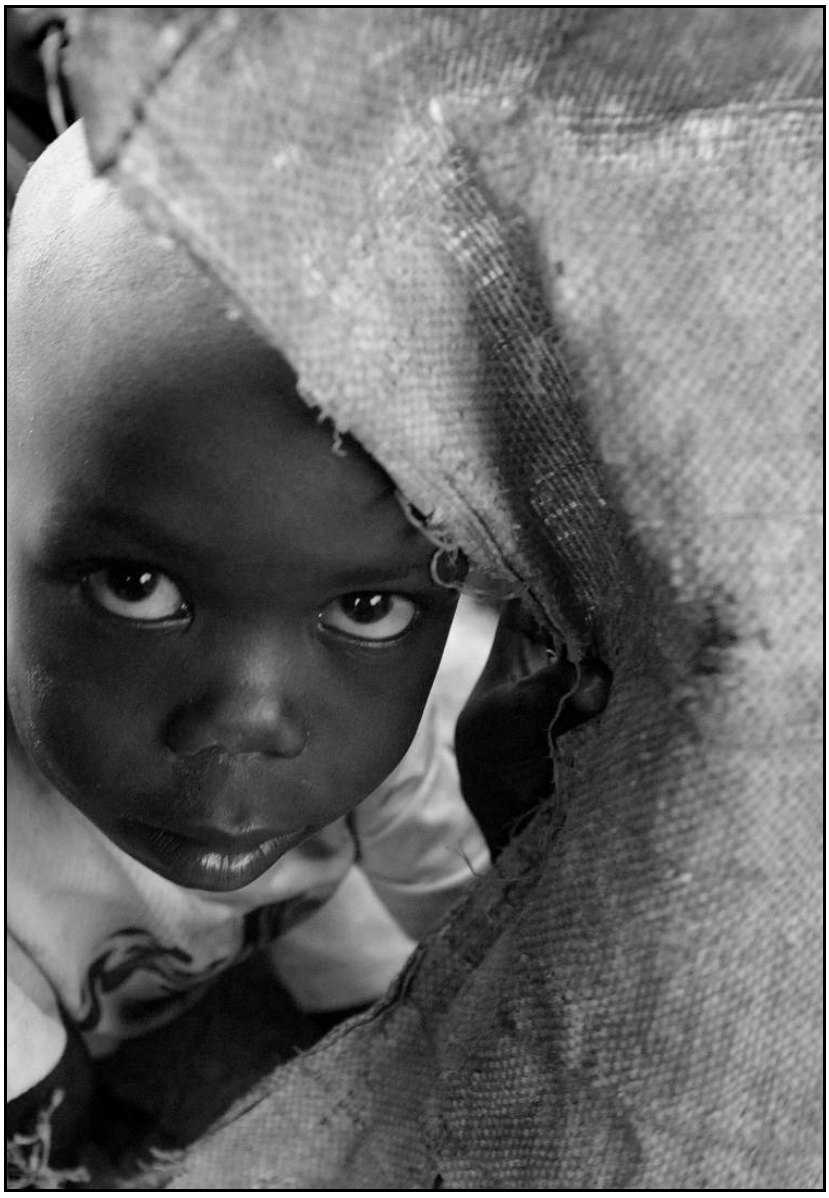
Global health at Liverpool and the medical arguments to stop the detention of asylum seeking children

Christopher Williams



"Today's real borders are not between nations, but between powerful and powerless, free and fettered, privileged and humiliated. Today, no walls can separate humanitarian or human rights crises in one part of the world from national security crises in another" [1]

Kofi Annan

Abstract

Background: Globalisation was originally thought to be of benefit to people's health, because of associated economic growth and reduced poverty. This has been rejected, and it is regarded as an ethical imperative to address global, national and local health care inequalities. Asylum seekers get a raw deal throughout the world and in the UK. They face: poor access to health care; stigma; high chance of mental health problems; detention at any time during their asylum application in the UK; and a ¾ chance of being refused asylum in the UK.

Aim: To take an overview of global health, focussing on the health of refugees and asylum seekers. Suggestions will be made on key issues to be addressed in a global health module at Liverpool University. The issue of child asylum seeker detention and it health affects as well as ethical implications will be examined in detail.

Method: An interpretive approach, with visits to various health centres, NGOs and a prison. Histories were taken from service users and asylum seekers. A literature review was performed using Medline, Cinahl, PsycInfo, Scopus, and Amed databases, focussing on the issue of child asylum seeker detention.

Results: The literature review yielded 41 publications; mostly of comment, few of original research. A key piece of research from the Lancet was critically appraised: '*Mental health of detained asylum seekers'* by Keller et al.

Conclusion: Detention is detrimental to the mental health of asylum seekers, particularly for children. The longer the time spent in detention, the worse mental health becomes, while release from detention improves it. Detention centres holding children are often poorly run, and the Chief Inspector of prisons has stated that immigration removal centres can never be a suitable place for children. Combining the poor access to health care within detention, the conditions, the ordeal and the research evidence showing the detrimental health affects, child detention goes against the International Covenant on Economic, Social and Cultural Rights of 1966. As has been done in Australia and Sweden, the UK must stop the imprisonment of asylum seeking children.

Contents

Learning objectives

- To understand the causes and consequences of seeking asylum, gain a basic understanding of the UK asylum process, and to be up-to-date with current literature in the area.
- To learn about the main clinical problems of asylum seekers, including mental health and torture, as well as barriers to health care and the best ways to provide NHS and other services for asylum seekers.
- Examine the Millennium development goals and the UK strategy for global health.

Core Activities

- Visits to various services including: Asylum Link; Liverpool Women's hospital Link antenatal clinic; Sheil park family health centre; HMP Kennet; and the Medical Foundation.
- Meet service users and take a case history from an asylum seeker.
- Visit the FADE library, perform thorough literature searches, critically appraise a relevant article and present this to the journal club.

