MIGRANT DETENTION AND THE INEQUITIES IN HEALTHCARE ACCESS

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Abstract

Immigration removal centres (IRC) have been deployed by the government in an attempt to secure the nation's borders. The normalisation of actions in the controlling of migration flows has been initiated by a perception placed on migrants as being a threat to the welfare and security of society and therefore "undeserving" as referred to by Foucault (2003). This research study aims to uncover and critique the political institutional structures that are placing undocumented migrants at health risk whilst going through the process of determining their residential and legal status.

The findings of this research project indicate that equity ceases to exist at the point where border enforcement and the right to healthcare converge. There is a new penal system that is being constructed within immigration detention that has enabled the mechanisms of disempowerment of migrant detainees to be conceived.

The analysis of this research project further reveals the perilous conditions of healthcare for migrants in UK's IRCs and the characteristics of UK immigration policy in providing healthcare to detainees. This research study explores the nexus of neoliberalism and state power, whereby detainees, deprived of their liberty and rights, become sources of private profits. The withholding of healthcare, the weak implementation of rights and policies, the discretionary use of state power to overrule medical advice and health rights is evidenced in the construction of the "hostile environment". Agamben's concepts of the state of exception and the camp, Schmitt's liberal legality and the social determinants of health (SDH) are used to explore how the hostile environment impacts on the accessing of healthcare for migrant detainees. Interviews with twelve former detainees and five service providers provide the empirical material at the heart of this research project.

The practices relating to health and healthcare in immigration detention highlights how the camp paradigm extends beyond the walls of detention centres through expectations of other public services to do the work of border control. This strange combination of public and private sector responsibilities and interests, contradicts and causes tensions in doctors' loyalties to the welfare of their patients and to the securitisation interest of the Home Office (HO), and other processes. Doctors are presented as advocates of

patients, and of NGOs which use legal expertise regarding detainees' rights to counter the detention system's abusive obstruction of detainees' access to health.

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Dedication

I dedicate this research study to my husband - Mr Charles Afari-Mensah and our three children – Michelle, Benjamin and Ariana, who have been a backbone of support and inspiration throughout the journey of this study and made embarking on this project possible.

Chapter 1

Introduction

1.1 Background

1.1.1 Context of research

The life chances of an individual may differ immensely as a result of where they are birthed and raised (Marmot *et al.,* 2008) for instance, the life expectancy of an individual birthed and raised in Sweden or Japan is 80 years, whilst Brazil is 72 years, India is 63 years with less than 50 years for those in a number of African countries (Marmot *et al.,* 2008). There is also the case of profound differences in the life chances of individuals within countries where premature mortality and high levels of illnesses are often found amongst the poorest people however, it is not only the worst off who are subjected to poor health. Health and illness follow a social gradient at every level of income causing those who are at the lower level of the socioeconomic group to be worse off in health (Marmot *et al.,* 2008). Where there are systematic differences present in the lives of different groups of people that may be avoided by means of a reasonable action suggests that the existence of the systematic difference is unfair and unjust (Marmot *et al.,* 2008). This is termed, imbalance health inequity which is one of the major attributes of social injustice that has caused the gross levels of mortality hence, the emphasis on reducing health inequities within and between countries has become vital where ethics is concerned.

This research project examines immigration detention in order to bring to light the mechanisms and variations of power within the social production of space and how it affects the migrant detainee's decision-making process in the accessing of healthcare services. The theoretical framework of governance and biopolitics are applied to assist in analysing the representations of migrant detainees and workers of immigration removal centres (IRC) on immigration detention in the United Kingdom (UK) where the criminalisation of undocumented migrants and governing techniques of border control are denying migrant detainees of accessing adequate healthcare services.

The public health framework supports the main theoretical structure to help explain the relations between health exposures and outcomes, where the Commission for the Social Determinants of Health (CSDH) takes on a holistic approach in using the Social Determinants of Health (SDH) (Solar and Irwin, 2007). The role of the SDH is to reveal the poor health of poor people – in this instance of migrant detainees, to address the social gradient in health within countries and the significant health inequities between countries. The role of the SDH in this research project will focus on immigration detention pertaining to the unequal distribution of power, income, goods and services, on a global and national level. The SDH is used in this study to further address the immediate implications resulting from the injustices that are visibly present in the living experiences of the migrant detainee concerning their accessing off healthcare services, the conditions and regimes of the IRC and the community.

The public health perspective helps to reveal the type of social, economic and political barriers that are presented to the migrant detainee which causes inequities in the accessing of healthcare services in an IRC. I came to the realisation that there is a lack of scholarly studies that systematically assess the public health implications of IRCs in the UK which result in the wider challenges of the UK healthcare system. Academic literature on assessing the inequities in healthcare provision to people detained in IRCs in UK is also lacking. Although such laws as the Health and Social Care Act (2012) and Equality Act (2010) do not place restrictions on the people it governs, immigration laws act as a barrier to accessing healthcare for migrants, particularly undocumented migrants by undermining their basic human rights which impacts on public health. I believe that it is important to research this area of topic as it may help to improve the tackling of health inequities and possibly ensure that public health providers are better equipped to meet their responsibilities in providing healthcare on a more equal basis, particularly for those detained in an IRC.

