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Locked up, locked out: health and human rights in immigration detention

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Locked up, locked out: health and human rights in immigration detention

A report by the British Medical Association

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Information about this and other subjects covered by the Medical Ethics Committee may be obtained from the BMA's website at www.bma.org.uk/ethics *or by contacting the Medical Ethics and Human Rights Department at: BMA House, Tavistock Square, London, WC1H 9JP, e-mail:* ethics@bma.org.uk

Table of Contents

Executive summary 4
- About this report 4
- The BMA view on immigration detention 4
- Equivalence of care 5
- The impact of detention on mental health and wellbeing 5
- Dual loyalties in immigration detention 5
- Advocating for patients and raising concerns 5
- Language and cultural issues 6
- Privacy and confidentiality 6
- Capacity and consent 6
- Professional isolation and morale 6
- Recommendations 7

Introduction 9
- What is this report about? 9
- A rights-based approach 10
- The BMA and immigration detention 11
- Scope and structure of the report 11

Part one – immigration detention in the UK: an overview 12
- Chapter one: policy overview 13
  - Who is detained? 13
  - Who is not detained? 14
  - Are children detained? 14
  - Where are people detained? 15
  - How long are people detained for? 16
  - What happens after detention? 16
  - How much does detention cost? 16
  - What is the purpose of detention? 16
  - What are the alternatives? 17
  - What is detention like? 17
- Chapter two: health and wellbeing needs in immigration detention 19

Part two – the challenges of providing healthcare in immigration detention 22
- Chapter three: equivalence of care 23
  - Identification of health needs 23
  - Availability of services 24
  - Staffing 24
  - Continuity of care 25
  - Meeting complex health needs in detention 26
- Chapter four: the impact of detention on mental health and wellbeing 27
  - Evidence on the impact of detention on mental health and wellbeing 27
  - Aspects of detention which impact on health 28
- Chapter five: dual loyalties in immigration detention 30
  - Clinical independence 30
  - Medical involvement in age disputes 31
  - Removal from the UK 32
  - Use of force and restraint 34
  - Use of segregation 35
- Chapter six: advocating for patients and raising concerns 38
  - Vulnerable groups in immigration detention 38
  - The Rule 35 process 40
  - The role of doctors 43
- Chapter seven: language and cultural issues 45

Chapter eight: privacy and confidentiality **47**
The basics 47
The detention environment 47
The use of interpreters 48
Health records and confidentiality 49
Disclosing confidential information 50
Chapter nine: capacity and consent **52**
The basics 52
Consent to examination and treatment 52
Patients who lack capacity 53
Children and young people 54
Food and fluid refusals 54
Chapter ten: professional isolation and morale **56**
Education and training 56

Part three – conclusions and recommendations **58**

Part four – Guidance for doctors **62**
General ethical principles **63**
Equivalence of care **63**
Dual Loyalties **63**
Clinical independence *63*
Medical involvement in age disputes *64*
Removal from the UK *64*
Fitness to travel *64*
Use of force and restraint **64**
Use of segregation **64**
Advocating for patients and raising concerns **65**
Rule 35 ..... *65*
Raising concerns about vulnerable individuals *65*
Language and cultural issues **65**
Confidentiality and privacy **66**
Health records and confidentiality *66*
Disclosing confidential information *66*
Capacity and consent **66**
Consent to examination and treatment *66*
Patients who lack capacity *66*
Food and fluid refusals *67*
Professional isolation and morale 67

Appendix one – the medical profession and human rights **68**
The structure of rights in the UK 68
Health and human rights 69
The relationship between medical ethics and human rights 69
Human rights and immigration detention 70
Immigration detention and the international community 70

References **72-84**

Executive summary

About this report

The BMA (British Medical Association) is the voice of doctors and medical students in the UK. We are an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and helping them to deliver the highest standards of patient care.

The BMA has worked for many years both nationally and internationally to promote health-related human rights. In addition to drawing attention to global abuses of these rights – particularly where doctors are the victims, witnesses, or perpetrators of abuse – we have long advocated on behalf of individuals and marginalised populations whose health-related rights are infringed. It is as part of this work that we have produced this report on the health and human rights of individuals held in immigration detention in the UK.

Immigration detention is the practice of detaining migrants and asylum seekers for administrative purposes – typically to establish their identity, process their immigration claim or, where applications have been rejected, to facilitate their removal from the UK. The UK operates one of the largest systems of immigration detention in Europe, holding around 3,500 individuals in 11 immigration removal centres (IRCs) at any one time. Few groups are as hidden from public view as the immigration detention population, vilified and ignored in equal measure, at a time when the issue of migration has become politicised like never before.

The immigration detention population is diverse and can present with various complex needs, high rates of mental health problems and specific vulnerabilities as the result of past traumatic experiences. Doctors working in IRCs must meet those complex needs in an environment that militates against good health and wellbeing. They must balance high workloads with limited resources; navigate their competing obligations to their patients and centre management; and maintain high standards of care and treatment largely in isolation from their colleagues in the community.

This report addresses immigration detention policies and practices insofar as they relate to health, and explores the role of doctors in protecting and promoting the health-related human rights of detained individuals. It has been produced with two main aims: to demand action from the Government and policy-makers on aspects of detention policy and practice that are detrimental to health; and to support doctors and other members of the healthcare team in providing high-quality care to those detained.

The BMA view on immigration detention

In our view, the detention of people who have not been convicted of a criminal offence should be a measure of last resort. Detention should be reserved for individuals who pose a threat to public order or safety. Ultimately, we believe that the use of detention should be phased out and replaced with alternate more humane means of monitoring individuals facing removal from the UK.

As long as the practice continues, however, we believe that there should be a clear limit on the length of time that people can be held in detention, with a presumption that they are held for the shortest possible time. The state must also meet its obligations to those it detains: detained individuals should not experience infringements of their health-related rights and must be able to access high-quality healthcare, commensurate with their needs. Where doctors are unable to meet their obligations to patients, systems and processes must be scrutinised and restructured. These principles underpin this report.

Equivalence of care

Detainees are entitled to the same range and quality of services as the general public receives in the community. Since 2013, NHS England has been responsible for commissioning healthcare in IRCs in England, while healthcare provision for detention facilities in Scotland and Northern Ireland remains the responsibility of service providers. There are no immigration detention facilities in Wales. This transfer of responsibility brings the principle of equivalence of care closer to a reality, yet problems with the provision of healthcare persist: problems with the accuracy and timeliness of health assessments, availability of services, staff shortages, and ensuring continuity of care have all been identified as adversely impacting on the standard of care provided in detention. For some detainees with complex health needs, there is a question of whether their needs can be met in the detention setting.

The impact of detention on mental health and wellbeing

Various studies have identified the negative impact of immigration on mental health, and that the severity of this impact increases the longer detention continues. Depression, anxiety, and post-traumatic stress disorder (PTSD) are the most common mental health problems, and women, asylum seekers, and victims of torture are particularly vulnerable. Even if it does not reach a clinical threshold, all immigration detainees will face challenges to their wellbeing during their time in detention.

Evidence of the impact of detention on mental health and wellbeing warrants careful consideration by the Home Office. If the detention environment cannot adequately protect the needs and interests of those held within it, there should be a serious reconsideration of current policy and practice.

Dual loyalties in immigration detention

Doctors working in IRCs are bound by the same professional and ethical obligations as they are in the community. The inherent tension between the purpose and aims of the IRC (to detain and secure) and the purpose and aims of doctors working in IRCs (to protect and promote health and wellbeing), can exert pressures on their professional obligations. Doctors may find their clinical independence being challenged by non-clinical staff, or find themselves drawn into disciplinary or security issues, such as being involved in Home Office processes around age-disputed detainees and removals from the UK, or in the use of restraint and segregation.

Advocating for patients and raising concerns

There are various safeguarding processes in place in immigration detention through which vulnerable individuals should be identified and have their detention reviewed. New Home Office guidance on vulnerability in detention remains poorly understood by those working in the detention estate, with no standardised approach to screening individuals for vulnerability before they enter detention.

Once in detention, the Rule 35 process exists to bring vulnerable detainees (namely, those whose health is likely to be injuriously affected by continued detention, those who are thought to be at risk of suicide, and those suspected of being the victim of torture) to the attention of those with responsibility for authorising, maintaining, and reviewing detention. The Rule 35 process has been beset with criticisms that it fails to adequately protect vulnerable detainees: there is significant variability in the numbers and quality of Rule 35 reports between IRCs; a shortage of appropriate training for IRC General Practitioners (GPs) and Home Office caseworkers about the process; and inadequate responses from the Home Office in refusing release.

The medical profession has a long history of advocating for patients and speaking on behalf of marginalised groups who may be less able to speak for themselves. In the UK, doctors have a clear duty to take prompt action if they believe patient safety, dignity, or comfort is or may be seriously compromised. In light of the various shortcomings in the current processes for identifying vulnerable individuals, the duty of doctors to be especially vigilant in acting on concerns about patients becomes all the more vital.

Language and cultural issues

The language differences and cultural issues found within the detained population can inhibit access to healthcare and make consultations far more complex. In addition to the difficulties involved in using interpreters during consultations, doctors may encounter different cultural understanding or even stigma around health problems, in particular, mental health problems. The trauma experienced by many individuals in detention may also affect willingness to engage with healthcare professionals. Overcoming language and cultural issues, and building a relationship of trust with patients, can be immensely challenging for doctors who may be balancing high workloads with insufficient resources.

Privacy and confidentiality

As with patients in the community, detained individuals have the right to privacy and confidentiality in medical settings. The reality of the immigration detention setting, however, means that these rights can be under stress. The wider system within which detention is situated means there are various individuals or bodies with an interest in some of the information being exchanged, and doctors may feel pressured to disclose confidential information. Other pressures on doctors, including the use of interpreters in consultations; uncertainty over their precise responsibilities with regard to sharing information; and issues relating to resources and the physical environment of the IRC can all threaten the standard processes of privacy and confidentiality.

Capacity and consent

Detained individuals do not lose their rights to make medical decisions for themselves by virtue of their detention, but there are various elements of the detention environment that can affect capacity and consent. The mental illness, distress, and language and cultural barriers that are commonly found amongst the detained population can all have an impact on an individual's capacity, and therefore their ability to consent.

Food and fluid refusals also pose unique challenges for doctors working in these settings. Capacity is decision-specific, but where individuals are found to lack capacity to make medical decisions in the detention setting, this may well trigger concerns about their wider capacity to make decisions, and be indicative of vulnerability.

Professional isolation and morale

The nature of working, often alone, in a closed setting like an IRC means doctors may become detached from their clinical role and find themselves absorbed, uncritically, into the detention system. Many doctors working in IRCs report a sense of isolation from their colleagues in the community, and feel the absence of peer support and clinical supervision. A lack of understanding from colleagues in the community and from the general public; a lack of training and continuing professional development; and the stress associated with dealing with the complex needs of patients can all take their toll on doctors.

Recommendations

Healthcare is one part of the wider practice of immigration detention, but a part that is fundamental to the state meeting its obligations to those detained. This report was conceived primarily to provide support and guidance for doctors working in these settings. In doing so, we recognise that various policies and practices can make it difficult, if not impossible, for doctors to meet their obligations to patients. For this reason, the report also makes a range of recommendations aimed at addressing aspects of the detention system that impact on health and wellbeing, and which impede the efforts of doctors to act in the best interests of their patients.

This report adds the voice of the medical profession to those already calling for change. We look forward to working with policy-makers and other organisations to restructure and develop policies and processes that meet the health needs of detained individuals and allow doctors to meet their legal, ethical and professional obligations to patients.

Recommendations

1. **Revise detention policies to address the significant health effects indeterminate detention can have on individuals.**
   - The detention of people who have not been convicted of a crime should be a measure of last resort.
   - The Home Office should consider more humane means of monitoring individuals facing removal from the UK by replacing the routine use of detention with alternate, more humane means. Detention should be reserved for those individuals who pose a threat to public order or safety.
   - Where individuals are detained, there should be a clear limit on the length of time that they can be held in immigration detention, with a presumption that they are held for the shortest possible period.
   - Detention can be especially detrimental to the health of more vulnerable individuals (including children, pregnant women, victims of torture, and those with serious mental illness) who should only be detained in exceptional circumstances.
   - The Home Office should consider how best to develop processes which routinely screen people before they enter detention for vulnerabilities which leave them particularly susceptible to harm, and explore the extent to which health professionals should be involved in this.
   - The Home Office should review its systems for raising concerns about detained individuals, including the current Rule 35 process.

2. **Address aspects of the detention environment which affect the health and wellbeing of those detained.**
   - There must be continued investment in the physical environments of IRCs in order to ensure obligations to patients (such as medical confidentiality) can be met.
   - Many detained individuals will present with complex health needs. Doctors working in IRCs must be provided with adequate time and suppport to best meet those needs.
   - The practice of moving detained individuals into and between IRCs at night or early in the morning should end, unless there are exceptional reasons for doing so.
   - Force restraint, and segregation should be used only as a last resort. The Home Office should take steps to amend its policy and guidance to reflect this.
   - In particular, segregation units should not routinely be used as a way of managing individuals at risk of suicide, self-harm, or those experiencing a serious mental health crisis.

3. **Reconfigure current healthcare provision to better achieve equivalence of care.**
   - Greater consideration should be given to how mental health therapies and interventions which may be more widely available in the community, can be provided in a detention setting.
   - Greater recognition should be given in policy and guidance to the fact that there will be circumstances where a person's health needs can no longer be adequately met in detention, and that this should trigger a review of the appropriateness of detention.
   - Problems with recruitment and retention across the IRC workforce must be addressed in order to prevent staff shortages negatively affecting the health and wellbeing of detained individuals.
   - In order to ensure that the health needs of detained individuals are being identified correctly, a standardised screening assessment tool should be developed and implemented.

- Healthcare staff should be given as much notice as possible ahead of the release or removal of a detained individual so that they can ensure, as far as possible, that individuals leave detention with the appropriate medication and health information. Where they are being released to the UK, this should include information about accessing healthcare in the community.
- Consideration should be given to how healthcare provision can be arranged and commissioned to ensure consistency across the immigration detention estate.

4. Provide training and continued support in health and wellbeing issues for all those working with detained individuals.

- The Home Office and NHS England must ensure that appropriate training is provided to all IRC GPs so they are appropriately skilled to carry out Rule 35 assessments. This should include GPs working in Dungavel House IRC in Scotland.
- Training in interpreting and assessing Rule 35 reports should also be provided to all relevant Home Office staff.
- The Home Office and NHS England should consider providing, as standard, training in the use of interpreters in consultations for all doctors working in IRCs. Similar training should be provided in Dungavel House IRC in Scotland.
- All health professionals working in IRCs should have access to regular training and clinical updating opportunities on mental health issues.
- All health professionals working in IRCs should have access to training on cultural and diversity awareness, and on LGBT issues and awareness.
- All staff in IRCs who have contact with detainees should have access to regular training and development opportunities in identifying and responding to mental health crises.
- The Home Office and NHS England should retain national oversight of training opportunities to ensure participation and consistency of approach. Similar opportunities should be provided to GPs working in Dungavel House IRC in Scotland.

5. Recognise the importance of doctors acting with complete clinical independence and ensure that that principle is enshrined and respected across the immigration detention estate.

- Considerations of cost or resources should not be allowed to override clinical judgment. When, in the view of the doctor, a detained individual requires care beyond that which can be provided in the IRC, that view must be respected and acted upon.
- Doctors should never be involved in disciplinary or non-therapeutic activities within IRCs.

Introduction

On the very first page of the foreword to his *Review into the Welfare in Detention of Vulnerable Persons*, Stephen Shaw CBE, former Prisons and Probation Ombudsman, expresses dismay over the lack of public knowledge of immigration detention policies and practice. "It is simply inconceivable," he writes, "that these cases would be so little known if they involved children in care, hospital patients, prisoners, or anyone else equally dependent on the state".[1]

His focus is on the number of court cases where immigration detention has been found to violate Article 3 of the European Convention on Human Rights (the right to freedom from torture and inhuman and degrading treatment or punishment); but his words apply to the use of immigration detention more generally. The use of detention in the immigration system is "one of the most opaque areas of public administration"[2]; those held within it invisible, vilified and ignored. If this were the case for any other population group, there would be an outcry. Yet apart from a small number of dedicated interest groups and parliamentarians, those detained have few public advocates or champions. At the same time, the issue of immigration has become highly politicised. A growing anti-immigration sentiment in the media, and heightened scrutiny of immigration forming the cornerstone of many recent political campaigns, combine to create the view that individuals who end up in immigration detention are at fault for their predicament and undeserving of "special treatment".[3]

The cumulative effect is that the rights of detained individuals receive little attention or support from the public, the media, or from politicians – rights which the state, in making the decision to detain, assumes an obligation to protect and promote. Day-to-day, these obligations are carried out by a number of individuals, including immigration detention staff, lawyers, Home Office caseworkers, nurses, and doctors. This report explores the role and responsibilities of this final group in fulfilling the state's obligations to those it detains.

What is this report about?

Immigration detention is the practice of detaining irregular migrants and asylum seekers for administrative purposes – typically to establish their identity, process their immigration claim, or, where applications have been rejected, to facilitate their removal from the UK. The UK has one of the largest immigration detention estates in Europe, holding up to 3,500 individuals at any one time, in 11 immigration removal centres (IRCs) across the country.[4] Decisions to detain are made by the Home Office, and until very recently were not subject to automatic review by a court or other independent body (the Immigration Act 2016 brought in automatic bail hearings at the four month point).[5] Individuals will rarely know the term of their detention, meaning that immigration detention is often referred to as "indefinite" or "indeterminate".

The use of immigration detention has been the subject of many fiercely fought political battles. For governments, past and present, detention is seen as a necessary part of maintaining immigration control and has become of increasing importance in a period of mass mobility.[6] For others, detention is seen as expensive, unnecessary, and harmful to vulnerable people, many of whom will have escaped oppression or persecution elsewhere.[7] A number of recent reviews of the system have called for the introduction of a maximum time limit for detention, and a review of existing policies and practices in detention.[8,9]

When a decision is made to detain an individual, the state becomes responsible for curtailing their liberty rights, and, simultaneously, for protecting and promoting their other rights. Meeting the health needs of detained individuals is one such responsibility, and one that exists not solely in relation to treating illness, but in promoting and realising general good health and wellbeing. In the context of immigration detention, this means providing high-quality healthcare to detainees, as well as creating the conditions and environment necessary for good health and wellbeing. There are many aspects of the immigration detention setting, however, which are far from conducive to good health and wellbeing: high rates of mental health problems amongst the detained population;[10] concerns about

the ability of healthcare provision to meet those needs;[11,12] and a growing body of evidence that detention itself has an adverse effect on health and wellbeing are all issues that will be explored in turn in this report.[13,14]

For doctors, working in IRCs brings with it various unique challenges. They are tasked with protecting and promoting health in an environment which prioritises detention and security. They must balance high workloads with limited resources; manage the care of a population with complex needs; navigate their competing obligations to patients and centre management; and maintain high standards of care and treatment largely in isolation from their colleagues in the community.