Acknowledgement and thanks

I thank Dr Joseph O'Neill for creating these SSMs in refugee and asylum health, homelessness and now global health. They present an area of medicine not otherwise dealt with in the undergraduate course. It is also an opportunity to visit health centres away from Liverpool and be introduced to a more alternative career pathway, for example working with NGOs. I thank Siobhan Harkin for dealing with the administration of the course and organising numerous visits to interesting placements. Many thanks to: Kieran Lamb and other staff at the FADE library; Angela Burnett, John Joyce, Celline Doswell and all staff at the Medical Foundation and Sanctuary Practice; Carmen Camino and other staff at Liverpool Associates of Tropical Health; the staff at Sahir house; Sue Robinson and other staff at HMP Kennet; Illa Kamal and all volunteers at Asylum Link; Susan Smith and other staff at the Link Clinic at Liverpool Women's Hospital; and Nora Stewart and other staff we met at Sheil Park Family Health Centre. Special thanks go to all the asylum seekers, refugees, victims of torture and prisoners that I met and were kind enough to share their experiences. They have opened my eyes to many truths hidden by misguided public opinion.

Introduction

We live in an era of globalisation. Traditionally an economic process, it has more recently been approached as a multidimensional concept, encompassing politics, culture, religion, environment and ideology. It was presumed that globalisation – with its rapid economic growth and associated reduction in poverty – would yield health benefits, but this has been rejected [2]. Indeed the WHO Commission on Social Determinants of Health, and the recent Marmot review found that reducing health inequities is an ethical imperative [3].

Many areas of global health cannot be divorced from the media or economics. The 24-hour news cycle and ability to communicate around the world instantaneously are a driving force behind some issues, for example humanitarian crises. These often-symbiotic relationships make it crucial for doctors working in these circumstances to uphold the core values and principles of being a doctor. Firstly, to justify the trust patients and the public place in doctors, one must show respect for human life and follow the GMC duties of a doctor, as shown in appendix 6 [4]. Secondly, the four ethical principles of autonomy, beneficence, non-maleficence and justice should be followed and used to make decisions. Justice is particularly relevant, as much ill health around the world is due to inequity and inequality [2].

This SSM aims to take an overview of global health and its main, current determinants, whilst focussing on the health of refugees and asylum seekers. The medical arguments against the detention of asylum seeking children will also be examined in detail.

One area of global health where there are inequalities and preventable illness is that of refugees and asylum seekers. In the UK, there is constant media and political attention to these groups of people. Much of what we hear, however, is a bias, confused and ignorant opinion. To explore the issues with a balanced approach, first it is helpful to define core terms and related ideas.

Table 1. Core Definitions

Global health – "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasises transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care." [5]

Refugee – a person, "owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." [6]

Asylum seeker – a person that has left their country of origin, arrives in another country and exercises their right to apply for sanctuary and refugee status. They are awaiting a decision on their application: successful to be acknowledged as a refugee; and unsuccessful to be termed a failed asylum seeker [7].

Detention centres – or immigration removal centres, are prisons for holding asylum seekers, illegal immigrants and those awaiting deportation. There are 11 in the UK, mostly former prisons; the more recently built centres are comparable to category B prisons [8].

Human rights – inherent to all human beings, whatever nationality, origin or status. The rights are all interrelated, interdependent and indivisible. All are entitled to human rights without discrimination; universality is a cornerstone of international human rights law, first emphasised in the Universal Declaration on Human Rights in 1948, and reiterated in numerous international conventions, declarations and resolutions since [9].

Key Global Statistics

By the end of 2008, there were 16 million refugees and asylum seekers worldwide. More than 7 million of these people – equivalent to the population of Greater London – were children below the age of 18; 16,300 were unaccompanied or separated [7]. The UK hosts the tenth most refugees and asylum seekers, behind the likes of Pakistan, Syria, Iran, Jordan and Chad [10]. If the host country's wealth is also factored in – taking a ratio of number of refugees to Gross Domestic Product per capita – the UK ranks 43rd. Indeed, in this list, the top 25 are all developing countries, and include the 15 least developed countries in the world [10].

Key National Statistics

31,315 people, including dependents, applied for asylum in the UK in 2008 [11]. In the same year, 590,000 people arrived to live in the UK [12]. Thus asylum seekers and refugees accounted for – at most – just 5% of migration into the UK.

In 2008, 70% of all asylum applications were refused at initial decision [11]. At appeal, however, almost 1 in 4 refusals were overturned to grant refugee status, humanitarian protection or discretionary leave to remain; incorrect initial decisions are common.

There are no incidence statistics showing the number of asylum seekers detained yearly. There are point prevalence statistics, however, showing that on 27th December 2008, 2,250 people were being held in immigration removal centres [11]. 70% of these were asylum seekers, and 40 were children. 150 people had been in detention for more than a year, while 5 of the 40 children had been detained for between 1 and 3 months.

Key statistics for Liverpool

The majority of asylum seekers arrive in the south east of England, and are then '*dispersed*' across the UK. 25% are sent to the northwest, and Liverpool – as a city – is the third biggest host to dispersed asylum seekers, receiving 1,205 in

2008 [11]. Regional statistics can be misleading, however, because they only include those receiving support or accommodation. Indeed many failed asylum seekers receive no support and are made destitute by the system. In Liverpool there have been at least 400 homeless asylum seekers over the past 3 years, but with the Independent Asylum Commission estimating that in 2008 there were 283,500 homeless failed asylum seekers in the UK, the actual prevalence in Liverpool is likely much higher than 400 [13].

Media portrayal of sanctuary seekers

The media has the greatest influence on the public's view of asylum seekers and refugees. The most widely read national newspapers include *The Sun* and *Daily Mail*. A search of their websites highlights that their portrayal of theses groups is bias, ignorant and quite irresponsible. Emotive language is used to depict them in a negative light: they are *"flocking to Britain,"* with numbers *"soaring,"* and the number being removed, *"booted out,"* or *"kicked out,"* is falling [14]. There is no divide between asylum seekers, illegal immigrants or general immigration. Articles often blame asylum seekers for booming immigration, but as already been discussed, they made up less than 5% of immigration into the UK in 2008 [14]. A search of *'asylum seekers'* on *The Sun's* website yields 77 hits, of which the relevant articles are all negative. Including *'torture'* or *'detention'* in the search yields no articles, as they choose not to present these stories to the public.

