OUT OF SIGHT?

Slow improvements in health care in immigration removal centres must speed up, argues Margaret McCartney

“I told them that I had angina, but no one took it seriously,” says a Middle Eastern asylum seeker currently in an immigration removal centre in England. He developed chest pains while in a similar centre and claims that the centre’s medical team ignored his symptoms. “I once had pain for several hours, and I was told that an ambulance had been called—it hadn’t been.”

When he was taken to hospital he was given treatment that resolved his symptoms before being sent back to the centre to await follow-up investigations. Now he has little confidence in the medical staff at the centre. Recently, he says, it was the detainees who diagnosed an outbreak of tuberculosis. “People were coughing with blood, a temperature, not feeling well. For three weeks they [the medical staff] didn’t do anything.” When the outbreak was diagnosed, some people were moved into isolation, but the asylum seeker is convinced that the outbreak could have been contained better if it had been diagnosed earlier.

He is one of the 3000 or so people currently held in the UK’s 11 immigration removal centres. There is no time limit restricting how long someone can spend in a centre. Prison medicine is well established in the UK with doctors, especially general practitioners, choosing to specialise and get further training in this area. However, removal centres are not prisons. People within them are being assessed for refugee status and are not criminals. Whereas health care within prisons is commissioned by the Department of Health, that within immigration removal centres is the Home Office’s responsibility.

Has this led to a schism in the quality of healthcare services available to refugees? There are numerous critics of health care available in removal centres.

**Failings**

The mental health charity Mind reported last year that the UK was “regularly failing refugees and asylum seekers.”¹ It found that the process of asylum itself was damaging to mental health and that centres had restricted mental healthcare resources with no specific guidelines about what mental health care should be in place.

Although many individuals tried their best to provide support to detainees, “they were restricted as to what they could offer,” said the report. Interviews carried out by Mind also showed the difficulty patients had getting seen in secondary care, with administrative priorities seeming to take precedence over clinical priorities.

A report written for the Equality and Human Rights Commission earlier this year by Peter Aspinall and Charles Watters from the University of Kent highlighted the problems refugees were likely to encounter—poor antenatal care, poorer pregnancy outcomes, HIV, problems surrounding female genital mutilation, and mental illnesses, especially post traumatic stress disorder and other effects of torture.

They concluded: “There is evidence of an institutional failure to address health concerns about asylum seekers in detention.”²

Her Majesty’s Inspectorate of Prisons is also unhappy with standards in some centres. In a report on services at Harmondsworth immigration removal centre in Middlesex, published in January this year, it wrote: “Detainees complained of difficulties accessing healthcare and lack of care from nursing staff. Clinical governance was weak, inpatient care was poor, with little focused care from staff. Primary mental healthcare was inadequate and there was limited access to secondary mental healthcare.”³

Although the medical rooms were clean and serviceable, it noted that on hospital visits, “there was a presumption that handcuffs would always be used unless health services staff made a case which was accepted by security staff.” It also noted that medical records were poorly collated and some were missing. Health care at Harmondsworth is now provided by Drummond Medical, which was bought by The Practice, a medical outsourcing group, in March.

These are not isolated concerns. In March this year, Her Majesty’s Inspectorate reported on Yarl’s Wood removal centre in Bedfordshire, where healthcare staff were still waiting for previously recommended training in the recognition and treatment of the signs of trauma and torture.⁴ There was also no consistent support for people at risk of self harm and assessment of mental health needs of adult detainees was inadequate.

A 2009 report into Tinsley House immigration removal centre, near Gatwick airport in west Sussex, saw Anne Owens, then HM Inspector of Prisons, conclude that health care was “deeply depressing . . . the arrangements for children and single women were now wholly unacceptable.”⁵

Although some health care was of a reasonable standard, she noted that previous recommendations to establish formal links with provider and commissioning sections of the local primary care trust in order to “promote quality assurance of services and ensure that the health needs of detainees are met” had not been acted on. Other failings included the fact that the health needs of children were not being met because health visitors were not contracted to the centre; there

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¹ Mind, Equally Healthy: The Mental Health of Asylum Seekers and Refugees, 2009
³ Her Majesty’s Inspectorate of Prisons, Yarl’s Wood, 2009
⁴ Her Majesty’s Inspectorate of Prisons, Harmondsworth, 2009
⁵ Her Majesty’s Inspectorate of Prisons, Tinsley House, 2009
was no external supervision for healthcare staff; and there were no multidisciplinary meetings to discuss whether continued detention was detrimental to the mental health of detainees.