This report addresses detention policies and practices insofar as they relate to health, and explores the role of doctors in protecting and promoting the health-related human rights of detained individuals – including the wider duty of doctors to strive to change harmful policies and practices. It will provide support and guidance to doctors working in immigration detention settings on the ethical and professional dilemmas they commonly face. In recognition of the various challenges facing doctors which are the result of policies, systems, and the nature of the IRC environment, the report will also make recommendations to the government, policy makers, and managers which address those aspects of the system which can undermine patients' rights.

A rights-based approach

Most professional guidance tends to focus on medical ethics rather than human rights but the two are not incompatible. A crucial difference between human rights and medical ethics – and thus, a reason for adopting this approach throughout the report – is that human rights regulate the relationship between individual and state, whereas medical ethics focuses on the relationship between individuals: doctor and patient. Immigration detention is a state action, and is carried out by those who fulfil the role of the state in their day-to-day life (in the context of immigration detention, Home Office officials and detention centre staff, including doctors and other healthcare professionals).

The UK is free of some of the more flagrant human rights breaches associated with repressive regimes, but problems can still occur. Doctors may often be the first to witness abuses of human rights by, for example, identifying victims of torture, violence, or abuse. Doctors may also find that there are some aspects of practice, health policies, or programmes which – whether consciously or unconsciously – contravene human rights. For doctors working in secure settings, these considerations are magnified, and they may be more likely than their colleagues in the community to confront situations in which breaches arise. The need to balance their responsibilities to ensure the safe and secure running of the centre with their primary obligations to patients can create tension in the form of dual loyalties or dual obligations, and exert subtle and coercive pressures on doctors which, if unchecked, can undermine the rights of patients.[15,16]

In the UK, doctors working in IRCs are not Home Office employees, but are engaged on behalf of the NHS. This separation is an improvement on previous arrangements, where the agency tasked with detaining and removing individuals from the UK was also tasked with arranging their healthcare. This distinction is not always clear cut in practice, however. Security concerns taking precedence over health concerns, medical involvement in or proximity to non-therapeutic processes, and the relationship between medical professionals and the Home Office are all ways in which dual loyalties can manifest themselves and doctors can find their primary obligations to patients tested. In these circumstances, a rights-based approach to dilemmas can help doctors and other health professionals focus on their primary professional duties.

The BMA and immigration detention

The BMA is the voice of doctors and medical students in the UK. We are an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a longstanding interest in human rights, and have worked for many years to promote fundamental human rights in the context of healthcare. This report sits within our wider work of reducing health inequalities, ensuring access to healthcare for all, and standing up for vulnerable groups. There are few groups for whom this is more pressing than in relation to those in immigration detention.

In our view, the detention of people who have not been convicted of a criminal offence should be a measure of last resort. Detention should be reserved for individuals who pose a threat to public order or safety. Ultimately, we believe that the use of detention should be phased out and replaced with alternate more humane means of monitoring individuals facing removal from the UK.

As long as the practice of detention continues, however, we believe that there should be a clear time limit on the length of time that people can be held in detention, with a presumption that they are held for the shortest possible time. The state must also meet its obligations to those it detains: detained individuals should not experience infringements of their health-related rights and must be able to access high-quality healthcare, commensurate with their needs. Where doctors are unable to meet their primary obligations to patients, systems and processes must be scrutinised and restructured. These principles underpin this report.

Mental health in immigration detention forms a key part of this report, and our recommendations and guidance should be read in the light of the wider work on mental health and parity of esteem carried out by the BMA. You can find out more about this work at: https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/mental-health

Scope and structure of the report

Part One of the report sets out the background to immigration detention in the UK by outlining when and how it is used, before providing a brief summary of the health needs of those detained. Readers who have knowledge of the immigration detention system may wish to start from Part Two of the report, which explores in detail the challenges of providing healthcare in immigration detention, with a particular focus on guidance for doctors working in those settings.

This report is aimed at practitioners working in IRCs, although doctors working in other settings used to hold people under immigration powers, such as short-term holding facilities or prisons, may also find some of the guidance useful. When facing specific ethical dilemmas, doctors can seek further advice from the BMA Ethics Advice Service, the General Medical Council (GMC), or their personal medical defence organisation.

This report is also intended to help inform the decisions of government and policy-makers that affect the care and treatment of individuals in immigration detention. The report concludes by making a series of recommendations aimed at addressing aspects of policy and practice which are detrimental to health.

The information contained in this report is largely focused on the detention of adults, but in recognition of the small number of children and young people under the age of 18 who enter detention each year, there will be some consideration of issues specific to their care. Where this is the case, it will be clearly noted in the text. Similarly, although the majority of IRCs are located in England, the information outlined in this report is applicable across all four nations of the UK. Where the report refers to policy or practice which differs between the nations, this will be clearly highlighted.

Part one – immigration detention in the UK: an overview

Chapter one: policy overview

Immigration detention is typically used to establish the identity of migrants or asylum seekers, to process their claims, or, where applications have been rejected, to facilitate their removal from the UK.[17,18] Immigration detention is a purely administrative process, not a criminal justice one: decisions to detain are made by Home Office officials, not judges, and can be enforced for indeterminate periods.

The Home Office sets out five circumstances when detention may be appropriate:
- When the person is likely to abscond if given temporary admission or release;
- Where there is insufficient evidence to decide whether to grant temporary admission or release;
- The person's removal from the UK is imminent;
- Detention is needed while alternative arrangements are made for the person's care;
- Release is not considered conducive to the public good.[19]

Who is detained?

The population in immigration detention is diverse and includes new arrivals seeking entry to the UK; those who have failed to leave the UK upon expiry of their visa or failed to comply with its conditions; undocumented migrants; asylum seekers and foreign national ex-offenders (FNOs) who have completed a UK prison sentence.[20]

In 2016:[21]
- 28,908 people entered immigration detention in the UK:
  - 24,814 (86%) were men;
  - 4,094 (14%) were women;
  - 13,230 (46%) had made a claim for asylum;
  - The largest group of foreign nationals in detention were from South Asia (including India, Pakistan, Bangladesh, Sri Lanka, and Nepal), followed by nationals from Sub-Saharan Africa (including Nigeria, Ghana and Somalia).[22]
- 71 children entered detention.

The number of people entering detention in 2016 decreased by 11 per cent from the 32,447 people who entered detention in the previous year.[23] This departs from the general trend which has seen the number of people entering detention increase year on year. The fall has been partially attributed to the closure of Dover IRC, and changes to the detained fast track system.[24]

The detained fast track policy

From 2000 to 2015, individuals seeking asylum could be detained if a quick decision was likely in their case – a policy known as "detained fast track" or DFT. In July 2015, the Court of Appeal held that that process was "systematically unfair and unjust" and the policy was subsequently suspended.[25] Since the suspension, a specialist detained asylum casework team examines asylum claims made by those in detention to an "indicative and non-accelerated timescale".[26]

Since the suspension of the DFT policy, there has been a 16 per cent decrease in the number of people seeking asylum being detained – down to 13,230 in 2016 from 15,713 in 2015.[27] People who have claimed asylum at some point in their immigration process continue to make up a significant proportion of those detained – 46 per cent of all detainees in 2016.[28]

Who is not detained?

The Home Office identifies certain categories of people for whom there should be a presumption against detention:

- Individuals suffering from a mental health condition or impairment;
- Victims of torture;
- Victims of sexual or gender-based violence, including female genital mutilation (FGM);
- Victims of human trafficking or modern slavery;
- Individuals suffering from post-traumatic stress disorder (PTSD);
- Pregnant women (where they are detained, the Immigration Act 2016 also imposes a 72-hour limit on their detention);
- Individuals suffering from a serious physical disability;
- Individuals suffering from other serious physical health conditions or illnesses;
- Individuals aged 70 or over;
- Transsexual or intersex persons.[29]

This does not mean that anyone falling within one of these categories will never be detained, however. Instead, these risk factors must be balanced against other immigration control considerations, and detention will be justified if immigration control considerations outweigh the presumption against detention. This policy is explored in more detail in chapter 6.

Are children detained?

Unaccompanied child migrants should be placed in the care of a local authority instead of being detained in IRCs.[30]

Families with children and young people under the age of 18 are no longer detained in IRCs, due to policy changes made in 2010 by the coalition government.[31] They can be held instead in what is known as "pre-departure accommodation" for up to 72 hours, immediately prior to their removal from the UK – extendable up to seven days with ministerial authorisation.[32]

Previously, a facility called Cedars provided this service. The closure of Cedars was announced in July 2016, with a discrete unit at Tinsley House IRC near Gatwick being designated as taking over this work. This was heavily criticised by MPs and campaign groups, who expressed concern that the government was quietly backtracking on the policy of ending child detention.[33]

In 2016, 71 children entered detention, a 94 per cent fall compared with the 1,119 children who entered detention in 2009, before the new policy took effect.[34] Whilst not insignificant, the numbers pale in comparison to the number of adults detained each year. For this reason, as stated at the outset, the information contained in this report is primarily applicable to adult patients. Doctors working in the immigration detention estate should be aware that they may be called upon to treat children and young people.

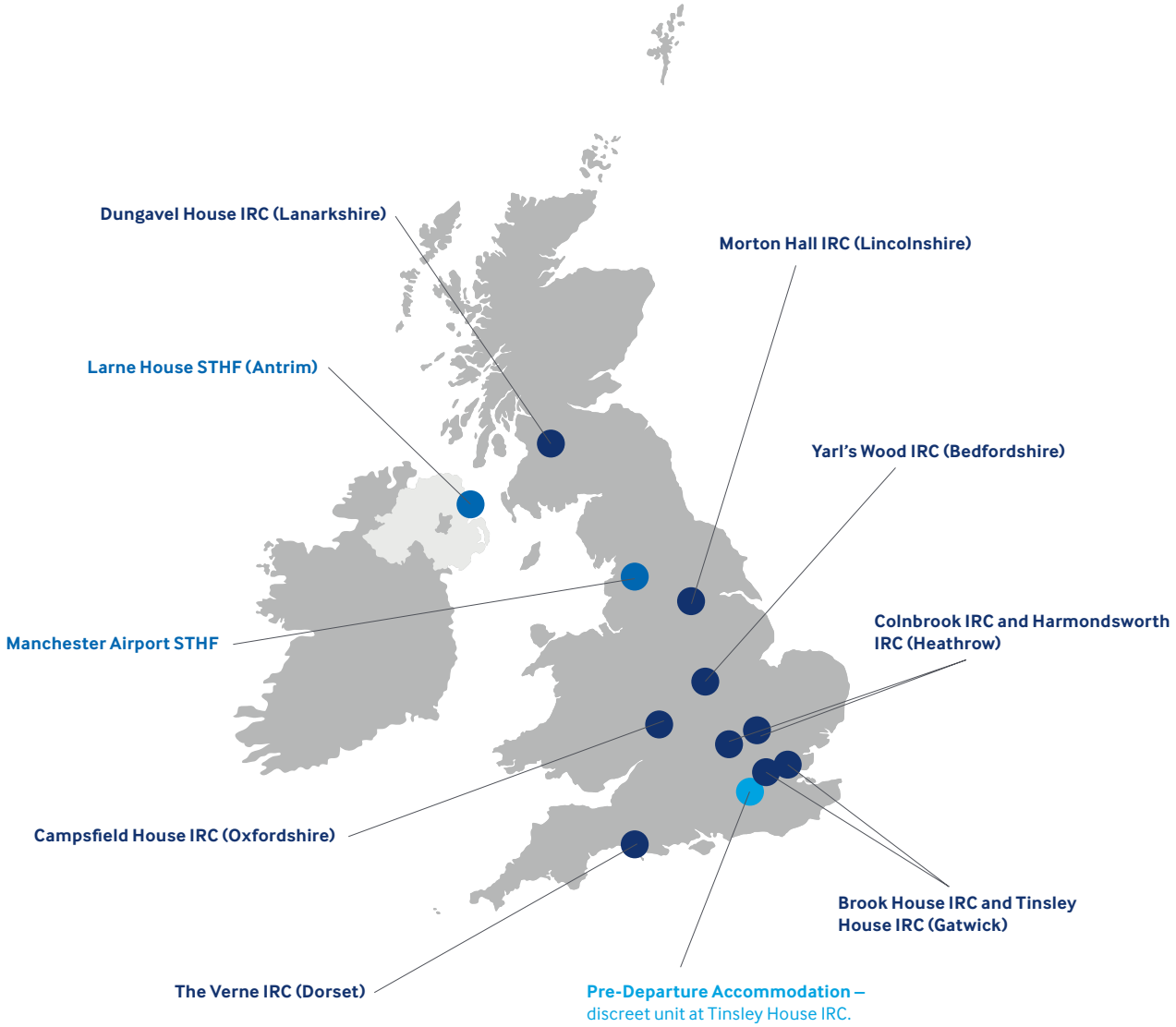
Where are people detained?

The UK has one of the largest networks of immigration detention facilities in Europe.[35] It includes:

- Nine immigration removal centres (IRCs);
- Two residential short-term holding facilities (STHFs). These are Larne House in Northern Ireland and Pennine House in Manchester. Pennine House is due to close soon as part of the Manchester Airport Expansion, but will be replaced by a similar STHF;
- One "pre-departure accommodation" (at Tinsley House IRC near Gatwick);
- 600 places for individuals to be held in prison under an agreement with Her Majesty's Prison and Probation Service (almost all of whom are foreign national ex-offenders awaiting removal following a UK prison sentence);[36] and
- Over 30 non-residential short-term holding facilities at ports of entry to the UK (which hold people for short periods immediately after arrival or before removal).

There is no single national provider for the immigration detention estate, and although the Home Office is ultimately responsible for centres, the running of institutions is divided between various different providers, including the Prison Service and private companies such as Serco or G4S.[37]

Figure 1: Map of immigration detention facilities in the United Kingdom



How long are people detained for?

No time limits are imposed on powers to detain, making the UK one of only a handful of countries in Europe not to impose a maximum time limit on detention.[38]

Home Office policy states that detention should be used "sparingly" and for the "shortest period necessary".[39] The courts have also made clear that detention is only lawful if the intention behind it is to remove the individual from the UK, and the individual is detained only for a period of time that is reasonably necessary for that purpose to be achieved.[40]

With no fixed time limit, detention can therefore be for an indeterminate period, and individuals will rarely know the term of their detention. Of the 28,661 people who left detention in 2016:

- 18,343 (64%) had been in detention for less than 29 days;
- 5,159 (18%) had been in detention for between 29 days and 2 months;
- 3,153 (11%) had been in detention for between 2 and 4 months.

Of the remaining 1,848 (6%):

- 179 (9.6%) had been in detention for between 1 and 2 years; and
- 29 (1.6%) had been in detention for longer than 2 years.

As of 31 December 2016, the longest period of time a person had been detained for was 1,333 days.[41]

The indefinite or indeterminate nature of detention is the focal point of much of the criticism levied at immigration detention.[42] Various senior bodies and officials have raised concerns about the continued use of indefinite detention, including Her Majesty's Chief Inspector of Prisons, who said that "there remains a pressing need for a maximum time limit on immigration detention, particularly in light of shortcomings in legal assistance".[43] The European Committee for the Prevention of Torture, has repeatedly recommended that the UK reconsider the policy.[44,45]

What happens after detention?

Of the 28,661 people who left detention in 2016:

- 13,446 (47%) were removed or voluntarily departed the UK;
- 11,931 (42%) were granted temporary admission or release;
- 2,833 (1.3%) were released on bail; and
- 61 (0.2%) were granted leave to enter or leave to remain.[46]

How much does detention cost?

In the year ending March 2016, immigration detention cost a total of £125 million.[47] In his report to the Home Office, Stephen Shaw estimated that it cost on average £34,000 to keep someone in detention for a year, a cost of £92.67 per night.[48]

There are other costs associated with immigration detention in the form of compensation payments to people who have been unlawfully detained: in the past three years, a total of £13.8 million has been paid to people who had brought wrongful detention claims.[49]

What is the purpose of detention?

The Detention Centre Rules set out the purpose of detention centres:

> *"to provide for the secure but humane accommodation of detained persons in a relaxed regime, with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression".*[50]

Detention represents a physical and symbolic exclusion from society, and is usually associated as being one of the most severe censures that can be imposed. Traditional theories of imprisonment focus on punishment, rehabilitation, or deterrence, but it is difficult to see how immigration detention fits into any of these categories: immigration detainees are not being punished for wrongdoing in being detained (immigration detention is imposed as an administrative matter rather than a criminal justice one); they are not being rehabilitated (there is no element of immigration detention that could "rehabilitate" them into a British citizen, or someone who has the right to remain in the UK);[51] and it does not serve as a deterrent to illegal residence or attempts to enter the UK).[52] In the broader context of detention and imprisonment, therefore, immigration detention is very much an anomaly.

What are the alternatives?

The International Detention Coalition (IDC), an international network of organisations and individuals who work with detained migrants and refugees, has identified over 250 examples of alternatives to detention from 60 countries.[53] In their view, the most successful alternatives were community-based models which had as their focus constructive engagement with individuals rather than enforcement, including:

- Allocating all individuals a case manager (someone who is not a decision-maker but who acts as an intermediary between the individual and the state);
- Electronic monitoring;
- Residence or employment restrictions;
- Reporting requirements;
- Bail surety.[54]

Evidence from the countries where alternatives are in place indicates success in the form of high compliance rates (up to 95 per cent in some countries); increased independent or voluntary departure rates (up to 69 per cent); and significant cost savings (up to 80 per cent.)[55] Alternatives to detention also have various other benefits, namely that they "reduce wrongful detention and litigation; reduce overcrowding and long-term detention; better respect, protect, and fulfil the human rights of migrants; improve integration outcomes for approved cases; and improve migrant health and welfare".[56]

In the UK, some alternatives to detention are already in use. Around 60,000 individuals per year are in the UK under a requirement to report weekly to a police station or immigration office (at a total cost of £8.6 million, and achieving a 95 per cent compliance rate) and around 500 individuals per year who are monitored using an electronic ankle bracelet (at a cost of £515 per person per month.)[57]

What is detention like?

There is considerable variation between IRCs in terms of the physical environment. For example, Colnbrook and Brook House IRCs were built according to highly restrictive Category B prison security standards, whilst Dungavel House was originally a 19th century hunting lodge. The various environments impact on how centres are run. Some operate a free flow regime where detained individuals can access most parts of the building, whereas in others, movement is far more circumscribed.[58] Her Majesty's Chief Inspector of Prisons described some centres as operating "prison-like conditions" and others as being "indistinguishable from prison units".[59]

Centres are required to provide educational and recreational facilities to detainees, including English language lessons, IT facilities, physical education, library services, and access to TV and CDs.[60,61] There are also some opportunities for detained individuals to perform paid work, although the issue of minimum pay has been the subject of a recent legal challenge.[62] The near constant movement of individuals into, out of, and between centres makes it difficult to plan for and provide education, training or other activities, and it will often not be seen as a priority for centres to invest in these sorts of opportunities for a group who may ultimately be removed from the UK.[63]

Reports show that IRCs can be volatile at times and there have been well-publicised instances of protests and disturbances.[64,65] Although the Chief Inspector of Prisons reported seeing "good interactions between staff and detainees" at all centres inspected, some centres remain beset with controversy and criticism over alleged abuse and ill-treatment. Yarl's Wood IRC in particular has been the subject of various allegations of misconduct and inappropriate behaviour,[66] and, at the time of finalising this report, G4S had suspended nine members of staff working at Brook House following covert footage from BBC's *Panorama* showing them "mocking, abusing and assaulting" detainees.[67]

Chapter two: health and wellbeing needs in immigration detention

Detained individuals present with many and varied health needs. Where some will have similar health needs to the general population in the community, others will have needs that are far more complex.

