Parliamentary brief
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BMA

Immigration detention

House of Commons

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The British Medical Association (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 membership of over 154,000 which continues to grow each year.

The BMA represents and supports doctors working in immigration removal centres (IRCs), and has worked for many years to promote fundamental human rights in the context of healthcare. This has included advocating for individuals and marginalised populations experiencing infringements of their health-related rights, both in the UK and internationally.

Executive summary

- The BMA believes that the detention of people who are not convicted of a criminal offence should be a measure of last resort, used only in exceptional circumstances.
- We believe that detainees should only be moved around the detention estate when absolutely necessary, due to the potentially harmful impact such movement may have on health.
- We are concerned that detainees lack access to appropriate healthcare services in many parts of the immigration detention estate – particularly for mental health and wellbeing. It is vital that detainees have access to the healthcare to which they are entitled and that frontline staff are adequately trained and supported in recognising and acting on mental health warning signs.
- The BMA recommends that Rule 35(3) reports should be written only by clinicians with relevant medical experience or appropriate training in identifying, documenting, and reporting the physical and psychological sequelae of torture.
- The BMA believes it is also crucial that all individuals involved in the process of reviewing the detention of suspected victims of torture have the necessary training and support.
- The BMA welcomes the transfer of commissioning responsibility for the commissioning of healthcare services within IRCs in England to the NHS, which we hope will overcome many of the problems associated with provision of care.

Introduction

The BMA submitted written and oral evidence to the Joint Inquiry by the All Party Parliamentary Group on Refugees and the All Party Parliamentary Group on Migration into the Use of Immigration Detention in the United Kingdom, outlining our concerns about the health and wellbeing of, and the provision of healthcare to, those held in immigration detention. We welcome the publication of the report, the recommendations made within the report, and the opportunity to debate these issues in Parliament.

This briefing outlines our views on the health-related recommendations made in the report of the Joint Inquiry. The BMA cannot comment on the use of detention as a response to immigration, which involves many complex political and legal issues.

Immigration detention and health

It is the BMA's view that the detention of people who are not convicted of a criminal offence should be a measure of last resort, used only in exceptional circumstances. In such cases, detainees should be informed, in a language they understand, of their rights and the procedures available to them. The lack of understandable information about the reasons for, and likely duration of detention, can contribute to anxiety and depression in this patient group.[1]

Detainees should receive accessible information relating to the provision of healthcare in the detention setting. All detainees are entitled to the same range and quality of services as the general public, including access to specialist services, to address their own specific health problems.

However, at present, the BMA has serious concerns about many aspects of health and healthcare provision in the immigration detention estate.

The recommendations of the Inquiry

Detainees should only be moved around the detention estate when absolutely necessary

We welcome the report's recommendation that detainees are only transferred between IRCs *"when absolutely necessary."*

Many doctors report that the transfer of detainees between centres - often at short notice, late at night, and with very little apparent justification - occurs with alarming frequency.

The Detention Service Orders (DSO) states that all detainees arriving at IRCs should be seen by a nurse for an initial health assessment within 2 hours of admission, and be seen by a GP within 24 hours of admission.

[1] British Medical Association Medical Ethics Department (2012) *Medical Ethics Today: The BMA's Handbook of Ethics and Law (Third Edition)* London: Wiley-Blackwell/BMJ Books, at 724. A copy is available in the House of Commons library.

Arrival late at night after a long journey can affect the usefulness of such an initial screening. Detainees may be too tired and distressed to disclose potentially very personal and important health information (including experience of torture and sexual assault) meaning, through no fault of the practitioner, they may not be appropriately treated.

Where detainees present on arrival at a new IRC with a health problem that requires immediate attention, the centre may be reliant on a local out-of-hours service, staffed by healthcare professionals who may lack sufficient knowledge about the specifics of treating detainees. The BMA is concerned that not all IRCs have arrangements in place overnight such that a detainee can be assessed face to face by a GP if required, causing the detainee either to wait until the next morning or to be transferred, perhaps inappropriately, to A&E.

The frequent movement of detainees from centre to centre can be incredibly disruptive to treatment plans, and make it very difficult to provide high quality of care and to develop care plans for chronic conditions.

The lack of adequate healthcare in detention centres

All detainees in IRCs should have available to them the same range of services and quality of care as members of the public in the community. However, doctors working in IRCs report concerns that detainees frequently struggle to access healthcare. This is due to a number of factors, including language and cultural issues (including accessing an interpreter); a lack of knowledge about their rights to healthcare and how to access it; and negative perceptions of healthcare, depending on their previous experiences and interactions with health professionals. It can be difficult at times for doctors to reassure detainees that the provision of healthcare services is independent of the act of detention itself, and that the role of healthcare staff is to act in the best interests of their patients.

Where detainees do access healthcare, the quality can be variable, due to the lack of consistency in the services available across IRCs, and in how healthcare staff are employed. We have particular concerns about the heavy reliance on agency staff in some areas. For those doctors working in IRCs, the workload can be extremely high and staffing levels in IRCs are often inadequate. The complex health needs of detainees, the high levels of mental health disorders, and communication difficulties mean that consultations often need to be substantially longer than ordinary consultations in the community, in order to properly address detainees' health needs.