Frank Arnold, a doctor who works for the charity Medical Justice, which provides medical and legal advice to people in detention centres, is unsurprised by these reports. He argues that substandard medical care is rife in detention centres and that there is little will to improve. Around 100 doctors are members of Medical Justice, and the concerns they have raised are multiple, he says, including “gross mismanagement of diabetes and tuberculosis, failure to recognise and treat serious mental illness, and restraint and denial of privacy during highly confidential consultations when taken to outpatients.”

Even clinical conditions such as sickle cell crisis are often dealt with badly, he says, with detainees not taken to hospital and in handcuffs when they are. He is angry at what he sees as the lack of progress in improving the quality of health care and frustrated with the low standards he feels are endemic within the centres.

“Even simple things like writing down, ‘This lady claims to be epileptic’ and was not receiving her epilepsy medication,” he says. “Can you imagine practising medicine and writing down ‘opinions are not.’”

Dr Arnold says there is copious evidence that this guidance is ignored daily.

The Home Office denies that there would be any difference in standards in services it commissions rather than the Department of Health.

David Wood, strategic director of criminality and detention for the UK Border Agency, says: “Each of our centres is equipped to provide professional and qualified medical care. All detainees are seen by a nurse within two hours of arrival and are given an opportunity to see a general practitioner within 24 hours. Doctors delivering primary care must be registered GPs. Our detention estate has been praised by independent monitors for the safeguards we have in place to protect the welfare of detainees.”

**Pressure for change**

The small but important positive changes that have occurred in the way refugees are treated in removal centres seem to have come about through public dissent. At least 1315 children were detained in the Tinsley House, Dungavel, and Yarl’s Wood removal centres during 2008 and 2009.

A petition, which had the approval of the royal colleges of GPs, psychiatrists, and paediatricians, was submitted to Downing Street in December 2009. The practice of holding children in detention has also been roundly condemned by children’s charities, the Children’s Commissioner, and refugee organisations. When a baby girl was placed in the care of Dungavel removal centre in May this year, public protest was immediate. A Home Office statement was swiftly released with the promise that children would no longer be detained in Dungavel overnight. Instead, children were to be taken with their family to Yarl’s Wood, which is equipped for families. Immigration minister Damien Green described this as a positive move and added that they were “committed to ending the detention of all children for immigration purposes.” Deputy prime minister Nick Clegg has said that it is an “ongoing outrage” and pledged to make alternative plans.

Children, though, are the thin end of the wedge. How many others are detained outside Home Office guidelines, and how sure can we be that this very vulnerable group is getting the care it should? Public pressure has probably played a part in changing the attitude towards children. Perhaps now we should also turn our attention to the health care of other asylum seekers.

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**Competing interests:** None declared.

**Provenance and peer review:** Commissioned; not externally peer reviewed.

6. UK Border Agency. Enforcement instructions and guidance. www.ukba.homeoffice.gov.uk/policyandlaw/guidance/enforcement/1

Cite this as: BMJ 2010;341:c4106
PAIN CONTROL

THE POLITICS OF PAIN

Pain relief is often taken for granted in the Western world, but in about 150 countries the use of morphine is severely restricted. Tatum Anderson investigates how this has come about, and what steps are being taken to stop patients living and dying in extreme pain.

Dozens of recycled plastic mineral water bottles are filled with brightly coloured solutions. The bottles are full of oral morphine, colour coded for different strengths—green for the weakest, then pink, and blue for the strongest. Every day, teams of nurses take them to paediatric and cancer wards and patients living at home near Kampala, Uganda.

In a country where fewer than 5% of cancer patients ever receive radiotherapy or chemotherapy, and with a high HIV/AIDS prevalence, the need for pain relief is crucial, says Anne Merriman, an Irish palliative care specialist who set up Hospice Africa there in 1993.

She agreed to establish the service on condition the government changed its rules on morphine provision. Previously only doctors, dentists, and vets were allowed to prescribe opioids—although midwives could prescribe pethidine. In the early 1990s oral morphine was used only rarely, and with a shortage of doctors, few patients ever met a health worker allowed to prescribe it. In 1992 the government agreed to allow nurses and clinical officers trained in palliative care at Hospice Uganda to prescribe oral morphine. “The government had seen so much suffering with the AIDS epidemic. Everyone had a family member who had died in agony,” says Dr Merriman.