The literature is marked by a lack of clear and consistent data and so it is difficult to obtain an exact picture of the range and scale of health needs amongst the detained population. Various methodological issues exist in relation to collecting data for this group, including difficulties in gaining access to a detained population, language barriers or a cultural reluctance to report or discuss personal issues, and a high "churn rate" of detainees moving between and out of detention settings before research can be completed.[68]

The information summarised below is therefore intended to give an overview of the types and scale of health needs in the detained population, and the particular health needs of specific groups.

Physical health needs:

- In a 2015 NHS Health and Wellbeing Needs Assessment, 85 per cent of detainees responded positively when asked about their physical health.[69]
- Certain ethnic groups represented in the detained population are known to have higher prevalence rates of some long-term conditions, such as diabetes or coronary heart disease. Long-term conditions may have been unidentified or untreated in countries of origin, and local evidence suggests that the incidence of long-term conditions is being underestimated in IRCs.[70]
- Generally low immunisation rates can mean that the detainee population is more susceptible to infectious diseases.[71]
- There may be a higher prevalence of communicable diseases such as HIV/AIDS or Hepatitis B or C in the detainee population.[72]
- Somatisation is a frequent occurrence, and many individuals will present with physical symptoms or non-specific pain, when in fact they are experiencing mental distress.[73]
- Anecdotal evidence suggests that a greater number of elderly people or individuals with physical disabilities are being detained. These groups will have specific health needs that will require appropriate responses.

Mental health:

- International evidence points to high rates of mental health problems in immigration detention – most commonly depression, anxiety and post-traumatic stress disorder (PTSD).[74]
- In the UK, studies have shown that a large number of individuals score at "clinically significant" levels for depression and anxiety. [75,76]
- The prevalence of mental health conditions is high as the result of a range of factors pertinent to the detained population, including previous experience of trauma, anxiety related to immigration status, and stress as the result of detention itself.[77,78,79]
- A small number of individuals (less than 6 per cent, according to NHS England) will experience serious mental illness while in detention,[80] although it has been disputed whether this captures the true extent of serious mental illness in immigration detention.[81] [82] [*NB. Mental health conditions or impairments are included on the list of conditions or experiences which indicate a person who may be particularly vulnerable under the Home Office guidance.*]
- Immigration detention can have a significant impact on health and wellbeing, even if it does not reach a clinical threshold. The Centre for Mental Health note that "every person in detention faces some challenge to their mental health or wellbeing and experiences psychological and emotional distress".[83]
- In 2015, there were 393 recorded incidents of self-harm requiring medical treatment.[84]

Substance misuse:
- Some IRCs have reported high levels of drug or alcohol misuse amongst detainees.[85]
- Just as in prisons, there has also been an increase in the use of new psychoactive substances ("legal highs") in IRCs.[86,87]

Disability and learning difficulties:
- Concerns have been raised that lesser known health needs such as acquired head injuries, learning disabilities, and Autism Spectrum disorders are not being identified.[88] (NHS England commissioners and the Home Office are currently working to develop a screening tool to identify learning disability/difficulty).[89]

Children and young people:
- Studies from before the change in detention policy in 2010 highlight that amongst detained children and young people, symptoms of depression and anxiety were common, along with sleep problems, somatisation, poor appetite, and emotional and behavioural difficulties.[90]
- In many cases, the mental and physical difficulties were of recent onset, suggesting that they were related to the experience of detention.[91]

Women:
- Various bodies of work show increasing evidence that women in detention have distinct needs and particular problems and vulnerabilities.[92]
- Pregnant women have specific health needs, and can be particularly vulnerable in detention.[93] [*NB: Pregnant women are identified in the Home Office guidance as being particularly vulnerable to harm in detention.*]
- Women experience the same prior traumatic experiences as men, but can also experience trauma that is specific to women, such as female genital mutilation (FGM). They are also more commonly, but not exclusively, the victims of domestic or sexual violence, or trafficking.[94] They are therefore likely to require care and interventions that acknowledge the differences in their experience and context. [*NB. Victims of sexual or gender-based violence (including FGM) or victims of human trafficking or modern slavery are identified in the Home Office guidance as being particularly vulnerable to harm in detention.*]

LGBT detainees:
- It is common for lesbian, gay, bisexual or trans (LGBT) detainees to have experienced psychological or physical abuse in the country of origin.[95]
- LGBT detainees can be subject to bullying, harassment or discrimination from other detainees and centre staff. They may choose to keep their sexual orientation or gender identity a secret, or it may be a fundamental part of a claim for asylum. This can adversely affect wellbeing.[96]
- There have also been concerning reports of discriminatory attitudes or a lack of experiences with LGBT issues amongst healthcare staff, and for trans detainees, for delays in accessing medication or treatment vital to their transition.[97] [*NB. Transpeople are identified in the Home Office guidance as being particularly vulnerable to harm in detention.*]

A note on deaths in detention

Her Majesty's Chief Inspector of Prisons reported a "significant" rise in deaths in detention in his 2016-17 annual report.[98] In the year from April 2016 to March 2017, the Home Office reported six deaths, compared with three in the previous year. Across a longer period of time, there were eight deaths in the 18-month period to June 2017, compared with a total of nine in the previous four years combined.

The causes of death vary. Of the most recent deaths, two were self-inflicted; one was a suspected homicide; three were drug-related; and two followed sudden illness.

The Prison and Probation Ombudsman investigates every death and, in the course of their investigations, have identified a number of failings which contributed to the deaths, and in how the aftermath of the deaths was handled.[99] In some cases, this included criticism of healthcare provision, or of the decision to detain someone with serious physical or mental illness in the first place.[100]

There are clearly lessons to be learned from some individual deaths for the immigration detention estate as a whole, particularly in relation to the identification of vulnerable detainees. For individual doctors, it is important to emphasise the duty to raise concerns about individuals whose health is deteriorating, or whose health needs cannot be adequately met in detention, and to pursue those concerns with the centre management.

The period after a death in detention can be distressing for other detainees and centre staff, and doctors may be in a position to provide additional support or to signpost to sources of additional support or information.

Part two — the challenges of providing healthcare in immigration detention

Chapter three: equivalence of care

The national operating standards for IRCs state 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"[101] – a principle widely recognised as "equivalence of care".

The principle of equivalence of care is "not to eliminate all health differences so that everyone has the same level and quality of health, but rather to reduce or eliminate those which result from factors which are considered to be both unavoidable and unfair".[102] In the context of detention, therefore, it does not mean that health services should be identically replicated between the community and the secure setting, but that the same outcomes be achieved. The means of achieving those may differ depending on the specific population and its unique context. In closed settings like IRCs, there may even be an argument that the population is owed a higher standard of care. In being detained, individuals are forced into a situation where they become completely dependent on the state to meet their needs – for example, they are unable to self-treat minor ailments or to consult a pharmacist as individuals are able to do in the community.

A crucial step forward in ensuring equivalence of care for detained individuals came in 2013 with the transfer of responsibility for commissioning healthcare from what was then the UK Border Agency (now UK Visas and Immigration) to NHS England. As healthcare is a devolved function, the exceptions to this are Dungavel House IRC in Scotland, and Larne House STHF in Northern Ireland where healthcare is commissioned by the service providers. There is little evidence available as yet of the results this has yielded, although a progress update from the Department of Health has reported success in the form of "increased availability of specialist healthcare staff, more direct availability of healthcare interventions and the delivery of a wider range of health promotion and wellbeing clinics and workshops".[103]

Despite this, healthcare provision remains the source of "deep frustration" for staff and detainees,[104] and various reviews have drawn attention to the variability in staffing levels, availability of on-site services and hours of access.[105,106,107] Underpinning the issue of equivalence of care is the question of whether all health and wellbeing needs can be adequately met in the detention setting.

Identification of health needs

A crucial element of meeting the needs of detained individuals is ensuring that they are first identified. Reception and induction is a key time for gathering important health information to inform decisions about support required in the detention setting, but questions have been raised about the quality of information obtained during these initial healthcare assessments in creating a true picture of an individual's health.

The Detention Services Operating Standards state that all individuals arriving at an IRC should:

- be clinically screened (including an assessment for risk of self-harm or suicidal behaviour) within two hours of arrival; and
- be able to request a GP appointment within 24 hours of arrival (GP appointments should be arranged as standard if a nurse or another member of staff raises concerns during the reception and induction process).[108]

There is no standardised screening assessment tool in use across the immigration detention estate, and most centres use their own assessment templates. This means that the information collected may vary across centres, making it difficult to obtain a true picture of health needs across the board (as highlighted in chapter 2), and that detainees will have to go through a new assessment process each time they move between IRCs. NHS England has itself identified that the lack of a standard tool creates challenges, and that "over time we would want to consider solutions over how this can be resolved".[109]

Initial assessments have also been criticised for their reliance on self-reporting, which means asking individuals to divulge sensitive and intimate details about their health and wellbeing to a relative stranger. This can be especially difficult for individuals who have experienced

trauma or violence, and who are culturally inhibited from sharing sensitive information with others.[110] Various groups have also drawn attention to the closed nature of the initial health questionnaire, which elicits "yes/no" answers, rather than providing the individual with the opportunity to discuss any concerns they may have.[111]

Individuals may be exhausted after a long journey or scared and anxious about the prospect of being detained, thus inhibiting their ability or willingness to share detailed information. Some reports have been made about these initial assessments taking place in the middle of the night, depending on the arrival time of the detainee.[112,113] The Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT) recommends that every effort should be made to avoid detainees travelling between the hours of 11pm and 7am, as it meant individuals were often tired and disorientated upon arrival, making the induction process less effective.[114]

In their visit to the UK in 2012, the CPT noted that a number of individuals did not understand the information provided to them upon arrival.[115] As part of the initial screening process, individuals should be provided with information – in a language and format they can understand – about how to access healthcare services.

Availability of services

Where some IRCs can guarantee same day triage and GP appointments, others might take up to two days for a nurse triage appointment, and longer for a GP.[116] Whilst this is comparatively better to some arrangements in the community, it should be remembered that detained individuals lack other options available to those in the community (see above).

Variation in the availability of mental health services is particularly acute. The Centre for Mental Health found that although examples of good practice existed in some IRCs (including initiatives such as wellbeing sessions, one-to-one sessions, peer support and mentoring), mental health provision "varied significantly" from centre to centre.[117] Other reviews, including the Tavistock Institute's review of mental health and the Shaw review of vulnerability in detention identified similar problems in ensuring equivalence of care in mental health, including inconsistent access to mental health specialists and a lack of training for staff on identification and assessment.[118,119]

Some IRCs have the facilities to treat in-patients and to commission specialist clinics on an occasional basis whilst others will be dependent on these services in the community. Access to those services can be further restricted on the basis of the associated costs of providing transport and escort for individuals (an issue explored in more detail in chapter 5). Many reports have drawn attention to the difficulties involved in transferring individuals with serious mental illness requiring treatment under the Mental Health Act 1983, or equivalent legislation in the devolved nations.[120,121]

A common theme in the availability of health services in immigration detention is the overreliance on medication to manage mental health problems, and a severe shortage of the type of psychological or talking therapies which might be more widely available in the community.[122,123] The Centre for Mental Health concluded that all IRC mental health services need to make improvements to become "genuinely psychologically informed services", in line with the "stepped care model" which is the mental health delivery model in the NHS.[124]

Staffing

Many reviews have been critical of staffing levels in IRCs.[125,126,127] Problems in recruiting permanent healthcare staff has led to an overreliance on agency workers in many centres, and there are further problems with the recruitment and retention of general centre staff. These staffing shortages not only affect the availability of health services, but can lead to tensions between security and healthcare – for example, where centre staff are not available to escort a detainee to external services, or where someone requires careful monitoring or supervision but there is not the capacity for a staff member to take on this responsibility.[128,129]

Continuity of care

The uncertainty inherent in immigration detention means that neither detainees nor centre staff will be aware of how long someone will be in detention, which can make it difficult to plan and implement care and treatment.

Treatment plans can be disrupted when individuals arrive in detention without essential medication, or miss routine medical appointments as a consequence of their detention. The impact of this can be particularly severe for individuals with HIV/AIDS or the small number of transpeople who are detained whilst transitioning.[130,131] The high turnover of detainees can also lead to difficulties in implementing care and treatment plans which might need time to work, such as psychological interventions, including talking therapies.

Individuals can be released from detention rapidly, making it difficult to ensure continuity of care.[132] Where individuals are being released permanently or temporarily to the UK, this process can be further complicated if it is not clear where an individual will be living. Wherever possible, individuals leaving the estate should be equipped with a reasonable supply of medicines, a summary record, and general information about how to access health services in the community. Detainees with particular needs – including those with mental health problems, HIV, or those who have been the victims of torture – should be released with proper referral to specialist care in the community, recognising that this may not always be possible if it is unclear where an individual will be living.

Eligibility for healthcare varies across the four nations, but in many places, is dependent on "ordinary residence", meaning that people released from detention may find it difficult to access healthcare in the community. Perversely, many doctors working in IRCs report situations where they feel a detainee with a long-term condition may receive better care in detention than in the community.

It is far more difficult to ensure continuity of care where an individual is being returned to their home country, where a lack of access to healthcare and treatment may prevent this from happening. At the very least, individuals being removed from the UK should receive an appropriate supply of medication, any necessary travel vaccinations or malarial prophylaxis, and a summary record of medical information and treatment.

Guidance for doctors

- Doctors should ensure that individuals released from detention in the UK have an appropriate supply of medication, a summary record of their medical notes, and information about accessing healthcare services in the community.
- Detainees with particular needs – including those with mental health problems, HIV, or those who have been the victims of torture – should be released with proper referral to specialist care in the community, recognising that this may not always be possible if it is unclear where an individual will be living.
- Individuals being removed from the UK should receive an appropriate supply of medication, any necessary travel vaccinations or malarial prophylaxis, and a summary record of medical information and treatment.

Meeting complex health needs in detention

The difficulties associated with the provision of equivalent care highlight a wider issue of whether the more complex health needs of detainees can be managed within the detention setting. This is a particular concern for individuals with mental illness.

The Royal College of Psychiatrists has noted that:
- treatment of mental illness requires a holistic approach;
- treatment of mental illness requires ongoing therapeutic input, and is not just a one-off episode requiring treatment;
- the success of treatment is dependent on the development of therapeutic relationships;
- the management of more complex mental health problems requires specialist therapeutic input that is not routinely available in detention; and
- a key factor in recovery is "a background context of basic physical and emotional security".

Ultimately, they conclude that "the very fact of detention... mitigates against successful treatment of mental illness".[133]

This view has been echoed by others. The Centre for Mental Health felt that a fundamental barrier to achieving equivalence of care lay in the ever present tension between the aims of the secure setting and the aims of healthcare: the former prioritises the speedy removal of those who are in the country illegally; the latter the welfare of those individuals detained.[134] In their review of mental health in IRCs, the Tavistock Institute concluded that these two priorities, and the current structure in place to deliver them can result in IRCs "being less effective and efficient at both".[135]

Some have expressed the view that the very conditions of detention are such that no therapeutic environment could ever be created within which to manage mental health problems. Stephen Shaw felt, however that it led "unhappily" to the conclusion that no attempt at improvement or change is worthwhile and said that "this is not a logic that I believe best serves the interests of detainees' welfare".[136]

The challenges associated with achieving equivalence of care place greater onus on doctors to recognise where harm is being caused to patients as a result of detention, and to press for adjustments to be made. Where doctors believe that the needs of a patient cannot be met in the detention setting, or that the setting is contributing to a serious and unacceptable deterioration in health, they should advocate for changes to be made. This may include the use of the Rule 35 process to highlight concerns and lead to a review of the decision to detain.

Guidance for doctors

- Where doctors believe that the needs of the patient cannot be met in the detentions setting, or that the setting is contributing to a serious and unacceptable deterioration in health, they should advocate for changes to be made.
- This may include the use of the Rule 35 process to highlight concerns and lead to a review of the decision to detain.

Chapter four: the impact of detention on mental health and wellbeing

The extent of mental health and wellbeing problems in detention led Stephen Shaw to commission a specialist sub-review as part of his review into vulnerability in immigration detention. This included UK and international academic work that could provide insight into the impact of immigration detention on mental health. There were a number of consistent findings across studies:

- Immigration detention has a negative impact on mental health;
- The severity of the impact on mental health increases the longer detention continues;
- Depression, anxiety and post-traumatic stress disorder (PTSD) are the most common mental health problems;
- Women, asylum seekers, and victims of torture are all particularly vulnerable groups; and
- The negative impact on mental health persists long after detention.[137]

Shaw concluded that "a policy resulting in such outcomes will only be ethical if everything is done to mitigate the impact, and if the countervailing benefits of the policy can be shown".[138]

This evidence warrants careful consideration by the Home Office, particularly with regard to whether the detention environment can adequately protect the needs and interests of those held within it. For doctors working in these settings, they should be aware of the ethical issues involved in treating patients in a setting which can, by its very nature, cause or exacerbate mental ill health or distress.