Table 2. Summary of case study – shown fully in appendix 4

- Jack (not his real name), a 42 year old from Eastern Africa
- Obtained student visas, to avoid stigma of asylum seeking in the UK.
- Had 2 children in England with his wife and settled into community well.
- Finally applied for asylum, was refused, but is currently appealing.
- He felt a change in the way people treated him; he now experiences the stigma he tried to avoid.
- The family was handcuffed and moved to detention for about 2 weeks. Their community, church and MP gathered to support them. They were released but soon after re-detained, then re-released with the MP support.
- In detention, other detainees were mainly men, speaking a variety of languages. Doors had no locks. There was no privacy and anyone could come into your room at night. The family did not feel safe, so – although given two rooms – they all sleep in one room.
- The children suffered from eczema, which they had not experienced before. On seeking healthcare, staff told them *'you should expect that here.'*
- Since the periods in detention, the children have been wetting their beds almost nightly, which did not happen before.
- The older child has become more withdrawn, is quieter, and has symptoms of depression.
- Jack took the children to the doctor in detention about new bed-wetting and depressive symptoms, but it was not deemed severe, so no treatment or help was given.
- Jack reported that many people's health complaints were not taken seriously; just given paracetamol or aspirin and not treated as they would be outside.
- In detention, Jack witnessed poor care. A mother worried about her sick 5-month-old baby with a high fever. At the health centre, there was no immediate care and she was told *'there are no appointments available… the doctor isn't here now… there are no nurses here now.'* She saw a nurse in the corridor so asked directly for help, but she replied *'I know when a baby's sick, and that's* not *a sick baby.'* In desperation, she called 999. Within minutes, having been told there were no doctors there, a doctor came running out to see her. The baby was sick, and received antibiotics.

The UK asylum process

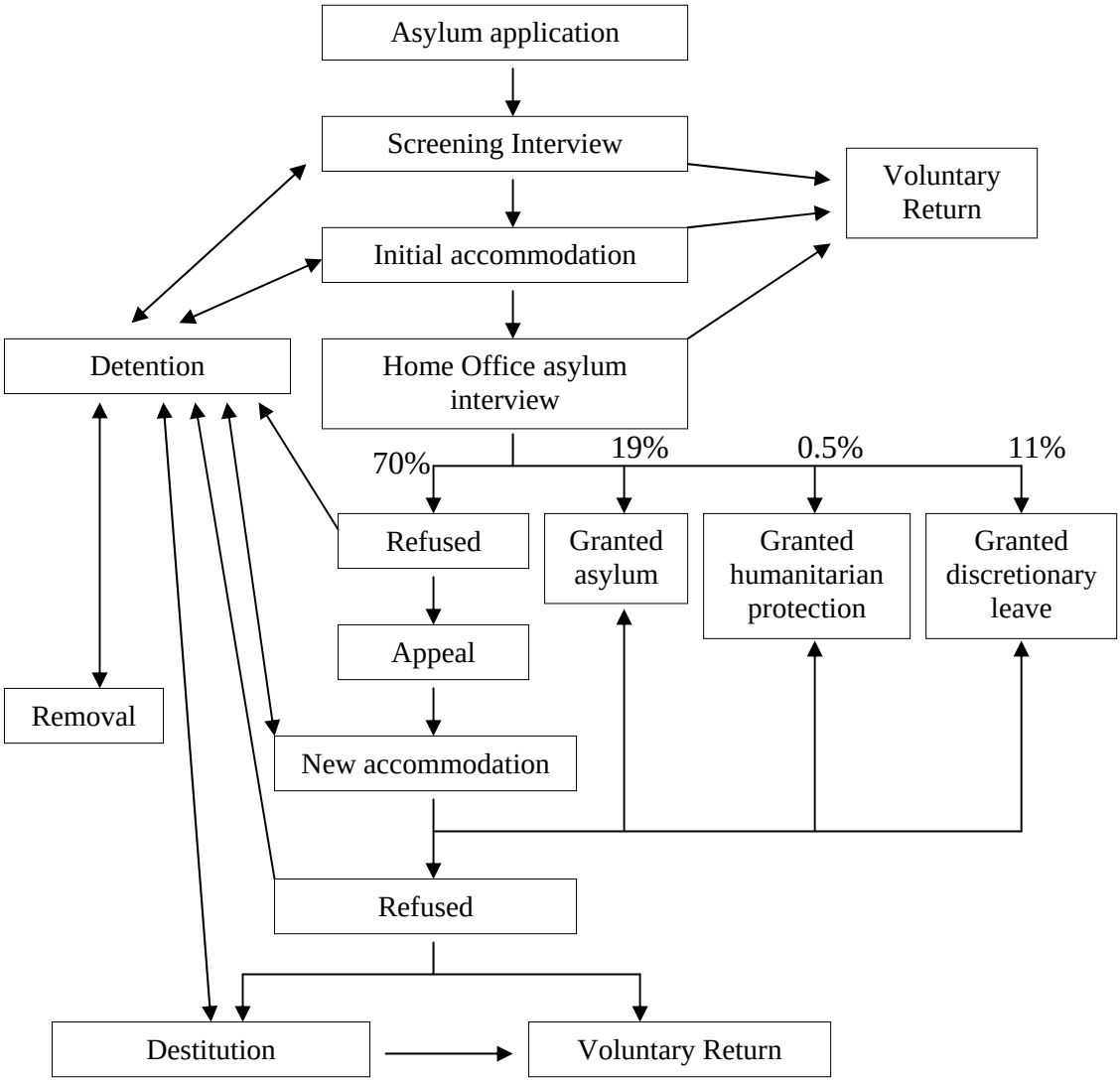


Figure 1. Showing a summary of the UK asylum process

Applicants have no right to work at any stage of the asylum process. They are not eligible for public funds, but can apply for support with accommodation and finance. Supported accommodation involves being *'dispersed,'* to anywhere in the UK where there is housing available: in hard-to-let areas, often resulting in vulnerable housing [15]. The financial support is £35.52 per week for single adults, significantly less than income support [16].

Despite having committed no crime, detention is becoming increasingly common and, as figure 1 shows, can occur at any stage. When an application is refused, they are often violently removed from the UK back to their home country.

