are available for meetings with legal representatives.

The health centre has several rooms for individual and group work, as well as a new pharmacy area where medication can be stored and dispensed as required.

There is a separate gymnasium with a variety of equipment, as well as a large games hall. There are pleasant gardens that the detainees can access.

Any other comments

In our discussions with managers, it was highlighted that when detainees are transferred to the centre from Scottish prisons there are often difficulties in obtaining the health records from the prisons. This is important information which will inform the initial assessment and ongoing health care and treatment of individuals. We understand that there have been discussions with Scottish Prison Service (SPS) but the problem still arises. We were concerned to hear this and will make further enquiries with the SPS.

We heard that there is good communication with NHS Lanarkshire, and also with NHS Scotland, and that the health staff are well supported by both services. Liaison with the Scottish Government regarding Ministerial authorisation to transfer patients under s136 and to return them generally works smoothly. However, there can be pressure from the Home Office to get people back from hospital in order for the removal process to be expedited. Health staff can be frustrated by this as it is not possible to give definitive timescales around recovery. Importantly, while a patient is transferred to hospital in Scotland, the lead responsibility for their care rests with the Scottish NHS and Scottish Ministers. Any Home Office involvement needs to recognise this, and should not attempt to challenge the local professional's medical expertise and knowledge of the patient. We know that the Centre liaises regularly with the Home Office and we hope that these issues can be appropriately managed.

Summary of recommendations

1. The health centre manager should review the use of templates in care plans to ensure care plans are fully person-centred and individualised.

2. The health centre manager should discuss with the advocacy service how to ensure that detainees have meaningful access to independent advocacy services.

Service response to recommendations

The Commission seeks a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to HM Inspectorate of Prisons, the Scottish Government and the Home Office.

Mike Diamond
Executive Director (social work)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors. Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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