Evidence on the impact of detention on mental health and wellbeing

International evidence (largely from Australia) indicates that prolonged detention has an adverse impact on mental health.[139,140,141] Longitudinal studies have observed a link between time in detention and severity of psychological symptoms: high levels of symptoms of depression, anxiety and PTSD were observed in detainees, with significant reductions observed at follow up in those who had been released.[142,143] The consequences of detention extend long after it has ended, and although an initial improvement in mental health can occur subsequent to release, more severe mental disturbance can persist for a number of years.[144,145]

Much of the evidence from the UK reinforces these findings. A pilot study of foreign national ex-offenders (FNOs) and asylum seekers in detention, and asylum seekers in the community, found high levels of anxiety, depression and PTSD across all groups, with far higher levels found in those detained, and in those who had a history of trauma.[146] The University of Oxford's Centre for Criminology has estimated the levels of depression at around 80 per cent of the population in immigration detention, and found that those who were depressed were more likely to have been in detention longer.[147]

Much of the literature has focused on the experiences of asylum seekers in detention, but evidence from other groups in immigration detention suggests they experience a similar impact. Whilst some FNOs may be more resilient due to their time in prison, they report high levels of frustration and stress around the uncertainty of their detention, lower satisfaction with their quality of life, and more difficulties in communicating.[148] Qualitative research from the Centre for Mental Health highlighted that many former prisoners can struggle to reconcile their previous experience of detention with the uncertainty of immigration detention.[149]

The fact that a detained individual does not meet a clinical threshold does not mean their mental health and wellbeing needs are negligible. The Centre for Mental Health stated that "every person in detention faces some challenge to their mental wellbeing and experiences psychological and emotional distress", and that in some cases this could be debilitating and even life-threatening.[150] The researchers highlighted that "levels of distress, problems with living conditions and daily activities and lack of both certainty and liberty" had a significant impact on health and wellbeing.[151]

Aspects of detention which impact health

There are many features unique to the immigration detention setting which may contribute to the impact it has on mental health. The indeterminate nature of immigration detention is a key cause of distress and anxiety.[152,153,154]

Experiences of indeterminate detention

"It is the worst part of it as you don't know when/if you will get out. You can't say to yourself tomorrow I'll be OK. Tomorrow you will be locked in, or flown back to the country where you are afraid for your life".[155]

"The uncertainty is hard to bear. Your life is in limbo. No one tells you anything about how long you will stay or if you are going to get deported. I could have been there any time or they could take me to the plane".[156]

"You tell yourself 'it's not going to be long, you're going to be out soon', but obviously you're seeing people that have been in there for three years. You're thinking: 'Am I going to be like them?'"[157]

In its most recent visit to the UK in 2016, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) noted the negative impact that indeterminate detention had on individuals, and expressed concern about the number of people detained for lengthy periods in IRCs.[158]

Pre-exposure to trauma is a key contributor to the rates of mental health problems in the detained population. One theme that emerges from the literature is that of the "retraumatisation" detention can cause – in particular for those who may have experienced trauma in the form of detention or at the hands of authority figures in their home country.[159] [160] Some have noted that this can be triggered by something as innocuous as the sounds of keys jangling, or shouting from another room.[161]

Experiences of "retraumatisation"

"I found myself having the worst flashbacks [to] prison in Cameroon. It was the same event repeating itself twice. When I see uniformed people I get so frightened".[162]

"Being here is reliving my trauma because it feels like the captivity I experienced when I was a sex slave..."[163]

"I get flashbacks of exactly what happened in Uganda. I get bad nightmares. When I was in detention I even heard voices of this man that raped me who would try to tell me I am worthless. I have tried twice to take an overdose when I was at detention because I couldn't take it anymore. The voice of this man would drive me mad".[164]

Retraumatisation can take on specific forms. Female asylum seekers, for example, report higher levels of sexual assault and gender-based violence, yet are frequently detained in centres with male custody staff, where a number of allegations of sexual assault have been made. The Home Office has continually refused to release details of the allegations or the outcomes of investigations.[165] The detention environment may also be particularly retraumatising for LGBT individuals, many of whom will have faced persecution, victimisation, and violence as a result of their identity.[166]

More generally, the loss of self-determination experienced by individuals in detention can lead to feelings of hopelessness, a lack of purpose, and an inability to deal with their predicament in any meaningful way.[167] A lack of opportunities for constructive or purposeful activity can also impact on wellbeing.[168] The lack of information about their immigration case and social isolation are key factors in the emotional and mental distress caused by immigration detention.[169,170]

Doctors working in IRCs will no doubt be aware of the impact detention can have on mental health and wellbeing. The previous chapter explored the question of whether health needs can be appropriately met in detention settings. Here, the same guidance for doctors applies: if patients are experiencing a deterioration in health as a result of detention, there is a duty for doctors to make their concerns known, and to press for alternative arrangements to be made. The onus must be on the government, however, to justify the current use of detention in light of this evidence, and to address the elements of detention policy and practice which impact negatively on health and wellbeing.

Chapter five: dual loyalties in immigration detention

Doctors working in IRCs are bound by the same professional and ethical obligations as they are in the community. Their primary concern is the care of their patient.

Dual loyalties, or dual obligations, arise when doctors who have direct obligations to their patients, also owe additional obligations to a third party. Whilst all doctors have various professional loyalties – for example, to colleagues, to employers, or to society at large – these largely remain in the background to their primary obligation to the patient. Dual loyalties can be express or implied, or be real or perceived.

For doctors who work in closed settings, such as IRCs, these dual loyalties can become more pronounced. They may be subject to subtle pressures which, if unchecked, could potentially contravene the human rights of detainees. Problems around access to healthcare, medical involvement in age assessment procedures, and the use of restraint and force in the detention setting are all areas where this tension might be more commonly seen in a UK setting, and where doctors must be especially vigilant.

In situations where doctors find their clinical independence being threatened it can be useful to refocus on their primary obligations as set out in the General Medical Council's *Good Medical Practice,* and summarised in the core principles below.

Core principles

- A doctor's primary duty is to their patient.
- Doctors must recognise and work within the limits of their competence, and take steps to keep their professional knowledge and skills up to date.
- Doctors must work to protect and promote the health and safety of patients and the public, and should take prompt action if they believe that is threatened or compromised.
- Medical care should be provided on the basis of clinical need, impartially, and without discrimination.
- Doctors are personally accountable for their professional practice, and must always be able to justify their decisions and actions.
- Recognising and understanding the circumstances in which dual obligations arise, and remembering that doctors are never absolved of their overriding ethical responsibilities to patients, are crucial in adhering to their core obligations.

Clinical independence

The dual loyalties operating in immigration detention challenge the extent to which doctors working in IRCs are able to act with complete clinical independence. Clinical independence is a cornerstone of a doctor's role. It ensures that doctors have the freedom to exercise their professional judgment in the care and treatment of patients without undue influence from third parties.[171] In a setting where the main focus and aims are on detention and security, and where the potential for rights to be undermined can be strong, the principle of clinical independence can bring genuine benefits to detained individuals.

All doctors, regardless of where they work, will have to take into account the structure of the health system and the resources available in the course of making clinical recommendations. They should resist, however, unreasonable constraints on their clinical independence which are not in the best interests of patients. Limitations on resources available to administer or monitor certain treatments can restrict the ability of doctors to provide certain interventions, and doctors may find themselves adapting or accommodating their medical skills as a result.

This is illustrated most clearly in many of the difficulties associated with ensuring access to external specialist services, due to the various associated costs in providing security escorts and transport for detainees. A doctor may make a clinical judgment, on the basis of the patient's best interests, that an individual requires a service which is not available within the IRC, but may meet resistance from centre staff or management on the basis of financial or resource considerations. Escorts are either not made available or, due to limited numbers, the appointment is cancelled because priority is given to escorting those who are being removed from the UK.

Although security and management of resources are appropriate concerns for those running IRCs, they should not be used to challenge a clinical decision made in the best interests of the patient. Where doctors are faced with resistance from management, they should make their clinical recommendations known and try to reach an agreement. If, after discussion, agreement cannot be reached, it may be helpful to seek a second opinion from a colleague working in another IRC or in the community, or to contact your personal medical defence union, the GMC, or the BMA.

Particularly problematic can be cases where a patient has a mental illness so severe that, if living in the community, they would be detained under mental health legislation. Mental health legislation across all four nations prohibits the delivery of compulsory mental health treatment outside of a hospital setting, which means that detainees who need this specialised care must be transferred to a hospital. This process can be subject to considerable delays (up to five weeks from the point of assessment, in some cases),[172,173] in which time patients may experience a subsequent deterioration in health, with doctors limited in what they can offer to prevent this.

Segregation or separation units are sometimes used to manage detained individuals experiencing a mental health crisis in the period between identification of need and the time of transfer. The conditions of such units can exacerbate mental health problems and lead to a further deterioration in health – an issue which is explored in more detail in the section on restraint and segregation, below.

Guidance for doctors

- Care and treatment should be provided on the basis of a doctor's clinical judgment.
- Where doctors are faced with resistance from management, they should make their clinical recommendations known and try to reach an agreement.
- If, after discussion, agreement cannot be reached, it may be helpful to seek a second opinion from a colleague working in another IRC or in the community, or to contact your personal medical defence union, the GMC, or the BMA.

Medical involvement in age disputes

Unaccompanied children and young people under the age of 18 can only be detained in exceptional circumstances. In many cases, children are easily identified long before the point of detention, but there may be occasions where IRC staff encounter an individual whose age is unclear or disputed. In these cases, a decision must be made as to their age so that individuals under the age of 18 can be appropriately safeguarded, in accordance with established safeguarding vulnerable children processes and procedures.

Many individuals in the immigration system will lack any formal documentation or evidence to support a claim of a certain age and so accurate assessment of age can be difficult. There is no single medical or psychological test which can definitively state a person's age, and age assessment should be holistic and take into account a range of social, emotional and psychological indicators. This is frequently done through what is known as a Merton compliant assessment. Despite this, there are frequent calls for medical professionals to be involved in an age determination process by, for example, providing radiographs of bone and teeth – an issue which came to the forefront in the controversy surrounding the

arrival of unaccompanied child asylum seekers to the UK from the Calais "Jungle" in 2016.[174] The Home Office later ruled out any such checks for young refugees coming to the UK.[175] In our view, given the unreliability of bone age assessment, the small but definite levels of risk involved in using ionising radiation, and the lack of clinical benefit to individuals, it would be unethical for doctors to use their clinical skills in this way.[176] There is a clear role, however, for doctors in identifying individuals who they believe to be under the age of 18, and reporting them to centre management so that appropriate child safeguarding measures can be followed.

Medical involvement in segregation is explored in detail in the section below, but it is worth noting at this stage that many age-disputed detainees may be placed in segregation whilst awaiting an age assessment – a process which can be subject to severe delays.[177] This is done with the intention of safeguarding and protecting individuals, but can ultimately lead to a deterioration in their health and wellbeing. Alternatives to using segregation as a safeguarding mechanism must be found, but as long as age-disputed detainees are held in segregation units, doctors should be mindful of the potential impact on health and visit them regularly for the duration.

Guidance for doctors

- Doctors should not use their clinical skills to be directly involved with age assessment processes, but have a role to play in ensuring such individuals are identified.
- Where doctors are concerned that a detained individual is under the age of 18, they should make those concerns known and ensure that the correct safeguarding vulnerable children procedures are followed.
- Where an age-disputed detainee is held in segregation, doctors should be mindful of the potential impact on health and visit them regularly for the duration.

Removal from the UK

Many detained individuals will understandably be anxious or scared about being removed. For individuals who have been unsuccessful in seeking asylum, they may be fearful of being returned to a country where the alleged violence or ill-treatment took place. Other individuals may have spent a considerable number of years living in the UK, and may have a family, friends, and a community who they will be fearful of leaving to live in a country which might now be completely unfamiliar to them. Clinicians report a feeling of powerlessness in being able to help or reassure individuals who talk about their fears of death or torture on returning to their home countries.[178]

Ordinarily, detainees will be served their removal directions "as soon as practicably possible", but no later than 72 hours before removal.[179] The Centre for Mental Health has noted that in some cases staff and managers may refrain from telling someone about their removal until legally required to do so do (i.e. 72 hours before removal), out of a concern that knowledge could increase the risk of suicide and self-harm.[180] Clinicians have described this as "ethically challenging", particularly where they felt that having additional time in the lead up to removal could enable them to provide support or information about resilience and coping mechanisms.

Where doctors believe that the benefits to the patient's health outweigh the harms of being informed of removal in advance of the 72-hour minimum period, they should document this, raise their concerns with centre management or a Home Office caseworker, and seek to reach a joint decision. In exceptional circumstances, where staff and managers decline to inform the detainee ahead of time, doctors should consider and seek advice as to whether they should inform the patient of the removal decision in advance – also informing centre management so that additional support and monitoring can be provided.

Doctors should be aware that prior to removal, some individuals are placed in segregation in order to minimise disruption or to monitor those at risk of suicide or self-harm.[181] The use of segregation in this way, and the role of the doctor, are explored in more detail in the section below.

Fitness to travel

When an individual is being removed from the UK, Home Office guidance states that the presumption should be that they are fit to travel, unless there are reasons to believe otherwise.[182] If there is doubt as to an individual's fitness to travel, an assessment should be sought from a healthcare provider – a task that usually falls to the IRC GP.

There is internationally agreed civil aviation guidance regarding fitness to travel.[183] There are, however, a number of challenges unique to assessing fitness to travel in detained patients. In many cases, individuals are unlikely to be departing the UK voluntarily. They may be anxious and stressed at the prospect of being returned to a country they do not want to go to. They may welcome an opportunity for being found unfit to travel, making objective assessment more challenging.[184]

There are ethical challenges involved too. In being involved in declaring someone fit to travel, doctors may feel they are being asked to use their medical skills to further immigration aims (i.e., the removal of an individual from the UK) rather than following their primary obligations to patients.

In these circumstances, it is important to note that the doctor is not affirming or endorsing the decision of the Home Office to remove someone, but raising concerns where individuals are not fit to travel. Doctors should remain focused on their obligations to their patients, and make statements that are truthful. Ensuring the individual understands the process for which examination is being undertaken will be crucial, as well as obtaining consent for the examination and sharing of relevant information with the Home Office.

Guidance for doctors

- The point of removal from the UK is a very difficult time for many detainees. Doctors should be aware of the need for increased support around this time.
- Where doctors believe that the benefits to the patient's health outweigh the harms of being informed of removal in advance of the 72-hour minimum period, they should document this, raise their concerns with centre management or a Home Office caseworker, and seek to reach a joint decision.
- In exceptional circumstances, where staff and managers decline to inform the detainee ahead of time, doctors should consider and seek advice as to whether they should inform the patient of the removal decision in advance – also informing centre management so that additional support and monitoring can be provided.
- Individuals are presumed fit to travel unless there are reasons to believe otherwise. Assessing someone's "fitness to travel" is a task that will fall to the IRC GP. In these circumstances, doctors are not affirming or endorsing the decision of the Home Office to remove someone, but raising concerns where individuals are not fit to travel.
- Doctors should remain focused on their obligations to their patients, and make statements that are truthful.
- Doctors should ensure the individual understands the process for which examination is being undertaken, and that consent has been obtained for the examination and sharing of relevant information with the Home Office.

Use of force and restraint

Doctors working within secure settings must have due regard for the rules and procedures necessary for the safe and secure running of the institution, but their role as health professionals should never be subordinated to this purpose. It is essential for the doctor-patient relationship that doctors very clearly demarcate themselves from the wider administration of the IRC and immigration system, and are seen by patients as being in IRCs to act in the interests of their health and wellbeing.

International standards of medical ethics make clear that any medical involvement in these measures will be in direct contradiction with the doctor's primary duty to patients. Doctors should therefore resist formal or informal involvement with centre administration or security tasks, such as the use of force or restraint.

The Detention Centre Rules state that security officers "shall not use force unnecessarily, and when the application of force is necessary... no more force than is necessary shall be used".[185] They further state that restraint can be used "where this is necessary to prevent the detained person from injuring himself or others, damaging property, or creating a disturbance".[186] These situations arise most commonly in relation to escorted moves or removal from the UK. There should be a presumption against the use of restraint, and any use must be made on the basis of an individual risk assessment, and be reasonable, necessary and proportionate, and used only for the minimum amount of time necessary.[187]

Restraint is also used where detainees are being escorted to external healthcare services (there is some anecdotal evidence that detainees will decline hospital visits due to the indignity of appearing in public in handcuffs).[188] In the course of its 2012 visit to UK detention settings, the European Committee for the Prevention of Torture (CPT) noted that handcuffing was routinely used when escorting detainees, despite assurances that it was only used following individual risk assessment.[189] The BMA has published detailed guidance on the medical role in restraint and control which will be of interest to doctors treating detainees in the community.[190]

Within IRCs, some data suggest that the use of restraint and force is more widespread and often used as a tool for managing "challenging" behaviour.[191] The CPT's visit in 2012 noted allegations of excessive use of force, and made a recommendation that IRC staff be reminded "that no more force than is strictly necessary should be used to bring agitated/recalcitrant detainees under control".[192] A Freedom of Information Act Release in 2014 reported 136 allegations of assault made by detainees against centre staff between 2011 and March 2014.[193] The use of force and restraint carries with it the risk of serious injury, and its most extreme consequences can be seen in the case of Angolan man Jimmy Mubenga, who died whilst being restrained by three private security guards on a removal flight in 2010.[194]

Since the decision to use restraint is not a medical one, doctors should have no role in the process. Under the Detention Centre Rules, however, medical practitioners should be informed "without delay" of a decision to restrain a detainee.[195] Upon receipt of that notice, the medical practitioner is required to inform the centre manager of any medical reasons why that person should not be restrained, and the manager must respect any recommendation they provide.

This is a clear illustration of some of the dual loyalties facing doctors working in these settings. Simultaneously, they must protect and promote the health of their patient and follow the rules and procedures necessary for the safe and lawful running of the institution in which they work. Being involved in disciplinary or security issues, even just observing and making recommendations, can blur the line between welfare and security.

The best way to avoid injury and harm is to not use restraint. As long as its use is lawful, however, doctors have a clear protective role in raising concerns about where its use will be particularly harmful. Doctors should therefore inform centre managers of any medical reasons why an individual should not be restrained, and should expect that recommendation to be acted upon. This level of involvement may still be ethically uncomfortable for some

doctors, as in excusing some individuals from the use of restraint, they are implicitly sanctioning its use on others. We believe, however, that as long as it is used, doctors have a crucial role in protecting the health and wellbeing of some by raising concerns which should help to ensure that harm is kept to a minimum.

Where there has been an incident of force or violence, individuals should always be offered the opportunity to be seen by a doctor or other member of the healthcare team. This is important not just so they can provide care for the injuries sustained, but to provide an assessment of mental health and wellbeing – the use of restraint on vulnerable individuals can be especially damaging. Importantly, doctors should never carry out medical examinations or treatment on individuals who are being restrained, unless they pose an immediate serious risk to themselves or to others.

As will be explored in more detail in the section below on raising concerns, doctors have a duty to speak out against violent, abusive, or negligent practices. Where doctors witness incidents of restraint or force which they consider to be unacceptable, they should make their concerns known.

Guidance for doctors

- It is crucial for the doctor-patient relationship that doctors remain independent from the running of the IRC and the wider immigration system. Doctors should make clear to detained individuals that they are in IRCs to act in a welfare capacity.
- Doctors have an important role to play in protecting health and wellbeing by raising concerns where there are medical reasons why someone should not be restrained. Their advice should be respected and acted upon, and in doing so, ensure that harm is kept to a minimum.
- Doctors should see all individuals after any incident of restraint in order to assess physical and psychological health and wellbeing.
- Doctors should never carry out medical examinations or treatment on individuals who are restrained, unless they pose an immediate serious risk to themselves or to others.
- Doctors have a duty to speak out against violent, abusive or negligent practices, and should raise concerns where they feel restraint or force is being used illegitimately.

Use of segregation

Segregation (also referred to as separation, removal from association, solitary confinement, or isolation) is the practice of separating individuals from the rest of the detained population, thereby limiting their interactions with others and subjecting them to a more restrictive regime. This should be distinguished from separating or "quarantining" an individual from the general population to prevent the spread of an infectious disease.

In IRCs, detainees can be segregated for two reasons: they can either be "removed from association" in the interests of safety or security, for up to 24 hours[196]; or "temporarily confined" to manage violent or refractory behaviour, for up to three days.[197] In both cases, the Home Secretary must authorise continued segregation after 24 hours, with a limit of up to 14 days.

Once a decision has been made to remove a detainee from association or to temporarily confine them, the IRC's medical practitioner must be informed of this "without delay", and should complete a medical assessment of the detainee to assess his or her health. If a doctor is of the opinion that segregation will be injurious to the health of the detainee, the doctor must make these concerns known to the centre manager.[198]

As with the use of restraints, this puts doctors in a difficult position by drawing them into disciplinary and security issues. Various international standards state that being involved in disciplinary or security issues is a direct contravention of the doctor's primary duty to their

patient, and that doctors should not certify someone as "fit" for segregation.[199,200] When someone is segregated in an IRC, however, that decision has already been made, and the role of the doctor is not to confirm or approve that decision, but to provide a healthcare assessment as part of good clinical practice.