Asylum seekers awaiting a decision on their application – and those granted status – are entitled full access to primary and secondary NHS care [17]. Failed asylum seekers, however, have limited access. At the GPs discretion, they can receive free primary care as registered NHS patients. Secondary care is chargeable if the treatment had not already started before their asylum application was refused. Immediately necessary treatment is not withheld, but is still chargeable, and can be pursued as far as the trust considers appropriate [17]. Even treatment for HIV/AIDS is chargeable. Given that many failed asylum seekers are destitute, they are made more vulnerable through lack of access to affordable healthcare; a prime example of the inverse care law. In Wales, legislation was recently amended to provide full access to NHS care for failed asylum seekers, as a *"humane decision… of a civilised country"* [18].

Key health problems of asylum seekers

Asylum seekers that have fled their country of origin, many with histories of torture, abuse and other negative life events, commonly suffer from psychological distress in the short term [19]. Prevalence of depression, anxiety and post-traumatic stress disorder are also all raised [20]. Physical health can also be a problem. Some may have had poor access to healthcare in their home country, so conditions go untreated. Some suffer from communicable diseases, less prevalent in the UK than elsewhere, for example TB. These people need to be given care and treatment, not be treated as vectors for disease [19].

Asylum seekers face barriers to health care. Expectations and experiences of health care will differ between the UK and their home country. Poverty and social isolation experienced in the asylum process have a negative impact on health. Professional interpreters are often essential for communication, but are seldom used effectively [19].

Global health and asylum seekers

Asylum seekers face barriers to health care around the world and through Europe as well as in the UK. Migrants from poor countries that reach the shores of wealthy countries face discrimination and persecution. Rights to health care irrespective of status should be included in national law, and barriers to health care should be broken down. Medical students – as future doctors – should be aware that, in their role as advocates, they could argue for their patients. Moreover, *"immigration policies should be enforced at the borders, not in the hallways of our hospitals and the waiting rooms of our GP surgeries"* [21]. For a future Global health course at Liverpool, asylum seeker and refugee health would be a key learning objective. Having examined the millennium development goals (MDG), and the UK strategy for global health, the table below shows ten issues that should be part of the Global health course at Liverpool.

Table 3. Global health at Liverpool – Top Tens Topics

- **Poverty and hunger**
  - The MDG aims to: halve the proportion of people whose income is less than US$1 a day, between 1990 and 2015; achieve full and productive employment and work for all; and halve the proportion of people who suffer from hunger. Recent rising food prices threaten the gains made in improving child malnutrition. [22]
- **Universal education and gender equality**
  - Education is hailed as a social intervention that can dramatically improve health. It is aimed that by 2015, children everywhere, male and female, will be able to complete a full course of primary schooling. Furthermore, in this time, the disparity between girls and boys in all levels of education should be eliminated. [22]
- **Child health**
  - A key MDG is to reduce under-five mortality by two-thirds from 1990 to 2015. There has been significant progress but, in 2006, 27 countries

had still made no headway in reducing childhood deaths. In all regions, child mortality is higher among rural and poor families and those whose mothers lack basic education [22]. The Marmot review also specifies giving every child the best start in life as a key health policy objective.[3]

- **Women's health**
  - The MDG aim to reduce maternal mortality ratio by three quarters and achieve universal access to reproductive health care. A combination of biological, social, political and economic factors combine to place significant risk to women, resulting in high levels or morbidity and mortality compared to men. [22,23]
- **Chronic and cardiovascular diseases**
  - Responsible for 30% of deaths worldwide, 80% of which occur in developing countries. Perhaps surprisingly, CVD causes twice as many deaths as HIV, malaria and TB combined in developing countries.[23]
- **Climate change and environmental stability**
  - Often quoted as the most pressing threat to global health, it is thought climate change will affect the health of billions, through food shortages, heat waves and changing patterns of infectious diseases. The MDG aim to: integrate sustainable development into country policies and reverse the loss of environmental resources; reduce rate of biodiversity loss; and by 2015 halve the proportion of people without access to sustainable, safe drinking water and basic sanitation. [22]
- **Combat HIV/AIDS and infectious diseases**
  - The MDG aimed to have universal access to HIV/AIDS treatment for all those that need it by this year. It is also aimed that by 2015, increasing incidence of HIV/AIDS, malaria and other major infectious diseases will be halted and begin to be reversed. Many prevention programs have yielded results, but simple targets for use of mosquito nets fall short of targets.[22]
- **Crisis, Conflict and health**
  - War, conflict, natural disasters, and climate related disasters all have huge impact on the health of populations. Delivery of humanitarian aid

is an interesting and important issue.

- **Global partnership & Health systems**
  - The MDG aim to address special needs of least developed countries; develop further an open, predictable, non-discriminatory trading and financial system; deal comprehensively with developing counties' debt; provide, in cooperation with pharmaceutical companies and the private sector, access to affordable essential drugs and new technologies in information and communication. [22]
  - This is a thought provoking, important issue, in a world where the UN estimated that US$20-23 billion would be needed to curb the AIDS epidemic in African nations through education, prevention and health care by 2010, and – in comparison – US$21 billion is paid by African nations to service their debts each year. [24]
- **Refugee and asylum seeker health**

Table 4. Global health at Liverpool – Top Ten Placements

- Asylum Link Merseyside
- Fade Library
- Liverpool School of Tropical Medicine
- Dr Camino and the Liverpool Associates of Tropical Health at Anson House
- HMP Kennet, Maghull
- Sahir House HIV and asylum support, Rodney St, Liverpool
- Link clinic at Liverpool Women's Hospital
- Missionaries of Charity, Seel St, Liverpool
- Student organised placement in hometown. For example the Medical Foundation, Project London or the Sanctuary practice for those from London.
- Medical Elective – explore, through literature searches, global health issues at the destination and set learning objectives to focus on while out on the 5-week elective.

Method

An interpretive approach was used in this study. Through a number of placements, meeting service users and talking to staff, insight was gained into global health and issues surrounding asylum seekers and refugees. Case studies were elicited from asylum seekers, and used as first hand information. Two conferences were also attended, where the effect of conflict and crisis on health as well as the topic of teaching global health to undergraduates was explored; opportunities for networking were also used, which led to further placements at health centres in London.