We also note that detainee access to specialist services can be inadequate. Due to the limitations of healthcare provision in the immigration detention estate, it may be necessary in some circumstances for detainees to use external, specialist services. There are many associated costs in providing transport and

escort for detainees, and doctors may meet resistance from centre management on the basis of financial considerations. Whilst security and use of resources are appropriate concerns for centre management, they should never be used to challenge clinical judgments. Access to specialist services should be available on the same basis as in the community, and it would be unacceptable for management priorities to dictate access.

The report of the Inquiry states that *"NHS England have recently taken over the commissioning of healthcare services within IRCs in England and we hope that this leads to improvements in the standard of care. We recommend that NHS England ensure that screening processes are suitable and that detainees have access to the healthcare they are entitled to."*

We would support this recommendation, and welcome the transfer of commissioning responsibility to the NHS, which we hope will overcome many of the problems associated with provision of care. A similar transfer of responsibility to the NHS for healthcare in prisons has yielded, at least anecdotally, positive results. We hope that the new commissioning arrangements will take into account the specific health needs of the detained population and the particular challenges faced by doctors working in these settings.

Detainees with mental illnesses are detained too often

The report of the Inquiry recommends that *"individuals with a mental health condition should only be detained under very exceptional circumstances"* and that NHS England should *"produce a training programme on identifying and treating mental illnesses that should be mandatory for all staff in detention centres."*

In addition to our general concerns about detainee access to healthcare, we have particular concerns about the provision of mental health services in the immigration detention estate, where there are high rates of mental health and wellbeing problems. Whilst in the community the treatment of most mental health problems is by a multi-disciplinary team (involving doctors, counsellors, and mental health nurses), the immigration detention estate lacks the breadth of resources required to adequately support those with mental health needs. More severe mental disorders will require further specialist treatment which IRCs cannot provide and, as with access to other specialist services, we are concerned that access to treatment for severe mental disorders can often be inadequate.

Whilst health professionals are only able to spend a limited amount of time with detainees, other centre staff will be present day and night, and so are best placed to identify concerns about behaviour or mental health and wellbeing. ***The BMA believes that it is vital that frontline staff are adequately trained and supported in recognising and acting on mental health warning signs.***

Rule 35 reports are not protecting vulnerable detainees

The BMA has a number of concerns about how individuals who may have been victims of torture are medically assessed within IRCs.

The identification, assessment, and reporting of injuries inflicted during torture is a highly specialised skill. The UN's Istanbul Protocol sets out internationally recognised standards and procedures for the assessment of symptoms of torture, and clearly identifies the need for reporting physicians to have the required competencies. We have serious concerns that the current Rule 35(3) process requires IRC GPs to exercise skills and knowledge which most GPs do not possess. Consequently, this can lead to reports of insufficient quality to enable the Home Office to reach a decision.

Furthermore, doctors frequently report that on completing and submitting Rule 35(3) reports to the Home Office, many are disregarded as being unsatisfactory, often on the basis that the report does not constitute independent evidence of torture, or that the evidence provided is not sufficient. Many of the reasons for rejecting a detainee's claim that they have been a victim of torture include the perception on the part of the decision-maker that the GP's view is not independent.

The current reliance on IRC GPs to complete Rule 35(3) reports is not only problematic due to the lack of training and competencies amongst a number of such GPs, but because the rejection of a Rule 35(3) report can have a profound effect on the doctor-patient relationship.

In parallel to our concerns about the lack of training for doctors working in IRCs, we are equally concerned about the capabilities of those reviewing these reports within the Home Office, and their ability to interpret and appropriately assess the evidence provided.

Accordingly, the BMA recommends that Rule 35(3) reports should be written only by clinicians with relevant medical experience or appropriate training in identifying, documenting, and reporting the physical and psychological sequelae of torture. The BMA believes it is also crucial that all individuals involved in the process of reviewing the detention of suspected victims of torture have the necessary training and support.

Dual obligations

A huge number of challenges to good medical practice in the immigration detention estate arise from "dual obligations". Traditional codes of medical ethics centre on the notion that a doctor's primary obligation is to the welfare of their patient. For many doctors working in IRCs, this ordinary obligation can come into conflict with the demands placed on them by the detention setting. Depending on how they are resolved,

these conflicting obligations to the patient and the employer can risk compromising patient care or infringing their rights.

The UK is free from many of the more flagrant human rights abuses that detainees suffer in other countries. However, the danger in IRCs of subordinating a patient's interests in favour of those of the institution can lead to more subtle pressures that undermine the rights of individual patients, such as those to consent, confidentiality and privacy. The BMA is concerned that doctors working in IRCs may feel pressurised to disclose confidential patient information to centre staff for non-health related reasons. There is also a risk that various pressures on consultations – including trying to overcome language and cultural barriers and manage complex conditions in a short period of time – could lead to a decrease in the quality of the consultation and ordinary processes, such as obtaining consent, becoming less robust.

For similar reasons of a conflict of interest, we also believe that IRC GPs should not be involved in 'fitness to fly' processes – an issue touched on in the Joint Inquiry report (page 58). If these processes are required, they should be a role for airline medical officers.

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