If, as part of that assessment, the doctor identifies concerns about the impact segregation will have on the health and wellbeing of the individual, they must raise these with the centre manager and press for the decision to be reconsidered. This can feel problematic: in objecting to the use of segregation on some individuals, doctors may feel that they are implicitly authorising its use on others. We believe, however, that as long as it is used, doctors have a crucial protective role in regard to individuals who may be particularly vulnerable to harm. Protecting the health and wellbeing of some by raising concerns should, if the doctor's advice is heeded, ensure that harm is kept to a minimum.

Individuals in segregation do not lose their rights to access healthcare, and should be visited daily by a member of the healthcare team for the duration of their segregation. This is particularly important considering the various negative health effects segregation can have on individuals.[201] Doctors and other members of the health team will be well-placed to identify a deterioration in health, and where this occurs, should bring that to the attention of centre management. This should prompt consideration of whether segregation should be maintained, and doctors may again feel a tension between providing care and treatment and being involved in security processes. At all times, the doctor's role should be focused on protecting and promoting health and wellbeing, and taking prompt action to prevent that from being threatened or compromised.

The importance of confidentiality in the detention setting is explored in detail in chapter 8, but at this point it is useful to emphasise that detainees in segregation retain their rights to privacy and confidentiality. Medical examinations and consultations should be carried out in a manner which respects that.

Guidance for doctors

- Doctors should never be involved in certifying an individual as "fit" to withstand segregation.
- If a doctor identifies any concerns about the impact segregation will have on the health and wellbeing of the individual, they must raise these with the centre manager and press for the decision to be reconsidered.
- Doctors should ensure those in segregation can continue to access healthcare, and report to centre management anyone whose health they believe is deteriorating in segregation.
- Medical examinations and consultations of individuals in segregation should be carried out in a way which respects their rights to privacy and confidentiality.

Use of segregation on detainees with mental illness or at risk of self-harm

The Detention Services Order is clear that segregation should not be used to manage detainees with severe mental illness, those presenting with mental health problems, or those at risk of suicide or self-harm, except in exceptional circumstances.[202] Despite this, segregation continues to be used to manage detainees with mental health problems, those experiencing a serious mental health crisis, or those awaiting transfer to a psychiatric hospital.[203,204,205]

As noted above, segregation can have a deleterious effect on mental health; for those already suffering mental ill health the effects can be particularly severe.[206] Segregation is not an appropriate substitute for mental healthcare: the environment is far from therapeutic and healthcare staff will be limited in what they can do to prevent health from deteriorating further.

Doctors have a crucial role to play in raising concerns about the use of segregation on detainees experiencing mental ill health, and in pressing for more appropriate arrangements to be made, such as transfer to a specialist psychiatric unit. For detainees experiencing a serious mental health crisis, it should be questioned whether detention is an appropriate environment for them at all, and doctors should make those concerns known not only to centre staff, but to the Home Office via the Rule 35(1) process. For as long as mentally unwell detainees are held in segregation, however, doctors and the healthcare team should be particularly vigilant in ensuring regular visits to and interaction with segregated individuals to minimise further deterioration.

Some monitoring reports indicate that segregation is also "routinely" used to manage detainees at risk of suicide or self-harm – largely due to the fact that it is seen as the easiest way to monitor them.[207] This is part of a wider issue of the effectiveness of the current framework for monitoring those at risk of self-harm or suicide – the assessment, care in detention and teamwork (ACDT) framework – which was described by HM Inspectorate of Prisons as "not effective enough to provide consistently good support".[208] The National Offender Management Service is currently undertaking a review of the ACDT's counterpart in prisons in England and Wales. Their conclusions will be helpful in informing any development of ACDTs in the immigration detention estate.

Detainees at risk of suicide or self-harm should not be held in segregation units other than in exceptional circumstances. As with detainees experiencing mental ill health, doctors have a crucial role to play in raising concerns with centre management and pressing for more appropriate arrangements to be made. Where it is simply unavoidable, doctors should ensure they maintain regular contact and interaction with them in order to mitigate the harmful effects of segregation.

Guidance for doctors

- Segregation is an inappropriate setting for individuals who are at risk of suicide or self-harm or who are experiencing a mental health crisis.
- Doctors should raise concerns about the use of segregation on detainees experiencing mental ill health, and press for more appropriate arrangements to be made, such as transfer to a specialist psychiatric unit.
- For many detainees experiencing a serious mental health crisis, it should be questioned whether detention is an appropriate environment for them at all, and doctors should make those concerns known not only to centre staff, but to the Home Office via the Rule 35(1) process.
- Those at risk of self-harm or suicide should not be held in segregation apart from in exceptional circumstances, but monitored and treated by more appropriate means.
- Where it is unavoidable for an individual to be held in segregation, doctors should ensure they maintain regular contact and interaction with them in order to mitigate the harmful effects.

Chapter six: advocating for patients and raising concerns

The medical profession has a long history of advocating for their patients and marginalised groups, speaking on behalf of those who may be less able to speak for themselves. In the UK, doctors have a clear duty under the GMC's *Good Medical Practice* to "take prompt action if [they] think that patient safety, dignity, or comfort is or may be seriously compromised".[209]

At various points in this report, we have drawn attention to circumstances where doctors may identify negligent or abusive practices, or where they may have concerns about vulnerable or seriously unwell patients being held in detention. This chapter draws that information together in one place, and highlights the formal and informal mechanisms available to doctors for advocacy and raising concerns.

Vulnerable groups in immigration detention

The concept of vulnerability is a complicated one, and definitions can sometimes be contentious. Broadly speaking, vulnerability refers to the idea that there are some people who, for reasons of personal characteristics, social factors, or environmental determinants, are less able to take care of themselves, or who are more susceptible to harm.

In his review of the welfare of vulnerable persons in detention, Stephen Shaw noted that vulnerability is "intrinsic" to detention and that in being deprived of liberty an individual is automatically placed in a disadvantaged and disempowered position.[210] There are various other factors associated with being in detention which contribute to vulnerability including detention for an indeterminate period, unclear immigration status, lack of strong family or community networks, feeling unsafe in the detention setting, and living with a near permanent sense of anxiety and uncertainty about what the future might hold.[211]

Shaw noted that many submissions to his review suggested that anyone in detention should be considered vulnerable. He accepted the notion that some vulnerability was pre-determined, but also noted that it was not constant and could decrease or increase as circumstances change. He was broadly supportive of a "category based" approach, which highlights groups who are considered to be particularly vulnerable in detention.

For doctors working in IRCs, it is important to understand the ways in which detained individuals can be vulnerable. In addition to the specific categories of vulnerability outlined below, doctors should keep a broad view of vulnerability in detention and raise concerns about any individual they feel should not be detained.

Home Office guidance on vulnerable groups

As part of the Government's response to the Shaw Review, the Home Office published new guidance on adults at risk in immigration detention, which listed the following conditions and experiences which indicate a person may be particularly vulnerable to harm:

- suffering from a mental health condition or impairment (including serious learning difficulties, psychiatric illness or clinical depression);
- having been a victim of torture;
- having been a victim of sexual or gender-based violence, including female genital mutilation (FGM);
- having been a victim of human trafficking or modern slavery;
- suffering from post-traumatic stress disorder (PTSD);
- being pregnant;
- suffering from a serious physical disability;
- suffering from other serious physical health conditions or illnesses;
- being aged 70 or over;
- being a transsexual or intersex person.[212]

The guidance notes that:

> *"It cannot be ruled out that there may be other, unforeseen, conditions that may render an individual particularly vulnerable to harm if they are placed in detention or remain in detention. In addition, the nature and severity of a condition, as well as the available evidence of a condition or traumatic event, can change over time".*[213]

The presumption underlying the guidance is that detention will not be appropriate if a person is considered to be at risk. This does not mean, however, that no one at risk will ever be detained. Instead "detention will become appropriate at the point at which immigration control considerations outweigh this presumption".[214] The immigration control considerations to be taken into account include: the length of detention (there must be a realistic prospect of removal within a reasonable period), whether the individual poses a risk to public safety, and how likely the individual would be to comply with alternative measures, such as residence or reporting restrictions.

The effectiveness of this new guidance is yet to be determined, but it does represent a departure from the previous policy, which was clear that once grounds for vulnerability had been established, detention would only be suitable in "very exceptional circumstances". Concerns have been raised by many non-governmental organisations (NGOs) that the policy "increases the burden of evidence on vulnerable people and balances vulnerability against a wider range of other factors", leading to "more vulnerable people being detained for longer".[215] The annual report of HM Chief Inspector of Prisons also highlighted the fact that the policy was not yet widely understood, and that centres could not "systematically identify and support all at-risk adults, nor monitor the impact of detention over time".[216]

The guidance was the subject of a High Court challenge in October 2017, where it was held that the Home Office had adopted an incorrect definition of torture, and that as a result, many victims of torture held in immigration detention on the basis of that definition had been unlawfully detained.[217]

The new Home Office guidance chose to adopt the UN Convention Against Torture (UNCAT) definition, which requires harm to have been inflicted "by, or at the instigation of or with the consent or acquiescence of, a public official or other person acting in an official capacity".[218] Previous definitions of torture adopted in the UK did not focus on the identity of the person carrying out the act, but on the reasons why it was inflicted: "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".[219]

In the case brought by seven victims of torture, supported by Medical Justice, Mr Justice Ouseley held that the use of the UNCAT definition of torture in the new policy lacked a "rational or evidence base". He held that it "excludes certain individuals whose experiences of the infliction of severe pain and suffering may indeed make them particularly vulnerable to harm in detention... the identity of the perpetrator, as a public, or non-public official, is of no real importance to whether the victims of the infliction of severe pain and suffering is particularly vulnerable to harm in detention".[220]

A key part of Mr Justice Ouseley's judgment was the fact that the UNCAT definition of torture required doctors to carry out investigations and make judgments "on political issues which they cannot rationally be asked to reach".[221]

Identifying vulnerable individuals

The Centre for Mental Health noted a "missing component" in the process of making the decision to detain someone, namely that there is no screening process in place to detect vulnerability before a decision is made to detain: in most cases reported in their analysis, vulnerability was identified after detention.[222] Shaw's review similarly identified problems with the stages at which vulnerability could be assessed. He noted that various factors of

entering immigration detention mitigated against early identification of vulnerabilities. This includes the lack of consistent screening for vulnerability – it is up to the Home Office official making the detention decision to ascertain and document any reasons why detention would not be suitable – and the lack of a single point of entry to detention. Individuals entering detention do so through a range of routes, all of which are managed separately.[223]

Shaw recommended the creation of new structures which would comprise a single "gatekeeper" for detention, whose main purpose would be to ensure consistent application of the vulnerable adults' policy and to ensure that vulnerable individuals are not detained.[224] The Centre for Mental Health suggested that lessons could be learned from the Liaison and Diversion services, commissioned by NHS England, and currently in place in the criminal justice system.[225] However it is developed, we believe the Home Office should consider how best to develop processes which routinely screen those entering detention for vulnerabilities, and explore the extent to which health professionals should be involved in this.

Once in detention, there are further opportunities for the identification of vulnerability. The reception process could be a crucial time to identify the presence of particular vulnerabilities at the same time as assessing health needs, but various elements of the assessment and screening process make this difficult. Chapter 3 identified some of these in detail – including a lack of standardised assessment tools, a reliance on self-reporting from detainees, and a fraught or anxious reception process. There are also various other mechanisms which exist for identifying and raising concerns about vulnerable individuals in detention – most notably, the Rule 35 process which is explored in more detail below.

The consequences of failing to identify vulnerable individuals and taking steps to address their detention can be severe. The continued detention of individuals experiencing a profound mental health crisis has been found to constitute a violation of Article 3 of the European Convention on Human Rights (the right to freedom from cruel, inhuman or degrading treatment).[226]

The Rule 35 process

A key safeguard for vulnerable individuals once they are in detention is provided by Rule 35 of the Detention Centre Rules, which is intended to bring vulnerable detainees to the attention of those with direct responsibility for authorising, maintaining and reviewing detention. A Rule 35 report must be completed by a doctor for every individual:

1. whose health is likely to be injuriously affected by continued detention or any conditions of detention;
2. who they suspect of having suicidal intentions;
3. who they are concerned may have been the victim of torture.[227]

A Rule 35 report being made does not result in the automatic release of a detainee. Instead, the information provided by doctors in the report is considered by a Home Office caseworker, before a decision is then made on whether continued detention is appropriate.

The Rule 35 process has been subject to numerous criticisms and allegations that it fails to adequately protect vulnerable detainees. The All Party Parliamentary Group (APPG) Inquiry into Immigration Detention highlighted serious shortcomings which meant the process was not working as it should,[228] echoed in Stephen Shaw's recommendation that the Home Office immediately consider an alternative mechanism.[229] HM Chief Inspector of Prisons noted that whilst there had been improvements made in the Rule 35 process since the publication of new guidance in 2016, "weaknesses remained in a process that should reflect the highest standards in every case, given the seriousness of the concerns that lead to Rule 35 letters".[230]

Rule 35 in numbers:

Between the third quarter of 2014 and the first quarter of 2015:[231]

- 1,626 Rule 35 reports were made in total.
  - 64 Rule 35(1) reports (individuals whose health would be injuriously affected by continued detention);
  - 14 Rule 35(2) reports (individuals suspected of having suicidal intentions);
  - 1,548 Rule 35(3) reports (individuals suspected of being victims of torture).

- In total, 15 per cent of all Rule 35 reports resulted in release.
  - 23 Rule 35(1) reports (36%);
  - 2 Rule 35(2) reports (14.3%);
  - 222 Rule 35(3) reports (14.3%).

Variability of Rule 35 reports

There is considerable variability in Rule 35 reports across the immigration detention estate, both in terms of numbers, and in quality. In the fourth quarter of 2016, for example, 129 Rule 35 reports were made at Harmondsworth IRC, compared to 35 made at Campsfield House.[232] In terms of quality, the Chief Inspector of Prisons has identified significant variability in the information contained in reports, the way in which concerns are recorded and documented, and problems with delays in assessments.[233],[234]

The numbers quoted above show very clearly that far fewer Rule 35(1) and Rule 35(2) reports are completed compared to Rule 35(3). The reasons for this are not clear, but it may be that there is a lack of knowledge about their existence and use (the majority of available guidance focuses on Rule 35(3)) or because concerns about individuals falling into these categories are being raised through other avenues – for example, through the assessment care in detention and teamwork (ACDT) framework, which is used to monitor individuals at risk of suicide or self-harm.[235]

The Centre for Mental Health noted that some IRCs had delays and backlogs in assessments for Rule 35 which they attributed to changes in the definition of "torture" in the new Home Office policy on adults at risk in detention.[236] The High Court ruling on the change of definition of torture is outlined above.

Training

The guidance on Rule 35 makes clear that "IRC medical practitioners are not expected to have specialist medical training".[237] Doctors will be more familiar with assessing and documenting serious health problems or suicidal ideation as part of their everyday practice, so specialist training may not be so urgent in relation to Rule 35(1) or Rule 35(2). It cannot be assumed, however, that all IRC GPs will have knowledge of the identification, assessment and reporting of injuries inflicted during torture, which can lead to problems in relation to Rule 35(3).

The lack of knowledge and training on the part of GPs has been highlighted in various reviews of the process. The Home Office guidance for staff on the Rule 35(3) process makes clear that it is "a mechanism for a medical practitioner to refer on concerns, rather than an expert medico-legal report" and that there is "no need for medical practitioners to apply the terms or methodology of the Istanbul Protocol".[238] At various points in time, however, reports have been rejected on the basis that they do not constitute independent evidence of torture, because doctors had recorded the signs of torture without expressing a clinical opinion as to whether the injuries were consistent with the account given by the individual.[239] This is an issue that could be addressed with further training.

Rule 35(3) reports should, therefore, be written only by clinicians who have the relevant experience and appropriate training in identifying and documenting the physical and psychological sequelae of torture, and of the Rule 35 process itself. It is crucial that doctors

working in IRCs receive this training and subsequent appropriate support in carrying out this task. In exceptional circumstances, where IRC GPs do not feel able to exercise the skills required of them, they should seek advice and support from local forensic medical examiners (FMEs) or volunteer doctors with organisations such as Freedom from Torture and the Helen Bamber Foundation.

The Home Office issued new guidance on the Rule 35 process in September 2016, and some training has already been provided at a national level.[240] This training is now the subject of local provision, and it is crucial that it is maintained and developed.

Home Office responses

As can be seen in the statistics quoted above, very few Rule 35 reports result in the release of the detained person, and huge numbers of individuals will have their detention maintained. This is clear evidence of clinical judgment being routinely overruled by the Home Office – often with little explanation as to why this has been done.[241,242]

The rejection of a Rule 35 report and continued detention can have a profound effect on the detainee. Keeping a vulnerable individual in detention clearly has potentially serious consequences for their health and wellbeing. A Rule 35 refusal can also irrevocably alter the doctor-patient relationship. If they perceive the doctor to be at fault for their continued detention, it could affect their willingness to access or co-operate with healthcare services. Upon receipt of a response to a Rule 35 report from a Home Office caseworker, doctors are able to challenge the decision reached if they disagree with it – though few are aware of this right. In light of the potentially devastating effects of continued detention on individuals, doctors have a clear duty to respond to decisions they disagree with, and to press for them to be reconsidered.

Our concerns about training and support for medical practitioners apply equally to those responsible for reviewing Rule 35 reports within the Home Office. All individuals involved in the process of reviewing the detention of suspected victims of torture must have the necessary training and support in order to interpret and appropriately assess the evidence provided.

In his review, Stephen Shaw was clear that changes to the existing system would not go far enough in protecting vulnerable individuals.[243] His recommendation for the Home Office to immediately consider an alternative to the process was echoed by the European Committee for the Prevention of Torture, which requested more detailed information on the steps being taken to address his concerns.[244] We believe there is much work still to be done on the Rule 35 process, and offer our support to any review being undertaken.

More detailed guidance about the disclosure of confidential medical information and individual consent is provided in chapter 8, but for the purposes of this section it is useful to note that the Rule 35(3) form itself includes a section which states that the detainee has authorised the release of the information contained within the report. Doctors should confirm that this is the case with patients who have capacity to consent. If the detainee refuses, the doctor can still submit the Rule 35(3) report, but must omit confidential medical information. The detainee should be informed of the possible implications of their refusal.

Guidance for doctors

- Rule 35 reports are not medico-legal reports, and so are not expected to be completed to that standard. They should, however, be clear, legible, and contain sufficient information to help the caseworker in responding to the report.
- Doctors should ask detainees with capacity to give their consent to medical information being shared with the Home Office. If the detainee refuses, the doctor can still submit the Rule 35 report, but must omit confidential medical information. The detainee should be informed of the possible implications of doing so.
- Upon receipt of a response to a Rule 35 report from a Home Office caseworker, doctors can and should challenge the decision reached if they disagree with it.