When researching the area, several resources were used, including the Internet, newspapers, radio and the Harold Cohen, FADE and Donald Mason libraries. This highlighted the large discrepancy between the media portrayal of asylum seekers, and more reliable sources such as the office for national statistics and personal experience.

A literature review was performed using the Medline, Cinahl, PsycInfo, Scopus and Amed databases. This range of databases – covering alternative and complementary medicine, nursing, allied health professions, psychology, science and medicine – was used to ensure no relevant literature was missed. Initially broad searches of the terms *'asylum seekers'* and *'health'* were preformed to gain insight into how much literature is available on the whole area.

Following a meeting with an asylum seeker at the FADE library, where an informal interview was conducted to elicit the case history, it was decided to focus the literature review on the detention of asylum-seeking children and associated health affects.

The databases mentioned above were searched with the terms *'asylum seeker'* or *'refugee,'* and *'child'* or *'children,'* and *'detention'* or *'prisons'* or *'prisoners,'* as exploded keywords. In experimenting how best to run the search, it was found that including the terms *'health'* or *'mental health,'* in fact cut out some relevant articles, so these terms were not included.

Publications were excluded if they were published before 2000, or their full text was not available in English. The abstracts of the resultant articles were read, and the most appropriate article was selected for critical appraisal. The article chosen for critical appraisal was preferably a randomised controlled trial, from a well-respected, peer-reviewed journal, for example the Lancet.

Results

Table 5. Showing results of various database searches	
Exploded keyword search term	Hits
Medline searches	
1. Refugees OR asylum seeker	5583
2. Child OR adolescent OR infant	2200392
3. Prisons OR Prisoners OR detention	15650
4. 1 AND 2 AND 3	51
5. Limit to English language and published year 2000-present	31
Combined Cinahl, PsycInfo, Scopus and Amed searches	
6. (Refugees OR asylum seeker) AND (Child OR adolescent OR infant) AND (Prisons OR Prisoners OR detention)	36
7. Limited to English language and published year 200-present and full text available	20
Resultant literature from database searches, with duplicates removed	41

The literature review yielded 41 publications. The majority were articles of comment; there were very few actual research papers, and the majority were not published in highly regarded peer-reviewed journals.

The article chosen for critical appraisal is titled: "*Mental health of detained asylum seekers,*" by Keller et al, published in the Lancet in 2003 [25]. Although it

does not specifically focus on the detention of children, it is a piece of original research and its results are still relevant in discussing child detention.

Critical appraisal of article

Table 6. Summary of the article critically appraised [25]

The researchers, from The Bellevue New York University Program for Survivors of Torture and Physicians for Human Rights, performed a cohort study looking at the effect of detention on the mental health of asylum seekers. The participants were from 5 facilities across New York, New Jersey and Pennsylvania, selected from clients of six local organisations providing legal representation to asylum seekers.

70 asylum seekers were interviewed and the self-reported Hopkins symptom checklist-25 and post-traumatic stress disorder (PTSD) subscale of the Harvard trauma questionnaire were used to measure psychological symptoms of anxiety, depression and PTSD. This was done at base line, then at follow-up – 2 or more months afterwards – to assess changes.

The results showed that, at baseline, 77% had clinically significant anxiety, 86% depression and 50% PTSD. At follow-up, 35 were still in detention, 26 were released, and 9 were lost to follow up. Marked reductions in all psychological symptoms were recorded in those that had been released. Those still detained had become significantly more distressed.

The study shows that detention of asylum seekers exacerbates symptoms of anxiety, depression and PTSD, which are common in this vulnerable population. The more time spent in detention, the worse the symptoms become. Release from detention ameliorates the symptoms.

Strengths of the article

The study is one of very few actual research articles exploring asylum seeker detention that has been published in a well-respected peer-reviewed journal. The issue addressed is clearly focussed. The method of the study adequately answers the question posed by the researchers, as to whether detention affects the mental health of asylum seekers.

Time spent in detention represents exposure. This is accurately and objectively measured. At baseline, the amount of time the participant has already spent in detention is recorded; median 5 months, over a range of 1-54 months. Then at follow-up, participants are either recorded as released or still detained. This is an objective measure, which reduces possible classification and measurement bias.

Outcome is the change in score of two self-reported questionnaires between baseline and follow-up. They are validated instruments for measuring standardised psychological symptoms. Both have been used successfully in studies of refugee populations before. The questionnaires are translated and back translated into several languages, meaning the questionnaire is translated into another language, then independently translated back, to check that words or meanings have not been lost in translation. This reduces bias and improves reliability of the results. The majority of interviews were done in English, French and Arabic, for which the back translation was done. 18 interviews, however, were done in *"other languages,"* and it is not clear if the questionnaires for these people had been checked so thoroughly.

The researchers state a number of important areas where confounding may have affected the study. They explain how they would ideally like to overcome confounding factors, and why this was not always possible.

Weaknesses of the article

Selection of participants was through organisations providing pro bono legal representation. Thus the cohort was from a relatively small, specific group of asylum seekers. This leads to confounding factors; perhaps those with this legal support differ from other detained asylum seekers. If so, results from the study cannot readily be generalised to all detained asylum seekers. Ideally sampling would be random, however this was not possible due to restrictions by the immigration authorities.

The outcome measure is subjective since it is a self-reported questionnaire. The questionnaires were completed during interviews with the participants. The study was not blinded, so the interviewer was aware if the participant was still in detention or had been released at follow-up. Thus measurement bias may have affected the results. Since the questionnaire is self-reported, however, this bias should be minimised.

Improvement in outcome for those released from detention may have been confounded by their asylum applications being granted. Despite this, correlation between symptom severity and length of time in detention supports the thinking that detention significantly contributes to distress. To overcome this potential confounding, a control group should be included; a random, matched group of non-detained asylum seekers.

Table 7. Limitations and further research

The study is limited in its design, having no control group, non-random sampling, and possible confounding factors already mentioned. Based in the USA, with its own asylum process, the study's results may not be directly applicable to the UK. The study does, however, agree with findings of other similar publications found in the literature review. Furthermore, limitations and difficulties are almost inevitable when researching these issues: gaining access to detained as well as non-detained individuals and obtaining their consent; discriminating between health problems caused by detention or caused by previous problems, in people who likely have complex, traumatic histories; cross-cultural and language issues in assessment of health.