Lack of oral morphine

Today, despite Hospice Africa’s attempts to export the model, widely available oral morphine remains an exception rather than the rule. In about 150 countries, including Indonesia and India, severe restrictions on the use of morphine for pain relief means patients are still living and dying in severe pain.

Although WHO guidelines for the treatment of moderate to severe pain in cancer state there can be no substitute for [strong] opioid analgesics such as morphine, weaker drugs are often used to treat pain in people with terminal cancer and HIV/AIDS patients. Gabriel Madiye, executive director of the Shepherd’s Hospice in Sierra Leone says: “We have tried codeine [a weak opioid], diclofenac, and paracetamol. They are not enough.”

Recently WHO estimated that 5.5 million people with terminal cancer, a million late stage HIV/AIDS patients, and 800 000 patients with unintentional injuries or injuries caused by violence are not receiving the pain relief they need. Also, many patients with conditions, such as sickle cell anaemia, those recovering from surgery, and HIV/AIDS patients on antiretrovirals, require relief but do not get it. Controlled drugs that are used to treat drug addiction or obstetric complications, such as ergometrine, are severely restricted too.

Most countries do not have bans on opioids for medical use, but their policies and rules are so onerous the result is lack of access for patients. In some countries only oncologists and palliative care specialists are allowed to prescribe opioids, or they can only prescribe extremely limited amounts. Some formulations, such as oral morphine, are not allowed (see box 1). Indian pharmacies require so many licences to stock controlled drugs that many do not bother (see

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**Box 1 | Armenia**

Hrant Karapetyan and colleagues have set up Armenia’s first dedicated pain control and palliative care centre, but face many restrictions. Most physicians cannot prescribe opioids, for example. “It’s a crazy situation,” says Dr Karapetyan. “I give lectures for oncologists in pain management. My student oncologists have permission to prescribe morphine, I have not.”

The only morphine available is an injectable form that can be prescribed for 10 days—although outpatient prescriptions are often limited to three days at a time. Very ill patients living in rural areas are forced to travel to municipalities each time they want another supply, says the Open Society Institute, which has studied Armenian palliative care. More worryingly, oncologists rarely prescribe more than 10 mg per day. “It is a very low dose and does not give adequate analgesia,” Dr Karapetyan says.

Things are improving gradually. Oral morphine may reach Armenia later this year, and palliative care training courses are planned. Finances remain a problem, however. Dr Karapetyan has been paying for the centre from his own pocket and staff work without pay. “The situation is very bad,” he says.
Artificially low demand

With so few people prescribing it, the perceived demand for morphine is artificially low. A report by Human Rights Watch last year found that in 2008 Egypt ordered enough morphine for just 3% of those who are estimated to need it, Philippines 8%, and Senegal 0.6%.

The situation is, to a large extent, the result of 100 years of international treaties, stigma, and fear. It means that Australia, Canada, New Zealand, the United States, and European Union countries in 2008 consumed more than 90% of the world’s legal morphine, and 96% of all fentanyl, a synthetic opiate.

At a time when Britain dominated the opium trade, an International Opium Commission met in Shanghai in 1909 to curb it for the first time. Faced with an opium addiction crisis, the international community—albeit only the 13 nations that attended the meeting—agreed that some drugs, including opium and derivatives, morphine, and heroin, represented a grave danger, and called for regulation and even prohibition.

That agreement laid the foundations for a series of legally binding conventions on drug control. The 1961 Single Convention, for instance, strictly controls the manufacture, trade, and distribution of narcotics, including opioids.

National policies and controlled drugs

But although the convention allows countries to use controlled drugs for medical and scientific purposes—it even enables countries to estimate how much they might need annually to match opium poppy growing quotas—many nations do not.

Most of their governments’ efforts are focused on preventing abuse. It’s all about control,” says Karen Ryan, a senior policy fellow at the Pain and Policy Studies Group (PPSG) based at the University of Wisconsin, which works with WHO and assists countries from Philippines to Guatemala to remove barriers to using pain killing drugs.

The problem is that policy makers believe morphine will cause addiction, or will be diverted into an illicit trade. That’s a mistake, says Ryan. Physical dependence on a drug, which is easily managed with good medical practice, is not the same as psychological addiction. But such misconceptions are still reflected in national rules. “These policies date back decades, to when it was thought that even a single exposure to this medication could create addiction,” she says. The evidence points to very low rates of addiction, and there is little evidence of diversion either, she adds.