The role of doctors

Doctors may be the first to become aware of individuals with vulnerabilities falling within the Home Office categories, either through a medical judgment about mental or physical health or wellbeing, or as the result of detainees confiding in them. When this is the case, they should bring their concerns to the attention of centre management or the Home Office through the relevant channels – for example, the Rule 35 process – with a view to the appropriateness of detention being reassessed. In light of the shortcomings in the current processes designed to identify vulnerable individuals, the duty of doctors to recognise vulnerability and to act on their concerns is all the more vital.

Many detainees perceive that they are not listened to or taken seriously if they disclose vulnerability to either healthcare or centre staff. The Centre for Mental Health also reported that many staff members felt it was easy to become part of a culture which automatically disbelieves detainees.[245] It is crucial that doctors who are the recipients of information about vulnerability respond sensitively and appropriately.

Even where they fall short of the categories of vulnerability identified by the Home Office, some doctors may have concerns about detainees they believe to be particularly vulnerable. As outlined in *Good Medical Practice,* doctors have a duty to speak out and take prompt action if they believe patient safety, dignity or comfort is or may be seriously compromised.[246] Doctors should bring to the attention of centre management or the Home Office any individual who they believe to be particularly at risk of harm in detention, and press for reconsideration of their detention.

All organisations should have clear mechanisms in place for reporting concerns, but it becomes more complicated when doctors feel the response to their concern has been inadequate, or where their concerns relate to the organisation itself. Some doctors may be in a position where they need to consider going beyond simply reporting their concerns, to a wider or more public disclosure. The key question for doctors is whether the current situation, if allowed to continue, is likely to result in harm to others, and whether their responsibility to protect and promote the health of patients can best be met by speaking out. In practice, these decisions can be very difficult for doctors and are often best taken through discussion with trusted colleagues or relevant medical defence bodies.

The BMA has produced guidance on raising concerns and whistleblowing, and BMA Employment Advisers can offer support and advice to members.[247] The BMA Counselling and Doctor Advisor Service is also available.[248]

Doctors working in IRCs should also feel able to speak out on wider structural or systemic issues where current policy or practice is having a detrimental impact on health. There is a key role here for professional bodies, such as the BMA, to campaign and lobby as a collective.

Guidance for doctors

- When doctors become aware of vulnerable individuals, as defined by the Home Office guidance, they should bring their concerns to the attention of centre management or the Home Office through the relevant channels with a view to the appropriateness of detention being reassessed.
- In light of the shortcomings in the current processes designed to identify vulnerable individuals, the duty of doctors to recognise vulnerability and to act on their concerns is all the more vital.
- Even where they fall short of the categories of vulnerability identified by the Home Office, some doctors may have concerns about detainees they believe to be particularly vulnerable.
- Doctors should bring these concerns to the attention of centre management or the Home Office, and press for reconsideration of their detention.
- Doctors working in IRCs should also feel able to speak out on wider structural or systemic issues where current policy or practice is having a detrimental impact on health.

Chapter seven: language and cultural issues

The immigration detention population is diverse, with people from different ethnic, religious, and cultural backgrounds. Language differences and cultural issues can inhibit access to healthcare, and make consultations far more complex. The ethical issues associated with using interpreters during consultations is discussed in detail in chapter 8 on privacy and confidentiality, but there are other more subtle or nuanced issues which prevent individuals from accessing healthcare or from participating fully in consultations.

Some detained individuals will have complex and sensitive health needs as the result of torture or violence. These experiences can cause deep-rooted feelings of shame, humiliation and guilt, particularly where it involved an element of sexual violence.[249] They may be reluctant to disclose intimate details to a relative stranger. Some detainees may come from countries where authorities are corrupt or who may have even played a role in their persecution. They may have a deep-rooted mistrust or suspicion of authority figures, and may associate or align medical staff working in centres with security staff or with the wider state functions. It may be helpful for doctors to explain to detained individuals that they are there for their welfare and are independent from the Home Office and centre management; and to emphasise that unless there are reasons otherwise, information shared with them will remain confidential. The circumstances where disclosure may be warranted are outlined in more detail in chapter 8.

Different cultural conceptions of mental health can also affect whether and how detained individuals experiencing psychiatric and psychological ill health interact with healthcare professionals. Many measures of psychological distress are distinctly Western notions, and so questions about mental health may be less relevant for some individuals. Somatisation is a frequent occurrence with individuals complaining of physical symptoms or non-specific pain when in fact they are experiencing considerable mental distress.[250] At the same time, however, doctors should not assume that odd behaviour or symptoms are simply attributable to cultural differences, and should ensure a sensitive and thorough response to each detainee.

There can also be considerable stigma in many cultures around mental health and many individuals will not want to be seen to be accessing services and support. Positive experiences have been reported from IRCs which use an outreach programme, through which healthcare staff spend time in the residential and common areas of IRCs and engage individuals in a more informal way. The Centre for Mental Health noted that this might be "less stigmatising for individuals, who may not see themselves as having a mental health problem, but are experiencing increased stress and distress since being detained".[251]

Other cultural barriers may exist in relation to sexual health or drug or alcohol use. Significant numbers of detainees (42%) refused to even answer the question of whether they had received a sexual health screening since arriving at the IRC in response to NHS England's Health and Wellbeing Needs Assessment.[252] Similar problems may exist in relation to drug or alcohol use. NHS England's Health and Wellbeing Needs Assessment identified significant numbers of detained individuals who reported drug or alcohol problems, but suggested that the real figure could be higher. A large proportion of the detainee population comes from religious or cultural backgrounds with a strong prohibition on the use of alcohol and drugs, and so cultural barriers and fears of recrimination could inhibit detainees coming forward.[253]

The process of building trust and getting to the root of the problem not only requires a sensitive and skilled communicator, but is dependent on health professionals having sufficient time. A crucial part of ensuring that doctors can meet their obligations to patients will therefore be for management to provide doctors with the time and space in which to address the needs of patients – for example, by providing longer consultation times, the technical equipment necessary for effective consultations, and appropriate time for non-clinical professional development.

Guidance for doctors

- Language differences and cultural issues can inhibit access to healthcare, and make consultations far more complex.
- It can take time to develop trust in the doctor-patient relationship so that the patient discloses sensitive information and to aid this, it may be helpful for doctors to emphasise their independence from the Home Office and centre management.
- Doctors should be aware that detained individuals may present with different conceptions or understandings of mental health, and that it may take time to get to the root of the problem and to gain the trust of patients.

Chapter eight: privacy and confidentiality

As with patients in the community, doctors have a duty to maintain the privacy and confidentiality of detained patients. However, this can be challenging within an immigration detention setting. Various individuals or bodies have an interest in some of the information being exchanged and doctors working in IRCs may feel pressurised to disclose confidential patient information to centre staff or the Home Office. Various other pressures on doctors, including the use of interpreters in consultations, uncertainty over their precise responsibilities in sharing confidential medical information, and issues relating to resources and the physical environment of the IRC can also impact on privacy and confidentiality.

The basics

Patients are able to decide with whom, when, and where to share health information. Once that information has been disclosed, they can expect that it will not be shared more widely. Doctors have a corresponding obligation to respect patients' rights to privacy, autonomy and choice, and to hold information that has been shared with them in confidence. This is not just a professional obligation, but part of the right to private and family life protected under Article 8 of the European Convention on Human Rights and guaranteed in the UK by the Human Rights Act 1998.

Confidentiality is fundamental to ensuring trust in the doctor-patient relationship. Doctors owe a professional and legal duty of confidentiality to all patients, and this applies equally to detained individuals and patients in the community. In the immigration detention setting, where patients may be more inclined to mistrust doctors – either as a result of previous negative interactions with healthcare professionals, or because to their mind they are aligned with the Home Office and running of the IRC – it can be particularly beneficial to emphasise the duty of confidentiality and reassure patients that their information will be kept confidential, with some limited exceptions.

Article 8 of the European Convention on Human Rights is not absolute, and may be derogated from where the law permits and where "necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others".[254] Any infringement of this right must be legitimate and proportionate. In other words, the right to privacy is an important principle which must be respected, but it may be breached where other significant interests prevail. Similarly, the common law duty of confidentiality in the UK makes clear that confidential information can be disclosed in a select number of circumstances: where patients consent to that disclosure, where the disclosure is required by law, where statute permits the disclosure, or where there is a sufficiently strong and overriding public interest in disclosure.[255] Whilst doctors should emphasise their duty of confidentiality to patients in IRCs, they should also make sure patients understand that confidential information may have to be shared in some limited circumstances.

The detention environment

The reality of life in a secure setting, where the focus is on surveillance and security, can put rights of privacy and confidentiality under stress. In his review, Stephen Shaw noted that "all but one IRC" had an area for initial assessment, appointment booking, and collecting prescriptions that was in full sight and earshot of other detained individuals.[256] The Centre for Mental Health's analysis similarly noted the "inadequate" number of private rooms and offices available for clinics and therapy to take place.[257] As a consequence, medical information is often shared within earshot of other detained individuals or non-healthcare staff, so undermining the right to privacy and confidentiality.

The use of interpreters

Statistics about languages spoken in IRCs are not available, but it is clear that many individuals will present with limited English, and that some will speak no English at all. The use of interpreters is therefore a crucial link in ensuring information is correctly shared and relevant services and support accessed. The Detention Service Orders state that professional interpreting facilities must be used whenever language barriers are identified.[258] There are reports, however, that this is not always achieved, or that professional telephone interpreting services are not available (particularly late at night) or that there is a reliance on other detainees who speak the same language.[259]

It will generally be inappropriate to ask another detainee to act as an interpreter for the purposes of a healthcare consultation. It raises potential problems with confidentiality, particularly where patients may wish to discuss intimate or sensitive issues such as sexual health or previous traumatic experiences. Depending on the nature of the relationship, there may also be questions about the accuracy of the information being shared. Furthermore, it is difficult to guarantee that gender or cultural preferences for an interpreter can be met when relying on other detainees. For example, women may be unwilling to disclose sensitive information in front of a male interpreter, or there may be individuals who, while they share a common language, come from different ethnic backgrounds which may have a history of conflict.

Unless there is an emergency, and there is no alternative, detainees should not routinely be asked to act as interpreters for other detained individuals. The services of a professional and accredited interpreter should be engaged, for example, through telephone interpreting services. Centres must be careful not to rely on embassies or official agencies of the patient's home country – particularly where the individual alleges torture or ill treatment at the hands of state authorities, as information may be collected that puts patients or their relatives at risk.[260]

There may be some occasions, however, where detainees specifically request that another detainee act as an interpreter in the consultation. This should only be done where the individual in question makes this request and consents explicitly to their use. Doctors should be aware of the risks of using another detainee in this manner, particularly of the possibility of there being coercive elements in the relationship, and make a decision on how to proceed on this basis.

For doctors who are not used to working with interpreters, their inclusion in the consultation can be challenging. Challenges in using an interpreter can include a tendency to speak directly to the interpreter instead of the patient, using third person statements (e.g. "tell her"; "he said"), and difficulties in building the ordinary rapport of a consultation. Training in the use of an interpreter should form a basic part of training for doctors working in IRCs.

Guidance for doctors

- Every effort must be made to secure the services of a professional and accredited interpreter.
- Unless there is an emergency, and there is no alternative, detainees should not be asked to act as interpreters for other detained individuals.
- Where detainees specifically request that another detainee act as an interpreter for them, doctors should respect that decision. They should, however, be mindful of the risks associated with doing so, and remain particularly vigilant to elements of coercion.

Health records and confidentiality

Doctors should familiarise themselves with their role and responsibility in keeping health records secure and confidential. The same basic principles from the community apply in relation to keeping manual records securely stored and preventing inappropriate access to electronic records. The BMA publishes detailed guidance on confidentiality and health records, which can be found online at www.bma.org.uk/ethics.

IRCs in England will shortly be moving to an electronic health information system which will allow all IRCs access to electronic patient records. We welcome timely and efficient flow of health information which this system integration should allow, with the important caveat that confidentiality is protected throughout.

At present, individuals frequently arrive in detention with no accompanying medical histories either because they do not exist, or because, where information-sharing is poor, existing health records cannot be obtained. Currently, the transfer of information can take considerable time, which is not always available in the immigration detention setting, where individuals can move on before notes have been identified and shared.[261] It will be crucial that arrangements are made to ensure the sharing of relevant medical information between England and those immigration detention settings in Scotland and Northern Ireland.

Concerns have been raised about the confidentiality of health records in IRCs with detainees being asked to consent to their medical records being shared with the Home Office.[262] The Shaw review into vulnerability in immigration detention also noted the concerns of some stakeholders that healthcare information provided for one purpose is then shared too widely within the IRC and Home Office.[263] There have been reports of medical information being recorded in non-clinical records – NHS England's Health and Wellbeing Needs Assessment of IRCs highlighted incidents of patients' HIV status being recorded on the front of IS91 forms (the warrant of detention form all detainees have).[264]

There are some circumstances within IRCs where health information will need to be shared more widely – an issue explored in more detail in the following section. In relation to health records, however, it is important to emphasise that there should not be wholescale sharing of complete medical notes. Where information does need to be shared with other centre staff or management, only the information necessary to fulfil this requirement should be disclosed.

Many patients in IRCs will not be aware of their rights in relation to access to health records. In addition to ensuring that patients understand that information will be recorded confidentially, doctors should make patients aware that they are allowed to view their health records and request copies.

Guidance for doctors

- Doctors should familiarise themselves with their role and responsibility in keeping health records secure and confidential.
- Doctors should be particularly vigilant in ensuring that medical information is not recorded in non-clinical records and that healthcare information is not shared widely within the IRC and Home Office.
- In addition to ensuring that patients understand that information will be recorded confidentially, doctors should make patients aware that they are allowed to view their health records and request copies.

Disclosing confidential information

As noted above, the right to confidentiality is not absolute and doctors can disclose confidential information in a limited number of circumstances. There are a number of basic principles which apply to any disclosure:

- patient consent should be obtained for the disclosure of confidential information other than in exceptional circumstances;
- consent should be informed and freely given;
- where consent cannot be obtained or is not given, information may still be disclosed where the law requires it, where statute permits disclosure, or where there is an overriding public interest which would justify disclosure;
- disclosures should be kept to the minimum necessary to achieve the intended purpose and shared on a strictly "need to know" basis;
- doctors must be able to justify any decision to disclose information without the patient's consent.

In the immigration detention setting, there will be a range of circumstances where disclosure may be necessary. Chapter 6 covered the Rule 35 process in some detail, and the circumstances in which information about a detainee will need to be shared. Doctors should explain to the detainee what information will be shared, and why, and ask detainees with capacity to give their consent to this information being shared. If the detainee refuses, the doctor can still submit the Rule 35 report, but must omit confidential medical information.

Removal is another circumstance where confidentiality can be compromised. Accompanying officers may require access to some medical information about the individual and will need to hold any medication needed during the journey. The confidentiality of this information must be emphasised with the escorts, and individuals should be asked to consent to that sharing of information ahead of time.

In the absence of consent, information may still be disclosed where it is required by law, or where there is an overriding public interest which is sufficiently serious to justify disclosure. Doctors have a duty under law, for example, to notify Public Health England of certain reportable infectious diseases.[265] A disclosure can also be made without patient consent where it is in the public interest – that is, essential to protect the patient or someone else from serious harm, or for the prevention, detection or prosecution of a serious crime.[266] The benefits of making such a disclosure must be carefully weighed against the harms associated with breaching confidentiality, and doctors must ensure they can justify their decision. All decisions to make a disclosure without consent should be explained to the patient and documented in the medical record.

Doctors working in detention settings are sometimes faced with a conflict between maintaining confidentiality and the obligation to assist in ensuring the legitimate security and safety interests of the IRC. When managers need information in order to protect the security or safety of detainees, doctors have an obligation to divulge it – for example, where doctors are the recipient of information or have concerns about allegations of bullying and harassment, or where doctors are concerned that an individual has suicidal ideations. It is essential that these concerns are acted upon and information is given promptly to an appropriate person or statutory body, in order to prevent future harm. In keeping with the general principles related to disclosure of information, only relevant health information should be shared, and the disclosure should be made on the strictest "need to know" basis.

There is also a long-established principle that relevant information can be shared with fellow health professionals on the basis of implied consent, and where there is no reason to believe that the patient has objected. This is based on the patient's reasonable understanding of who has access to their medical information and the reasons why it is being shared. Where that might involve sharing particularly sensitive information, it is helpful to confirm that understanding explicitly. It is important to note that information in relation to treatment for sexually transmitted diseases is subject to statutory restrictions and should not be disclosed other than to a medical practitioner in connection with the treatment of that disease or the prevention of transmission.[267]

Guidance for doctors

- All patients are owed a duty of confidentiality, but this is not an absolute duty.
- It can be particularly beneficial for doctors working in IRCs to emphasise their duty of confidentiality to patients who may be hesitant to divulge sensitive information. They should, however, also make clear that confidential information may have to be shared in some circumstances.
- Patient consent should normally be sought for the disclosure of confidential information.
- Where consent cannot be obtained or is not given, information may still be disclosed where the law requires it, where statute permits disclosure, or where there is an overriding public interest which would justify disclosure.
- The benefits of making such a disclosure must be carefully weighed against the harms associated with breaching confidentiality, and doctors must ensure they can justify their decision. All decisions to make a disclosure without consent should be explained to the patient and documented in the medical record.
- Patients should be fully informed as to what information is being shared, who it will be shared with, and how it may be used.
- Where centre management requires information in order to protect the security and safety of patients or other detainees, doctors have a duty to disclose, regardless of consent.
- Disclosures should be kept to the minimum necessary to achieve the intended purpose and shared on a strictly "need to know" basis.

Chapter nine: capacity and consent

It is a well-established principle in medical ethics and law that patients with capacity have the right to consent to, or refuse, medical care and treatment. This is an expression of the fundamental right of autonomy and self-determination. Detained individuals do not lose their fundamental rights to make medical decisions for themselves, but there are various elements of the detention environment which can affect capacity and consent. The mental illness, distress, and language and cultural barriers commonly found amongst the detained population can have an impact on an individual's capacity, and therefore, their ability to consent to or refuse treatment. The refusal of food or fluids as an act of protest also poses unique challenges for doctors working in these settings.

More detailed guidance about assessing capacity, and the process of consent and refusal, can be found at www.bma.org.uk/ethics.

The basics

Patient consent is required on every occasion the doctor wishes to initiate an examination or treatment or any other intervention. There are a very limited number of exceptions to this, which include emergency treatment, or where the law states otherwise (for example, where compulsory treatment is authorised by mental health legislation). Consent may be express or implied. Consent is not a one-off decision, but a continuing process of information giving and explanation that facilitates informed decision-making.

For consent to be valid, the patient must have capacity (which is governed by the Mental Capacity Act 2005 in England and Wales; the Adults with Incapacity Act (Scotland) 2000 in Scotland; and the common law in Northern Ireland), be fully informed, and be consenting voluntarily. It is a basic legal principle that adults are assumed to have capacity, unless it is proven otherwise. Adults with capacity can refuse treatment at any time, and this refusal must be respected, even where it may result in serious harm.

Children and young people judged as having capacity can also consent to treatment on their own behalf, although there are some restrictions on their ability to refuse treatment (explored in more detail below). Where patients lack capacity, treatment should be provided in their "best interests" (or "benefit" in Scotland).