It could be suggested that more research is needed into the health affects of detention on asylum seeking children: a prospective study with a large number of participants randomly selected from the population of detainees, with health assessments repeated over time. Asylum seeking children in detention would be compared to a matched control group of living in the community: matched for age, gender, country of origin, nature of past experiences such as torture and time spent in the UK. Indeed a recent pilot study based in the UK made this conclusion. [26]

It could be strongly argued, however, that this research into detained asylum-seeking children in the UK is unnecessary. The majority of the research published in this area is from Australia in the early 2000s: about 15 of the articles in the literature review. Following this growing base of evidence and interest, Australia recently ended detention of asylum seeking children [27]. A minority – about 5 articles – are from the UK, published more recently around 2009. Carrying out more research in the UK over the coming years would almost certainly yield similar results to those already found here and elsewhere. This would culminate in an end to child detention in the UK, but one that should have occurred years earlier. Thus further research is not needed into the health of detained asylum-seeking children; the evidence is already great enough to show that it is detrimental and should be stopped. When child detention ends, further research should be focussed on health affects of detention in adults in the UK.

Discussion

It is clear from the article, wider literature, and the case study performed, that detention is detrimental to mental health. Furthermore, the greater the length of time spent in detention, the more mental health is affected, while release from detention improves mental health [25]. Detention of asylum seekers is commonplace, and the Home Office continue to expand their detention estate for this purpose [8]. The fast track system, used when a decision on an application can be made relatively quickly, detains all asylum seeker claimants. It is important to bear in mind that everyone has the right to seek asylum and sanctuary in another country. Even if the application is refused, no crime has been committed.

Children and families are often detained in the UK. Although the Home Office only aims to detain children for sort periods – days rather than weeks – this is not always the case. The Home Office statistics show that on the 27th December 2008, 40 children were in detention [11]. The period of detention had lasted: less than a week for just 5 of them; 1-2 weeks for 15; 2-4 weeks for a further 15; and 1-3 months for 5 of the children [11]. There are no reasons to hold children in detention centres, having committed no crime, for these extended periods. If they are detained prior to removal, this should be organised logistically so the period of detention is short.

It may be hypothesized that detention affects the health of a child more than the health of an adult. In the case study performed, during and after detention, the children's health was clearly affected more severely than the parents. One child remained very withdrawn, and wet the bed at night, having been very sociable and dry at night before the ordeal of being detained. Other negative life events can have a great affect on children, such as bereavement, abuse or domestic violence. Thus it follows that the experience of being an asylum seeker, reaching your goal of sanctuary but then being treated as a criminal – locked in detention centres – would also have a large impact on children's current and future mental health. Using Piaget's theory of child development, these detained children may think

that imprisonment has been a direct consequence of their bad behaviour or actions. Children will also lack coping mechanisms to deal with such ordeals in a productive way, giving rise to psychological distress and possible mental health problems.

The study critically appraised was performed in and around New York, in the USA. Thus it could be argued that their immigration detention centres are worse than the ones in the UK, and the results of the study cannot be applied to the UK. The conditions in many UK detention centres, however, are poor. Children are mainly held in Tinsley House, Dungavel and Yarl's Wood immigration removal centres; results of recent inspections are shown in the table below.

Table 8. Findings from recent inspections of detention centres holding children

An announced inspection of **Dungavel House** by the Chief Inspector of Prisons, found it to be one of the best detention centres in the UK [28]. It should be a model for other detention centres, but there are still areas for improvement. The centre had aimed to reduce incidence and length of child detention but both had increased since the last inspection, with some children being held for a month.

An unannounced inspection of **Tinsley House** had very different findings [29]. It found that since its last inspection, conditions – mainly for women and children – had deteriorated, are now wholly unacceptable and require urgent action. Children continued to be detained for more than the 72-hour target limit. There was no progress in developing child protection measures, and parents felt worried about their children's safety in a largely adult male environment. Indeed single women were intimidated to the extent that they rarely left their rooms. Childcare and education was inadequate, and children had limited access to fresh air. An increased prison culture was found, and there was a report of unnecessary force used on children when removing families.

An announced inspection of **Yarl's Wood**, which detains the most asylum seeking children and families, also had negative findings [30]. The Chief Inspector of prisons concluded *"an immigration removal centre can never be a suitable place for children and we were dismayed to find cases of disabled children being detained and some children spending large amounts of time incarcerated… Any period of detention can be detrimental to children and their families, but the impact of lengthy detention is particularly extreme"* [30]. There was ineffective and inaccurate monitoring of length of detention. Education and after-school activities were inadequate. Healthcare was also poor, particularly in addressing mental health and child health needs.

It has been recognised that mental health problems are more prevalent in asylum seeking populations [20]. Detention centres cause psychological distress to detainees and breed mental health problems. A vulnerable population should not be subjected to further ordeal and risk to their mental health.

The International Covenant on Economic, Social and Cultural Rights states that the widest possible protection and assistance should be accorded to families, and special protection should be taken on behalf of all children and young persons [31]. It also states the *"right of everyone to the enjoyment of the highest attainable standard of physical and mental health."* To achieve this, the covenant says countries should: prevent, treat and control epidemic, endemic, occupational and other diseases; and create *"conditions which would assure to all medical service and medical attention in the event of sickness."* [31]

The highest attainable standard of physical and mental health for asylum seekers in the UK involves the absence of being detained in immigration removal centres, since mental health problems are directly correlated with length of time in detention. Indeed it is known that mental health problems are almost endemic in asylum seeking populations, so care should be taken in preventing and treating these diseases. Prevention would involve prohibition of detaining asylum seekers as they are now.

Furthermore, in detention centres, access to healthcare is often reported as poor[29,30]. Thus, conditions are created in which there is not assurance to all medical service and attention in the event of sickness. An excellent example is found in the case study, where a mother had to call 999 for medical care within a the detention centre having been told there is no one to help her and her baby. This breaches the international law stated above.

"Special measures of protection and assistance" should be accorded to children[31]. Therefore the first step in tackling these problems is to stop child asylum seeker detention in the UK. Other countries have already ended this poor treatment of the most vulnerable. Australia, renowned for tough immigration policies and practice, recently ended child asylum seeker detention, housing families in communities rather than prisons [27]. Sweden has also adopted this approach, and the UK should follow.