Such misconceptions have permeated through to the medical profession, and patients. Several generations of Indian doctors have been taught that morphine is bad says M R Rajagopal, an Indian palliative care specialist. “For half a
Recently WHO estimated that 5.5 million people with terminal cancer, a million late stage HIV/AIDS patients, and 800,000 patients with unintentional injuries or injuries caused by violence are not receiving the pain relief they need.

For its part, INCB disagrees about the level of attention paid to medical uses. Pavel Pachta, deputy secretary of the board and chief of the INCB secretariat’s Narcotics Control and Estimates Section, says, “I think INCB is doing a lot in this area. It is a matter of opinion whether it is enough or not but definitely INCB is very much putting emphasis on dialogue with governments.”

INCB insists it constantly negotiates with countries, has been behind a host of resolutions and speeches aimed at promoting change, and has set up an “access to controlled medications” unit with WHO, which is working on a number of projects, including guidelines to help countries improve their morphine demand estimates.

Action and support from the global health community that usually champions drug access, is curiously absent too. The Bill & Melinda Gates Foundation, the Global Fund to fight AIDS, Tuberculosis and Malaria, Médecins Sans Frontieres, and Oxfam do not have specific initiatives to improve access to opioids for medical use—all though the Global Fund has placed a strong focus on opioid access for the treatment of addiction because, for example, in Russia methadone is still illegal.

It may be that agendas are already stuffed, but some believe that because opioid access is about making people comfortable, it doesn’t have the same value to donors as interventions that save lives. Promoting palliative care for people with HIV/AIDS might also be interpreted as a signal that activists are going up on the fight for universal access to lifesaving antiretrovirals.

International action to help countries change policies is lacking; from up to date evidence based guidelines for treating acute pain and chronic pain in children and adults to model laws that help countries amend national legislation to more accurately reflect a balance between medical use and control of opioids; controlled medicine policy recommendations are years old and focus on cancer. That said, Willem Scholten, head of the access to controlled medications programme at WHO, is insistent it constantly negotiates with countries, has collected anecdotal evidence that some cultures view pain and suffering as a test of faith, may be fatalistic about pain, which they feel they cannot control, or value stoicism and may not disclose their pain.

International involvement to improve access to opioids

That national policies persist, however, can be also attributed to an absence of international involvement, says activists. The feeling is that UN international drugs control agencies, for instance, have not done enough to promote medical uses because they have spent 50 years focusing on the war on drugs and are often dominated by representatives from ministries of justice and law enforcement who do not traditionally take a health perspective.

Diederik Lohman, senior researcher at Human Rights Watch, says the International Narcotics Control Board (INCB), a United Nations body set up to police adherence to the single convention and other drugs treaties, pays scant attention to medical uses in its annual report, compared with pages of text on illicit drug controls. He reckons it is also impossible to determine how strongly INCB impresses the importance of medical uses on individual governments compared with controls, whether it seeks specific commitments and checks that promises are kept. “INCB is much less transparent than other UN agencies. We don’t know anything about what they discuss,” he says.

Not all bad news

That’s not to say there has been no progress. INCB says opioid consumption has increased globally by a factor of 2.5 over the past 20 years as countries from Serbia to Vietnam have begun to change policies and increase training. Colombia has tripled the number of days a patient can be prescribed morphine to 30, and the Philippines has removed the confusion between psychological and physical dependence within its laws. The African Palliative Care Association says attitudes in Africa are changing too. Several pharmacies will now stock morphine in Tanzania; Zambia and Sierra Leone are embarking on oral morphine pilots at hospices.

And international approaches are developing too. Personnel changes at the rather conservative INCB are expected to improve approaches. And unexpectedly, another UN drugs body, the Commission for Narcotic Drugs in March this year passed a groundbreaking resolution instructing governments to do more to make opioids available for medical uses, and for the INCB to report them. A lot of good could come out of it, says Alison Crocket, a senior adviser at the UN’s Department for International Development, who witnessed the resolution. “It was a fairly unusual thing to happen and quite a coup,” she says.

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Competing interests: None declared.

Provenance and peer review: Commissioned; externally peer reviewed.


Cite this as: BMJ 2010;341:c3800