Consent to examination and treatment

In detention, individuals are ordinarily more vulnerable due to the loss of autonomy and choice. This does not mean, however, that consent can never be freely given in an IRC setting. When seeking consent for treatment in an IRC, doctors should be mindful of the impact that specific factors may have on an individual's ability to consent. The effects of illness, or general fear and anxiety about their immigration status or detention can all undermine an individual's ability to freely and voluntarily consent to treatment.

Effective communication is an essential component of the consent process, both in terms of providing patients with sufficient information to ensure that consent is valid, and making sure that patients are not coerced into consenting to treatment. The validity of consent can be compromised if patients do not speak English, and no translation or interpreting services have been provided. Special effort may need to be made to explain information in a way in which a detainee can understand. The emphasis on autonomy and consent may be a more alien concept to some detained individuals, so doctors should clearly explain their role in the examination and treatment process, and ensure that the detained individual is aware of their rights of consent and refusal.

Where an adult has capacity and refuses an examination or treatment, that refusal should be respected and clearly documented in the patient's notes. An exception exists under the Immigration and Asylum Act 1999, whereby the manager of a centre can require that a detainee undergo a medical examination if it is suspected that they have a certain transmissible disease. In these cases, the doctor must still seek consent, explain the nature of the suspected disease, and tell the patient that refusal, without a reasonable excuse, is an offence.[268]

Guidance for doctors

- Doctors should seek consent for all examinations and interventions if a patient has capacity.
- Doctors should be mindful of the impact that some elements of the detention setting can have on a patient's ability to consent. They may need to make special effort to maximise a patient's ability to be involved in decision-making.
- An adult patient with capacity has a right to refuse any medical examination or treatment for any reason, even where the decision could lead to serious harm.
- If it is suspected that a detainee may have an infectious disease, the manager of the centre can require that they undergo a medical examination. In these cases, the doctor must still seek consent, explain the nature of the suspected disease, and tell the patient that refusal, without a reasonable excuse, is an offence.

Patients who lack capacity

As noted above, adults should be assumed to have capacity unless there are grounds to suspect otherwise. The assessment of capacity is "decision-specific", which means that it asks if the individual has the capacity to make a specific decision at that specific time, not whether they have the ability to make decisions generally. The responsibility for proving that an adult lacks capacity falls upon the person who calls it into question.

Before it is decided that someone lacks capacity, everything practicable must be done to maximise decision-making capacity. Additional communication support may be necessary, and consideration should be given to whether an individual's capacity is affected by other external factors, such as the time of day or medication.

Decisions about care and treatment for incapacitated adults must be made on the basis of their best interests (or "benefit" in Scotland), following the guidelines set out in the relevant legislation. Among the factors to be taken into account in making a decision about proceeding on best interests are:

- the patient's own wishes and values (where these can be ascertained);
- clinical judgment about the effectiveness of the proposed treatment, particularly in relation to other options;
- where there is more than one option, which option is less restrictive of the patient's future choices; and
- the likelihood and extent of any degree of improvement in the patient's condition if treatment is provided.

A "best interests" or "benefit" decision must take into account the individual's welfare in the broadest sense, which extends beyond medical factors to incorporate social and psychological dimensions of wellbeing. A crucial part of any best interests judgment will involve a discussion with those close to the individual, including family and friends, where it is practical and appropriate to do so, bearing in mind the duty of confidentiality. In the immigration detention setting, where large numbers of people will lack established relationships or social contacts in the UK, this will be difficult, if not impossible.

A lack of capacity is not itself an indicator of risk of vulnerability in detention for the purposes of the Home Office guidance, but it may indicate the presence of another condition or impairment which might mitigate against detention. Even where this is not the case, doctors may be concerned by an individual's lack of capacity to make medical decisions, and question whether this indicates a wider lack of capacity to make other decisions while detained – including legal decisions about their immigration or asylum claim. At present, these two aspects of capacity are very much viewed in isolation, and there is currently no formal mechanism in place for concerns about mental capacity to be shared with the Home Office.[269]

Despite the lack of a formal mechanism for raising concerns, doctors should express their concerns to the centre manager or a Home Office caseworker, with a view to exploring safeguarding options and ultimately, a review of the decision to detain.

Guidance for doctors

- Decisions about care and treatment for incapacitated adults must be made on the basis of their best interests (or "benefit" in Scotland), following the guidelines set out in the relevant legislation.
- A lack of capacity is not itself an indicator of risk of vulnerability in detention for the purposes of the Home Office guidance, but doctors should consider whether it indicates the presence of another condition or impairment which might mitigate against detention, and take appropriate action.
- Even where this is not the case, doctors may be concerned by an individual's lack of capacity in the detention environment. Despite the lack of a formal mechanism for raising concerns, doctors should express their concerns to the centre manager or a Home Office caseworker, with a view to exploring safeguarding options and ultimately, a review of the decision to detain.

Children and young people

Doctors should be aware that they may occasionally be called upon to examine or treat children and young people detained with their families. All people aged 16 and over are presumed in law to be competent to give their consent to medical treatment and to the release of information in England, Scotland, Wales and Northern Ireland. Children and young people under the age of 16 can also be competent, but this needs to be assessed on an individual basis.

Children and young people who are deemed competent have the same rights to consent as adults. However, they may not always be able to refuse treatment, particularly where it is for a serious condition and, from a clinical perspective, is demonstrably in his or her best interests. This usually relates to refusals of life-saving treatment or treatment that would prevent permanent injury.

Where a child or young person lacks capacity, others are legally entitled to give consent for treatment, including their parents or those with parental responsibility. In some circumstances, where a parent's decision is contrary to the interests of the child, it may be necessary for doctors to make a decision on the basis of their best interests. In some cases, this may require the involvement of the court.

Specific guidance about consent and capacity in children and young people can be found online at www.bma.org.uk/ethics.

Food and fluid refusals

The refusal of food or fluids (often referred to as a "hunger strike") is often used as a form of protest in detention settings, as it is often perceived by individuals as the one way in which they can assert their autonomy in an otherwise tightly controlled regime. A Freedom of Information Act request brought by an organisation called No Deportations found that there were 218 food and fluid refusals (defined as not eating for 48 hours or drinking for 24 hours) in immigration detention settings across three months in 2016.[270]

The Detention Services Order 03/2013 sets out the procedures that must be adopted for handling food and fluid refusals by detained individuals in IRCs. It is intended to be read in conjunction with the Department of Health's own guidelines for the clinical management of food and fluid refusals in detention settings, which includes comprehensive information on both the legal aspects and physical effects of food and fluid refusal.[271]

When individuals refuse food and fluids, they should be offered a medical examination. Doctors should also consider whether the individual has capacity to be able to make this decision, bearing in mind that, if in doubt, specialist psychiatric assessment may be required in order to determine an individual's ability to make a valid refusal. Doctors should be mindful of the potential coercive nature of some protests, as where these are a form of group protest, some detainees can be under considerable peer pressure to participate. Doctors should ensure that they speak to patients privately about their decision and, if it becomes clear that they are acting non-voluntarily, efforts should be made to remove the pressures on the patient.

If an individual is deemed to have the capacity to make this decision, doctors should provide them with accurate clinical information about the foreseeable consequences of their action. Discussion with the patient about their aims and intention is also crucial in order to determine what they wish to happen in the event of an emergency once they have lost capacity. Respecting the voluntary refusal of patients with capacity accords with the principles set out in the World Medical Association's Declaration of Malta, which affirms that patients with capacity who refuse food should not be fed artificially.[272]

Individuals who are seriously ill as a result of their actions should also be transferred to an in-patient setting. The Detention Services Order 03/2013 on the management of food and fluid refusals states that consideration may be given to transferring detainees to a prison medical facility at the point where they are clinically assessed to require in-patient care. We believe that it would be inappropriate to transfer individuals who have not been convicted of a crime to a prison setting, and that individuals should always be transferred to an NHS hospital where they can receive appropriate care.

Guidance for doctors

- Doctors should assess any patient who undertakes a hunger strike in order to establish whether they have the capacity to do so.
- In some cases, specialist psychiatric assessment may be required.
- Doctors should be mindful of the coercive nature of some protests. Where it is clear that a person is not acting voluntarily, doctors should take action to remove the coercive pressures on the patient.
- Where individuals with capacity refuse food or fluids, that decision should be respected.
- Doctors should provide patients with accurate clinical information about the foreseeable consequences of their actions, and discuss with them what they wwish to happen in a future emergency where they lack capacity.
- Individuals who are seriously ill as a result of their actions should be transferred to an NHS hospital where they can receive appropriate care.

Chapter ten: professional isolation and morale

Working, often alone, in a closed setting like an IRC means it can be easy for doctors to become detached from their clinical role and find themselves absorbed, uncritically, into the detention system.

In the UK, doctors working in IRCs are not Home Office employees, but are engaged on behalf of the NHS. Significant numbers of IRC GPs do not work there full-time, and most will balance their work with sessions in the community, which provides an important link between the two. Many doctors working in IRCs, in common with their colleagues working in prisons, still report a sense of profound professional isolation from their colleagues in the community – a consequence of a lack of peer support and clinical supervision from within their workplace.[273] Doctors working in IRCs can feel to some degree, professionally marginalised and undervalued. Theirs is a "Cinderella service" – under-funded and under-appreciated. A lack of understanding from colleagues in the community and from the general public can compound these feelings.

The lack of scrutiny and support for doctors working in secure settings, in the most extreme cases, can result in doctors becoming inured to abusive or negligent practices, or it becoming harder to speak out or raise concerns about those practices. Most concerning for doctors working in IRCs is the risk that they become cynical and absorb the "culture of disbelief" – the assumption that individuals are lying or exaggerating for attention or to further their own aims – which pervades the immigration system.[274] A frequent concern of the way that healthcare is provided in IRCs is that individuals complaining of physical or mental health problems are assumed to be lying about or exaggerating them in an attempt to manipulate or disrupt the system. Many detainees and ex-detainees have complained of doctors and nurses refusing to prescribe anything other than paracetamol,[275] or centre staff refusing to call out ambulances when detainees report an emergency.[276] It is vital that doctors maintain an approach which meets professional standards and is compassionate. Continuing practice in a community setting may assist in allowing a doctor to do this.

The complex nature of practising in an IRC setting, the traumatic nature of many detained individuals' histories, and the difficulties in ensuring detained individuals receive appropriate care can take its toll on doctors and morale can suffer. Staff responsible for implementing ACDT approaches have reported a lack of support being available to them following distressing incidents.[277] As one mental healthcare practitioner told the Centre for Mental Health, "I think some of the things we hear are really difficult and I don't really get much opportunity to talk things through".[278] Working in networks with colleagues, and taking full advantage of opportunities for personal and professional development, can help support morale. Advice and support can also be sought from professional bodies such as the BMA.

Education and training

The lack of training and continuing professional development available to doctors working in IRCs can be a contributing factor to low morale and professional isolation.

Training for staff working in IRCs has also been frequently identified as a concern with regard to the provision of mental healthcare. The Centre for Mental Health identified variability in access to training on mental health issues, with many mental health staff working in IRCs reporting that they felt they needed more training on assessment and management of trauma and severe mental and emotional distress.[279] [280] It is deeply concerning that health staff feel ill-equipped to treat and support individuals with mental health problems, and we support the recommendations of the Centre for Mental Health that practitioners in IRCs should receive access to training and clinical updating.

It is also crucial that all security staff members working in IRCs receive training in mental health awareness: as the staff members who will interact with detained individuals on a daily basis, they are best placed to identify changes or deterioration in an individual's health or wellbeing. We welcome plans to ensure all staff in IRCs have access to continued professional development in managing welfare issues and in identifying and responding to manifestations of torture.[281]

Guidance for doctors

- Doctors should take advantage of opportunities for professional development in order to alleviate some of the isolation associated with working in IRCs.
- Doctors should familiarise themselves with resources and support available to them, such as the BMA's counselling and advice services.
- Doctors should be familiar with the processes in place for raising concerns.

Part three – conclusions and recommendations

Part three – conclusions and recommendations

The UK immigration detention system detains upwards of 30,000 people each year, up to 3,500 at any one time, in 11 centres across the UK. It is one of the largest systems of immigration detention in Europe. Some of those detained will have endured peril and persecution and look to the UK for safety and security, whilst others will have been in the country for some time prior to their detention. Some will remain in detention for a few weeks, others for years; some will leave detention to be removed from the UK, whilst others will be released in the UK either temporarily or permanently. Regardless of when, how, or why they are detained, every person who enters the detention estate can and should expect their fundamental rights to be safeguarded.

Healthcare is one part of the wider practice of immigration detention, but a part which is fundamental to the state meeting its obligations to those detained. This report was conceived with two main purposes: to provide support and guidance for doctors working in these settings and, in recognition of the fact that various policies and practices can make it difficult, if not impossible, for doctors to meet their obligations to patients, to make recommendations aimed at addressing aspects of the detention system which affect health and wellbeing.

This report was driven by the BMA's growing concern about health and human rights in detention settings, and follows on from the publication of *Young Lives Behind Bars* in 2014 which explored the health and human rights of children and young people in the criminal justice system. It forms part of our commitment in advocating for those groups and individuals who may be experiencing infringements of their rights. Few groups are as hidden from public view as the immigration detention population; a group that is vilified and ignored in equal measure. Various lobby groups, parliamentarians, and reviews of the system have already called for change. We hope this report will add the voice of the medical profession to that debate.

Immigration detention engages a myriad of issues – political, legal and social. It is not for the medical profession to dictate far-reaching policy change or review. What we have done in this report, is to highlight current areas of policy which impact most strongly on the health and wellbeing of detained individuals or affect the ability of doctors to act in the best interests of their patients. Below, we present a number of recommendations grouped under five key headings aimed at addressing those issues.

None of these challenges are insurmountable, although some may require more investment than others. We look forward to working with policy makers and other organisations to restructure and develop policies and processes which meet the health needs of detained individuals and allow doctors to meet their ethical and professional obligations to patients.

1. **Revise detention policies to address the significant health effects indeterminate detention can have on individuals.**
   - The detention of people who have not been convicted of a crime should be a measure of last resort.
   - The Home Office should consider more humane means of monitoring individuals facing removal from the UK by replacing the routine use of detention with alternate, more humane means. Detention should be reserved for those individuals who pose a threat to public order or safety.
   - Where individuals are detained, there should be a clear limit on the length of time that they can be held in immigration detention, with a presumption that they are held for the shortest possible period.
   - Detention can be especially detrimental to the health of more vulnerable individuals (including children, pregnant women, victims of torture, and those with serious mental illness) who should only be detained in exceptional circumstances.
   - The Home Office should consider how best to develop processes which routinely screen people before they enter detention for vulnerabilities which leave them particularly susceptible to harm, and explore the extent to which health professionals should be involved in this.
   - The Home Office should review its systems for raising concerns about detained individuals, including the current Rule 35 process.

2. **Address aspects of the detention environment which affect the health and wellbeing of those detained.**
   - There must be continued investment in the physical environments of IRCs in order to ensure obligations to patients (such as medical confidentiality) can be met.
   - Many detained individuals will present with complex health needs. Doctors working in IRCs must be provided with adequate time and suppport to best meet those needs.
   - The practice of moving detained individuals into and between IRCs at night or early in the morning should end, unless there are exceptional reasons for doing so.
   - Force, restraint, and segregation should be used only as a last resort. The Home Office should take steps to amend its policy and guidance to reflect this.
   - In particular, segregation units should not routinely be used as a way of managing individuals at risk of suicide, self-harm, or those experiencing a serious mental health crisis.

3. **Reconfigure current healthcare provision to better achieve equivalence of care.**
   - Greater consideration should be given to how mental health therapies and interventions which may be more widely available in the community, can be provided in a detention setting.
   - Greater recognition should be given in policy and guidance to the fact that there will be circumstances where a person's health needs can no longer be adequately met in detention, and that this should trigger a review of the appropriateness of detention.
   - Problems with recruitment and retention across the IRC workforce must be addressed in order to prevent staff shortages negatively affecting the health and wellbeing of detained individuals.
   - In order to ensure that the health needs of detained individuals are being identified correctly, a standardised screening assessment tool should be developed and implemented.
   - Healthcare staff should be given as much notice as possible ahead of the release or removal of a detained individual so that they can ensure, as far as possible, that individuals leave detention with the appropriate medication and health information. Where they are being released to the UK, this should include information about accessing healthcare in the community.
   - Consideration should be given to how healthcare provision can be arranged and commissioned to ensure consistency across the immigration detention estate.

4. **Provide training and continued support in health and wellbeing issues for all those working with detained individuals.**
   - The Home Office and NHS England must ensure that appropriate training is provided to all IRC GPs so they are appropriately skilled to carry out Rule 35 assessments. This should include GPs working in Dungavel House IRC in Scotland.
   - Training in interpreting and assessing Rule 35 reports should also be provided to all relevant Home Office staff.
   - The Home Office and NHS England should consider providing, as standard, training in the use of interpreters in consultations for all doctors working in IRCs. Similar training should be provided in Dungavel House IRC in Scotland.
   - All health professionals working in IRCs should have access to regular training and clinical updating opportunities on mental health issues.
   - All health professionals working in IRCs should have access to training on culture and diversity awareness, and on LGBT issues and awareness.
   - All staff in IRCs who have contact with detainees should have access to regular training and development opportunities in identifying and responding to mental health crises.
   - The Home Office and NHS England should retain national oversight of training opportunities to ensure participation and consistency of approach. Similar opportunities should be provided to GPs working in Dungavel House IRC in Scotland.

5. **Recognise the importance of doctors acting with complete clinical independence and ensure that that principle is enshrined respected across the immigration detention estate.**
   - Considerations of cost or resources should not be allowed to override clinical judgment. When, in the view of the doctor, a detained individual requires care beyond that which can be provided in the IRC, that view must be respected and acted upon.
   - Doctors should never be involved in disciplinary or non-therapeutic activities within IRCs.

Part four – guidance for doctors

Part four – guidance for doctors

Doctors, through providing high-quality care to patients, play a crucial role in ensuring that the state's obligations to detained individuals are met. As has been stressed throughout this report, doctors working in IRCs owe the same ethical and legal obligations to their patients as they would in any other setting. For this reason, our intention with this report was not to develop a separate code of ethics for doctors who work in these settings. Instead, in acknowledgment of the particular challenges which face doctors working in the immigration detention environment, we have provided a series of guidance notes throughout the report. These are summarised here.

General ethical principles

- A doctor's primary duty is to their patient.
- Doctors must recognise and work within the limits of their competence, and take steps to keep their professional knowledge and skills up to date.
- Doctors must work to protect and promote the health and safety of patients and the public, and should take prompt action if they believe that is threatened or compromised.
- Medical care should be provided on the basis of clinical need, impartially, and without discrimination.
- Doctors are personally accountable for their professional practice, and must always be able to justify their decisions and actions.
- Recognising and understanding the circumstances in which dual obligations arise, and remembering that doctors are never absolved of their overriding ethical responsibilities to patients, are crucial in adhering to their core obligations.