Conclusion

- Asylum seekers of all ages are commonly detained during their applications for asylum in the UK. Studies show that length of time spent in detention is directly proportional to prevalence and severity of mental health problems, while release from detention improves mental health.
- Despite international law giving everyone the right to the highest attainable standard of physical and mental health, the health of asylum seekers is being pushed to one side for policing of Home Office targets for deportation. Entirely preventable mental health problems are being allowed to proliferate in asylum seeking populations that are detained in prison-like environments.
- Immigration removal centres can never be suitable places for children. There is poor access to healthcare, education, activities, fresh air, safety and sanctuary. As a civilised, affluent country of the world, no matter how much contempt for asylum seekers the media can drum up in the public at large, we should never persecute the persecuted. A child that has committed no crime should not be held in an immigration removal centre.

Recommendations Nationally

- The UK should stop the detention of asylum seeking children. They should follow the lead of Australia and Sweden, housing young people in communities.
- Access to healthcare in detention centres must be improved. Rather than using private companies to provide this service, the NHS should be commissioned. Much as this improved the healthcare in prisons over the past years, it would also improve healthcare in detention centres.
- Teaching of current health inequalities of socially isolated groups and the need for advocacy in the medical profession should be taught more widely to undergraduate students; this sort of SSM should be available nationally. Not only would his be an interesting, valuable learning experience for students, but would also help in addressing health inequalities and global health in years to come.

Recommendations for Liverpool

- As a major host to dispersed asylum seekers, the truth rather than media myths about this vulnerable group of people should be spread to people in the local area as well as colleagues and healthcare professionals.
- All asylum seekers should be treated as individuals, with respect and dignity. Their care should be the first concern, not their permanent address, status or asylum application.
- Barriers to healthcare for asylum seekers and refugees should be broken down at the local level. Official translators should be used readily, whenever needed.

Word count: 3290

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Appendix 1: **Personal Reflection**

This SSM diversified my view of what it is to be a doctor. Global issues, climate change, poverty, natural and humanitarian disasters, war and human rights all have relevance in medicine and health. We learn about health inequalities in the UK regarding the inverse care law, and those often with the most need in fact have the least access to health care. But this is relevant on a Global scale too. The millennium development goals are an important issue, which I had never heard of before this module. Now that the target year of 2015 is coming up, this will undoubtedly come back as an issue of debate. Much improvement has been made but it is the responsibility of the coming generations to continue the trend of actively improving health inequalities worldwide as well as in the UK and locally.

I have also learnt a lot about the health of asylum seekers and refugees in the UK. I will take on this truth that I have experienced into my future practice and pass it on to others that carry the misguided views from the media. As well-informed doctors we must act as advocates for the vulnerable and persecuted. We are not enforcers of the UK borders, but we have a responsibility for the patients we see and should act in their best interest as stated in the GMC duties of a doctor.

Appendix 2: **Ten Key Contacts**

Dr Joseph O'Neill and Siobhan Harkin
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Kieran Lamb

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Brunswick Business Park, Liverpool

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Kieran.lamb@fade.nhs.uk

Sue Robinson

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Parkbourn, Maghull,

L31 1HX

0151 213 3152

Susan Smith

LINK Clinic

Liverpool Women's Hospital

Crown Street, Liverpool,

L8 7SS

0151 708 9988

susan.smith@lwh.nhs.uk

HIV Asylum support

Sahir House

80 Rodney Street, Liverpool

0151 708 9080

Nora Stewart

Sheil Park Family Health Centre

2a Valley Road, Liverpool

L6 3BY

Appendix 3: **Ten Key Websites**

Medical Justice Network
www.medicaljustice.org.uk/index.php

UNHCR
www.unhcr.org/cgi-bin/texis/vtx/home

The Refugee Council
www.refugeecouncil.org.uk

UK Borders Agency
www.ukba.homeoffice.gov.uk/

Medical Foundation
www.torturecare.org.uk

Department of Health
www.dh.gov.uk/en/index.htm

Office of the High Commissioner for Human Rights
www.ohchr.org

Physicians for Human Rights
http://physiciansforhumanrights.org/torture/

UN Millennium Development Goals
www.un.org/millenniumgoals/

WHO
www.who.int/en

Appendix 4: **Case Study**

Jack (not his real name) a 42-year-old man from Eastern Africa

Jack has been living in the UK for a few years. He did not want to share specific details of why he left – or why he will not return – partly because of his ongoing appeal for asylum. When asked, however, he said it involved the death of a man and politics; he became visibly distressed at even mentioning this. He first came to the UK with his wife, as students. They did not want to apply for asylum immediately because they did not want to be seen as a burden to the UK people or face the stigma of being labelled asylum seekers. They had two children, and settled very well into their community. Eventually they had to apply for asylum as their student visas expired. Jack was refused, and is currently appealing. Being an asylum seeker, he felt a real change in the way people treated him; he now experiences the stigma he tried to avoid. Despite meeting all requirements to check in with immigration offices regularly, early one-morning immigration forces came to remove the family to a detention centre.

The family spent about 2 weeks in detention. During this time, their community and church gathered to support them. On two occasions one of the children's teachers made the trip across England to visit them. Eventually their local MP also became involved, and they were released. Soon after, however, the early morning knock on the door came again, to take the family back to the detention centre. Again with community support they were released, but these two periods of imprisonment left their cruel mark on the family.

Jack's family were given a family room; two normal rooms with an adjoining door. The other detainees were mainly men, speaking a variety of languages. None of the doors had locks, so there was no real privacy and anyone could come into your room at night. The family did not feel safe in the centre because of this. Although they were given two rooms, they decided to all sleep in one room; Jack did not want to leave his children or his wife in these circumstances – so he slept on the floor while the others shared the bed.

During their detention, both children suffered from eczema, which they had never had before. On seeing the healthcare staff in the centre, they were told that *'you should expect that in a detention centre.'* The children were not examined and the staff did not seem bothered about the parents' concerns.

One of Jack's children has braces on his teeth, and saw an orthodontist regularly before they applied for asylum. In the detention centre, the braces came loose so they asked to see an orthodontist as he would at home. Eventually they received an appointment with a dentist – not an orthodontist – who said the braces were fine. This frustrated the family, because they did not receive the same quality of care that they would have normally.

During and since their imprisonment, the children have been wetting their beds almost nightly, which did not happen before. The older child in particular has become more withdrawn, is quieter, and has symptoms of depression. Jack thinks the children were seriously affected by seeing the immigration officers handcuffing their father and treating them all as criminals. Whist in detention, Jack took the children to see the doctor about the bed-wetting and depressive symptoms, but because these symptoms were not deemed severe, no treatment or help was given. Jack reported that many people's health complaints in the centre were not taken seriously, just given paracetamol or aspirin and not treated as they would be outside.

Jack told a story about another family they became friends with inside the detention centre. The mother had a 5-month-old baby with her. She thought the baby was sick, with a high fever. Having gone to the health centre, there was no immediate care and she was told *'there are no appointments available,'* and *'the doctor isn't here now.'* Despite being able to see a nurse walking past in the corridor, she was told *'there are no nurses here now.'* The mother ran to the nurse asking for help with the baby, but she replied *'I know when a baby's sick, and that's* not *a sick baby.'* In desperation, the mother called 999. Within minutes – and having been told there were no doctors in the health centre – a doctor did come running out to see her. Indeed the baby was sick, and received antibiotics.

Despite these problems Jack reported with the treatment his family and others were receiving, he said he would not make formal complaints. He felt that if he did introduce any sort of dispute into his life, the Home Office would find out, and it would reflect negatively on his asylum application.

Appendix 5: **Timetable**

Table showing timetable of work through course of SSM	
Week Commencing	Summary of Work
Monday 4th January	Met Siobhan Harkin for introduction to SSM. Met Nora Stewart and health visitors working at Sheil Park family health centre. Met Dr O'Neill for introductory convenor session at Brooke place substance misuse centre, Tuebrook. Overview of SSM, learning objectives and timetable discussed.
Monday 11th January	FADE library session with Kieran Lamb. Tutorial on how to search databases, critical appraisal and useful resources. Met asylum seeker and took case history in form of informal interview.
Monday 18th January	Met Dr Camino at Anson house, Liverpool Associates in Tropical Health. Tutorial and lecture on an introduction to global health. Also introduced to Millennium development goals and the UK strategy for global health. Started reading 'Globalisation: a very short introduction.'
Monday 25th January	Visit to Asylum Link. Tutorial on the work of asylum link and current issues for asylum seekers nationally and locally in Liverpool.
Monday 1st February	Literature searches, following meeting with asylum seeker at FADE library, decided to focus on detention of asylum seekers and children. Found relevant article to present at journal club.

Monday 8th February	Link Clinic at Liverpool Women's Hospital. Antenatal clinic for asylum seekers, refugees and other patients that have difficulties with communication in English; translators used extensively to break down barriers to health care.
Monday 15th February	Convenor review and journal club presentations at Everton road health centre. Made 6-slide presentation of article researching mental health of detained asylum seekers. Listened to other students' presentations.
Monday 22nd February	Refined literature review, focussed reading to detention of child asylum seekers. Read relevant chapters of Global Health Watch 2.
Monday 1st March	Visit to Asylum Link, met more asylum seekers and took another case history. Further reading of relevant websites and literature.
Monday 8th March	Researched asylum process, rights to healthcare and key statistics. Started writing introduction. Wrote short article about my experiences and opinion of the SSM.
Monday 15th March	Visit to HMP Kennet. Sat in on morning surgery with GP, then nurse clinic. Also visited prisoners in solitary confinement (the block/cooler) for mandatory medical check up.
Monday 22nd March	Reflected on Conflict and health conference at Liverpool Guild of students attended on Saturday 20th March. Contacted Angela Burnett that I met and did workshop with at the conference. On Thursday 25th March, attended meeting with Dr O'Neill at Global Inclusion office about RCGP conference and potential for poster presentation, reviewed my short article.
Monday 29th March	Organised visits to the Sanctuary and Medical foundation in London for coming weeks. Made changes to short article and started making poster to present at RCGP conference.
Monday 5th April	Continued reading relevant literature and writing introduction and method for SSM. Finished making poster for RCGP conference. Sent out my short article to Fiona Godlee at the BMJ, Fiona Sim at the faculty of public health and Judy Jones at the Department of health.

Monday 12th April	Heard back, with thanks from F Godlee, F Sim and J Jones. Submitted article formally to student BMJ. Visited Medical Foundation on Friday 16th April, involved in medico-legal meeting in morning and met 2 clients in afternoon. Very interesting day and clients with remarkable histories and medical problems.
Monday 19th April	Reflected on visit to Medical Foundation. Continued writing SSM method and critical appraisal.
Monday 26th April	Prepared poster presentation for RCGP Health inequalities conference at LMI on Tuesday 27th. Attended conference all day on Tuesday
Monday 3rd May	Continued to write up SSM, critical appraisal, discussion, conclusion and recommendations.
Monday 10th May	Convenor review with Dr O'Neill at Everton Road health centre. Continued to write up SSM, making changes throughout.
Monday 17th May	Re-drafting and changes to SSM, cutting down to word limit and improving flow.
Monday 24th May	Proof reading, final changes, bound and handed in.

Appendix 6: **GMC duties of a doctor**

Good Medical Practice: Duties of a doctor

The duties of a doctor registered with the General Medical Council:
Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
    - Keep your professional knowledge and skills up to date
    - Recognise and work within the limits of your competence
    - Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
    - Treat patients politely and considerately
    - Respect patients' right to confidentiality
- Work in partnership with patients
    - Listen to patients and respond to their concerns and preferences
    - Give patients the information they want or need in a way they can understand
    - Respect patients' right to reach decisions with you about their treatment and care
    - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
    - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
    - Never discriminate unfairly against patients or colleagues
    - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions. [4]

Sent to Fiona Godlee at the BMJ, Fiona Sim at the faculty of public health and Judy Jones at the Department of health. Submitted to the student BMJ online.

Poster presented at 'Health Inequalities on the Medical Undergraduate Curriculum' RCGP conference on 27th April 2010.