Equivalence of care

- Doctors should ensure that individuals released from detention in the UK have an appropriate supply of medication, a summary record of their medical notes, and information about accessing healthcare services in the community.
- Detainees with particular needs – including those with mental health issues, HIV, or who have been the victims of torture – should be released with proper referral to specialist care in the community, recognising that this may not always be possible if it is unclear where an individual will be living.
- Individuals being removed from the UK should receive an appropriate supply of medication, any necessary travel vaccinations or malarial prophylaxis, and a summary record of medical information and treatment.
- Where doctors believe that the needs of the patient cannot be met in the detention setting, or that the setting is contributing to a serious and unacceptable deterioration in health, they should advocate for changes to be made.
- This may include the use of the Rule 35 process to highlight concerns and lead to the review of the detention decision.

Dual Loyalties

Clinical independence

- Care and treatment should be provided on the basis of a doctor's clinical judgment.
- Where doctors are faced with resistance from management, they should make their clinical recommendations known to centre management and try to reach an agreement.
- If, after discussion, agreement cannot be reached, it may be helpful to seek a second opinion from a colleague working in another IRC or in the community, or to contact your personal medical defence union, the GMC, or the BMA.

Medical involvement in age disputes

- Doctors should not use their clinical skills to assist with age assessment processes, but have a role to play in ensuring such individuals are identified.
- Where doctors are concerned that a detained individual is in fact under the age of 18, they should make those concerns known and ensure that the correct safeguarding vulnerable children procedures are followed.
- Where an age-disputed detainee is held in segregation, doctors should be mindful of the potential impact on health and visit them regularly for the duration.

Removal from the UK

- The point of removal from the UK is a very difficult time for many detainees. Doctors should be aware of the need for increased support around this time.
- Where doctors believe that the benefits to the patient's health outweigh the harms of being informed of removal in advance of the 72-hour minimum period, they should document this, raise their concerns with centre management or a Home Office caseworker, and seek to reach a joint decision.
- In exceptional circumstances, where staff and managers decline to inform the detainee ahead of time, doctors should consider and seek advice as to whether they should inform the patient of the removal decision in advance – also informing centre management so that additional support and monitoring can be provided.

Fitness to travel

- Individuals are presumed fit to travel unless there are reasons to believe otherwise. Assessing someone's fitness to travel is a task that will fall to the IRC GP. In these circumstances, doctors are not affirming or endorsing the decision of the Home Office to remove someone, but raising concerns where individuals are not fit to travel.
- Doctors should remain focused on their obligations to their patients, and make statements that are truthful.
- Doctors should ensure the individual understands the process for which examination is being undertaken, and that consent has been obtained for the examination and sharing of relevant information with the Home Office.

Use of force and restraint

- It is crucial for the doctor-patient relationship that doctors remain independent from the running of the IRC and the wider immigration system. Doctors should make clear to detained individuals that they are in IRCs to act in a welfare capacity.
- Doctors have an important role to play in protecting health and wellbeing by raising concerns where there are medical reasons why someone should not be restrained. Their advice should be respected and acted upon, and in doing so, ensure that harm is kept to a minimum.
- Doctors should see all individuals after any incident of restraint in order to assess physical and psychological health and wellbeing.
- Doctors should never carry out medical examinations or treatment on individuals who are restrained, unless they pose an immediate serious risk to themselves or to others.
- Doctors have a duty to speak out against violent, abusive or negligent practices, and should raise concerns where they feel restraint or force is being used illegitimately.

Use of segregation

- Doctors should never be involved in certifying an individual as "fit" to withstand segregation.
- If a doctor identifies any concerns about the impact segregation will have on the health and wellbeing of the individual, they must raise these with the centre manager and press for the decision to be reconsidered.
- Doctors should ensure those in segregation can continue to access healthcare, and report to centre management anyone whose health they believe is deteriorating in segregation.
- Medical examinations and consultations of an individual in segregation should be carried out in a way which respects their rights to privacy and confidentiality.
- Segregation is an inappropriate setting for individuals who are at risk of suicide or self-harm or who are experiencing a mental health crisis.

- Doctors should raise concerns about the use of segregation on detainees experiencing mental ill health, and press for more appropriate arrangements to be made, such as transfer to a specialist psychiatric unit.
- For many detainees experiencing a serious mental health crisis, it should be questioned whether detention is an appropriate environment for them at all, and doctors should make those concerns known not only to centre staff, but to the Home Office via the Rule 35(1) process.
- Those at risk of self-harm or suicide should not be held in segregation apart from in exceptional circumstances, but monitored and treated by more appropriate means.
- Where it is unavoidable for an individual to be held in segregation, doctors should ensure they maintain regular contact and interaction with them in order to mitigate the harmful effects.

Advocating for patients and raising concerns

Rule 35

- Rule 35 reports are not medico-legal reports, and so are not expected to be completed to that standard. They should, however, be clear, legible, and contain sufficient information to help the caseworker in responding to the report.
- Doctors should ask detainees with capacity to give their consent to medical information being shared with the Home Office. If the detainee refuses, the doctor can still submit the Rule 35 report, but must omit confidential medical information. The detainee should be informed of the possible implications of doing so.
- Upon receipt of a response to a Rule 35 report from a Home Office caseworker, doctors can and should challenge the decision reached if they disagree with it.

Raising concerns about vulnerable individuals

- When doctors become aware of vulnerable individuals, as defined by the Home Office guidance, they should bring their concerns to the attention of centre management or the Home Office through the relevant channels with a view to the appropriateness of detention being reassessed.
- In light of the shortcomings in the current processes designed to identify vulnerable individuals, the duty of doctors to recognise vulnerability, act on their concerns, and press for change is all the more vital.
- Even where they fall short of the categories of vulnerability identified by the Home Office, some doctors may have concerns about detainees they believe to be particularly vulnerable to harm.
- Doctors should bring these concerns to the attention of centre management or the Home Office, and press for reconsideration of their detention.
- Doctors working in IRCs should also feel able to speak out on wider structural or systemic issues where current policy or practice is having a detrimental impact on health.

Language and cultural issues

- Language differences and cultural issues can inhibit access to healthcare, and make consultations far more complex.
- It can take time to develop trust in the doctor-patient relationship so that the patient discloses sensitive information and to aid this, it may be helpful for doctors to emphasise their independence from the Home Office and centre management.
- Doctors should be aware that detained individuals may present with different conceptions or understandings of mental health, and that it may take time to get to the root of the problem and to gain the trust of patients.
- Every effort must be made to secure the services of a professional and accredited interpreter.
- Unless there is an emergency, and there is no alternative, detainees should not be asked to act as interpreters for other detained individuals.
- Where detainees specifically request that another detainee act as an interpreter for them, doctors should respect that decision. They should, however, be mindful of the risks associated with doing so, and remain particularly vigilant to elements of coercion.

Confidentiality and privacy

Health records and confidentiality

- Doctors should familiarise themselves with their role and responsibility in keeping health records secure and confidential.
- Doctors should be particularly vigilant in ensuring that medical information is not recorded in non-clinical records and that healthcare information is not shared widely within the IRC and Home Office.
- In addition to ensuring that patients understand that information will be recorded confidentially, doctors should make patients aware that they are allowed to view their health records and request copies.

Disclosing confidential information

- All patients are owed a duty of confidentiality, but this is not an absolute duty.
- It can be particularly beneficial for doctors working in IRCs to emphasise their duty of confidentiality to patients who may be hesitant to divulge sensitive information. They should, however, also make clear that confidential information may have to be shared in some circumstances.
- Patient consent should normally be sought for the disclosure of confidential information.
- Where consent cannot be obtained or is not given, information may still be disclosed where the law requires it, where statute permits disclosure, or where there is an overriding public interest which would justify disclosure.
- The benefits of making such a disclosure must be carefully weighed against the harms associated with breaching confidentiality, and doctors must ensure they can justify their decision. All decisions to make a disclosure without consent should be explained to the patient and documented in the medical record.
- Patients should be fully informed as to what information is being shared, who it will be shared with, and how it may be used.
- Where centre management requires information in order to protect the security and safety of patients or other detainees, doctors have a duty to disclose, regardless of consent.
- Disclosures should be kept to the minimum necessary to achieve the intended purpose and shared on a strictly "need to know" basis.

Capacity and consent

Consent to examination and treatment

- Doctors should seek consent for all examinations and interventions if a patient has capacity.
- Doctors should be mindful of the impact that some elements of the detention setting can have on a patient's ability to consent. They may need to make special effort to maximise a patient's ability to be involved in decision-making.
- An adult patient with capacity has a right to refuse any medical examination or treatment for any reason, even where the decision could lead to serious harm.
- If it is suspected that a detainee may have an infectious disease, the manager of the centre can require that they undergo a medical examination. In these cases, the doctor must still seek consent, explain the nature of the suspected disease, and tell the patient that refusal, without a reasonable excuse, is an offence.

Patients who lack capacity

- Decisions about care and treatment for incapacitated adults must be made on the basis of their best interests (or "benefit" in Scotland), following the guidelines set out in the relevant legislation.
- A lack of capacity is not itself an indicator of risk of vulnerability in detention for the purposes of the Home Office guidance, but doctors should consider whether it indicates the presence of another condition or impairment which might mitigate against detention, and take appropriate action.
- Even where this is not the case, doctors may be concerned by an individual's lack of capacity in the detention environment. Despite the lack of a formal mechanism for raising concerns, doctors should express their concerns to the centre manager or a Home Office caseworker, with a view to exploring safeguarding options and ultimately, a review of the decision to detain.

Food and fluid refusals

- Doctors should assess any patient who undertakes a hunger strike in order to establish whether they have the capacity to do so.
- In some cases, specialist psychiatric assessment may be required.
- Doctors should be mindful of the coercive nature of some protests. Where it is clear that a person is not acting voluntarily, doctors should take action to remove the coercive pressures on the patient.
- Where individuals with capacity refuse food or fluids, that decision should be respected.
- Doctors should provide patients with accurate clinical information about the foreseeable consequences of their actions, and discuss with them what they wish to happen in a future emergency where they lack capacity.
- Individuals who are seriously ill as a result of their actions should be transferred to an NHS hospital where they can receive appropriate care.

Professional isolation and morale

- Doctors should take advantage of opportunities for professional development in order to alleviate some of the isolation associated with working in IRCs.
- Doctors should familiarise themselves with resources and support available to them, such as the BMA's counselling and advice services.
- Doctors should be familiar with the processes in place for raising concerns.

Appendix one – the medical profession and human rights

All health professionals will be familiar with medical ethical frameworks. As we have stressed throughout this report, doctors working in secure settings are bound by the same legal, professional, and ethical obligations as all other doctors.

Fewer health professionals will be as familiar with a human rights framework. Throughout this report, we have identified the susceptibility of doctors working in detention settings to dual loyalties, or dual obligations, and outlined the usefulness of a human rights approach in resolving these conflicts. This section will be of interest to those wishing to understand more about the relationship between the medical profession and human rights.

The structure of rights in the UK

In the UK, human rights are defined and guaranteed by various international conventions, regional treaties, and domestic legislation. A key source of human rights in the UK is the UN's Universal Declaration of Human Rights (UDHR), which was adopted by the UN General Assembly in 1948. It is not legally binding on states. As a signatory to the UDHR, the UK is not legally bound by what it says – it only indicates support for the principles. The UDHR does not contain any enforcement mechanisms to compel states to comply with the principles of the convention, so there is no legal recourse for anybody alleging a breach of a right enshrined in the UDHR.

The legal force of human rights comes from their ratification into domestic law. The main source of human rights in the UK is the Human Rights Act 1998 (HRA), which gives direct effect to the European Convention on Human Rights (ECHR) by ensuring that a remedy for breach of a Convention right is available in a UK court (previously, claimants would have to take their case to the European Court of Human Rights in Strasbourg).

Some of the key rights enshrined in the ECHR, and thus protected by the HRA, include:

Article 2	Right to life
Article 3	Right to freedom from torture and inhuman and degrading treatment or punishment
Article 5	Right to liberty and security
Article 8	Right to respect for private and family life, home and correspondence
Article 9	Right to freedom of thought, belief and religion
Article 10	Right to freedom of expression
Article 14	Right to protection from discrimination in respect of these rights and freedoms

Public bodies carrying out public functions (including IRCs) are bound by an obligation to respect and protect these rights – it would be unlawful for them to act in a manner contrary to those rights. The HRA also requires Parliament to enact new laws that are compatible with Convention rights. This will remain so even after the UK exits the European Union, as the Convention is tied to the UK's membership of the Council of Europe, rather than the Union.[282]

Health and human rights

The right to health is recognised internationally under the International Covenant on Economic, Social and Cultural Rights (ICESCR), which was adopted by the UN in 1966.[283] It recognises a right to health in its broadest sense, in that it recognises health as not merely the absence of disease or infirmity, but the state of complete physical, mental and social wellbeing.[284] Under this definition, it is not enough for the state to provide health services to ensure the absence of ill health; they must deliver the conditions and environment (e.g. safe drinking water and sanitation, food, and adequate housing) necessary for complete health.

As a signatory to the ICESCR the UK is bound by international law to respect the right to health, but as it is not recognised by the ECHR or HRA, it is not enforceable in a domestic or European court. There are many other rights protected by the HRA, however – such as the right to life, right to liberty and security, right to private and family life, right to non-discrimination – which will have applications to health and healthcare related issues.

As the NHS is a public authority, and therefore must be compliant with human rights legislation, doctors fulfilling functions on behalf of the NHS have enforceable obligations not to contravene human rights standards. Doctors also have an obligation to speak out when they encounter human rights violations whether that be in seeing evidence of maltreatment, systemic failures that breach human rights, or more subtle contraventions.

In *The Medical Profession and Human Rights: Handbook for a changing agenda,* we provide a further four reasons for doctors being involved in human rights activity:

- As responsible citizens, doctors should understand and respect human rights as those rights apply to them equally as they do to their patients;
- There is a risk of health professionals breaching human rights – as evidenced by health policies, programmes, practices and clinical research throughout history which have either knowingly or unwittingly violated human rights;
- Violations of human rights usually have adverse health implications for groups or individuals, and doctors may be the first to uncover this evidence; and
- Promoting human rights is an essential part of efforts to protect and promote public health.[285]

The relationship between medical ethics and human rights

Although medical ethics and human rights provide alternate frameworks for approaching and analysing clinical decision-making, they are not necessarily incompatible: ultimately, they both seek to promote morally desirable outcomes. In many cases, the two approaches may lead to the same final conclusion, but differ in the way the decision is reached.

There are some differences between a medical ethical and a human rights approach. First and foremost is that human rights focuses on state-level action, whereas medical ethics focuses on relationships between individuals. This can mean that a medical ethics approach will focus only on the relationship between patient and doctor, without necessarily considering the wider context in which that relationship is situated.[286]

A second key difference between the two approaches is that they can place different emphasis on different values. For example, the language and concepts of human rights articulate relatively recent phenomena and are heavily influenced by Western values, particularly that of individualism. They may appear to be less applicable to individuals or communities that favour more communitarian approaches, and so in some situations the language of medical ethics may be more helpful.

Finally, as there is no agreement on how competing ethical principles should be prioritised, different moral theories and philosophical approaches can be used to give relative weight to different ethical principles in various circumstances. This means that there can be variability in moral decision-making. The universality of human rights, however, means they can be more absolute and less dependent on context.

Human rights and immigration detention

Immigration detention in the UK engages various human rights – most obviously the Article 5 right to liberty and security of person. This right is not absolute, however, and deprivation of liberty can be justified in a number of prescribed cases, where a clear legal process has been followed – for example, after a person has been convicted of a criminal offence by a court.

The argument has been made that the detention of asylum seekers for administrative reasons amounts to a breach of the right to liberty under Article 5 – but the highest UK court has held that detention can be justified under Article 5(1)(f), which states that deprivation of liberty can be justified if it is done in order to "prevent an unauthorised entry into the country or [where] action is being taken with a view to deportation or extradition".[287]

In detaining individuals, the state retains an obligation to ensure that their other rights are respected and promoted. The Detention Centre Rules state that the purpose of detention centres "shall be to provide for the secure but humane accommodation of detained persons in a safe and secure environment...whilst respecting in particular their dignity and right to individual expression".[288] The remainder of the Rules set out the standards by which all IRCs are run, including obligations to provide:

- suitable and adequate clothing, where required;
- "wholesome, nutritious, well prepared and served" food which respects any religious, cultural, or dietary needs;
- appropriate accommodation, the size, lighting, heating and ventilation of which are adequate for health;
- facilities for daily baths or showers;
- the means by which detainees can remain in contact with and receive visits from family and friends; and
- access to healthcare.

The Rules also set out guidance on the maintenance of security and safety, and dictates in what circumstances security measures such as the use of force, removal from association, and restraint may be used, in order to ensure compliance with human rights guidelines.

Arguments have been made that the circumstances of immigration detention can be so severe as to constitute a breach of the Article 3 right to freedom from torture or inhuman or degrading treatment. The UK courts have found a breach of Article 3 in six immigration detention cases since 2011, which, it was made clear, were decided on the basis of the facts of each case. There is no blanket claim that being held indeterminately in immigration detention amounts to torture or inhuman or degrading treatment. These cases generally involved individuals with severe mental disorders (e.g. psychosis, schizophrenia) whose treatment in detention centres (e.g. lack of appropriate medical treatment, being held in isolation) amounted to humiliation, debasement, and a lack of respect for human dignity.[289]

Immigration detention and the international community

As there is no single UN body with a mandate dedicated to immigration detention, several bodies look at the issue within their wider remit. Various UN monitoring bodies have been critical of the practice of indeterminate detention in the UK, including the UN Human Rights Committee in 2015,[290] the UN Committee Against Torture in 2013,[291] and the UN Special Rapporteur on the Human Rights of Migrants.[292] Of grave concern is the fact that in 2015, Rashida Manjoo, the UN's Rapporteur on Violence Against Women, was denied access to Yarl's Wood IRC as part of a routine inspection, despite widespread claims of abuse and sexual assault.[293,294]

The UN General Assembly has also made several statements about immigration detention. In 2009 it called upon states to "respect the human rights and inherent dignity of migrants and to put an end to arbitrary arrest and detention".[295] The Assembly further called for periods of detention to be reviewed and alternatives to detention to be implemented. In 2010, the Assembly again adopted a resolution on the protection of migrants and repeated its call for states to reduce the detention of undocumented migrants.[296]

The Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) conducts visits to places of detention in all member states, in order to assess how persons deprived of their liberty are treated. Its most recent report, from 2016, has been quoted throughout, but it is worth restating its concern over the number of persons detained for lengthy periods in IRCs, and its repeated recommendation that UK authorities reconsider their policy of indefinite detention.[297] Its report also raised concerns about the use of night moves into and between IRCs, delays in accessing psychiatric hospitals beds, and the use of the Rule 35 process.

The question of whether indeterminate detention for the purposes of immigration control can be classed as cruel, inhuman or degrading treatment has received some traction elsewhere. In Australia, allegations of abuse, ill treatment and appalling conditions in off-shore detention centres have led some to suggest that Australian immigration policy constitutes a human rights violation.[298,299,300] The Australian Medical Association has been quick to condemn the policies of the Australian Government. Following a special forum on the healthcare of asylum seekers and the harms caused by detention, they called for an immediate end to the detention of children, the establishment of a national statutory body of clinical experts to investigate the health and welfare of detainees, and, if satisfactory healthcare could not be provided in detention, for the Government to revisit its policies.[301] As has been noted elsewhere in this report, the policies and conditions of detention in Australia differ vastly from our own – but they act as a powerful reminder of the more extreme consequences of detention.

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