I was also intrigued and had questions concerning the issues surrounding the reasons why the government was placing people at health risk whilst they were going through the process of determining their legal and residential status. I felt strongly about finding ways that may help in reducing health inequities of the migrant population, particularly those with undocumented status. This is as a result of the situations undocumented migrants are placed in which are beyond their control where they end up in their host country seeking political or religious refuge to work, study, tour or be united with their

spouse and find themselves in circumstances where they become exploited, abused or discriminated against. As a health professional, the basis of my research leans towards the public health implications concerning migrant detainee health and the role health practitioners and the stakeholders of IRCs have to play in the provision of healthcare services. A critical examination of the systems at work in the institution of immigration detention is made to draw out issues pertaining to policy implementation, institutionalised culture and the impact on the health professional's ability to do their duty.

Immigration detention in the UK began in the form of camps which the government set up in order to detain and control the influx of refugees and protect the nation against alien spies coming into the UK during the first and second world wars. Soon after these wars, the camps evolved into immigration detention centres which were intended for the administration of undocumented migrants, mainly asylum seekers and refugees who were going through the process of applying for their legal status. The term "immigration detention centre" was eventually renamed "immigration removal centre" where the intention was to detain people who are facing expulsion from the UK. The government began to detain migrants in the IRCs on a mass scale for indefinite periods including migrants fleeing war or persecution from their country of origin, pregnant women, children and those who have completed their sentence in prison. The majority of these people are victims or survivors of human rights abuses and are therefore vulnerable where they are exposed to the risk of being harmed by detention. Those who are not classified as vulnerable are made vulnerable by the environment, treatment, regimes and indefinite stay of the IRC where health conditions are acquired and or exacerbated. The Home Office's (HO) decision to maintain the detention of an individual who has been classified as a "vulnerable person" under their own policy, yet maintaining the decision to continue their detention or even deport them whilst denying them of their healthcare and human rights suggests that IRCs have been constructed mainly for the purposes of punishing and controlling migrants, particularly those classified as "economic migrants". The term economic migrant is used by the government (Bosworth, 2008a) to differentiate between who is the "genuine" migrant and who is not, which the government bases its decision on who to detain and who not to detain. The three variations of political power (based on concepts derived from the paradigms of governmentality, the camp and security) are used in context of this research project

based on concepts derived from the paradigms of governmentality, which pertain to; governance and public health (Rose, 1999), the camp (Agamben, 1998) and security (Agamben, 2005). These paradigms help support the argument based on sovereign or state power in relation to decision-making techniques to securitise the nation against perceived threats. The neoliberal technique of governing executes its state power by deploying the strategy of delegating power and responsibilities to the local people with the inclusion of market mechanisms, that is the use of private contractors to manage IRCs.

1.1.2 The conceptual framework

My research topic seeks to capture the governing strategies deployed by the government in its attempt to control and manage immigration in the UK. I work towards understanding the governing strategies and the power relations of immigration detention by referring to the overarching concepts of this research project constructed by the work relating to the biopolitics of Agamben (1998; 2005) in his Homo Sacer: The Camp Paradigm and The State of Exception projects respectively including the governance of Rose (1999) in The Powers of Freedom: Reframing Political Thought. This framework is supported by Schmitt (2004) concerning Liberal Legality where there is a crisis in contemporary governing techniques, due to the use of discretionary power and Bachrach and Baratz's (1962) on The Two Faces of Power in the exercising of power during the decision-making process where certain views and opinions may be denied or blocked based on the interest of the political party. These concepts are used to help form the basis of my analysis for this research project.

The SDH is used in this research project to help bring into context Rose's (1999) notion on healthism in discussing about the lived experiences of migrant detainees and the implications of public health. The SDH is formed from the public health pathways and are based on the CSDH model (Solar and Irwin, 2007) devised by the World Health Organisation (WHO) which is also addressed in this research project to enable the public health pathways of migrant detainees to be located. This reveals the pathways where health inequities may arise as a result of the SDH, which is based on a socioeconomic and political context and is linked to the intermediary determinants of the migrant detainee that impact on the opportunities available in accessing healthcare services. It has become necessary to address the socioeconomic and political context of

the SDH in this research project as they involve the various factors that are relevant to the lived, conceived and perceived spaces experienced by the migrant detainee. This helps to reveal the social production of space that have been constructed in IRCs based on Lefebvre's (1980) Trialectics of Space pertaining to the practices and representations of the three spaces mentioned above (please refer to Appendix F).

Scholarly papers have argued from a criminal justice view point and often focus on the criminalisation of undocumented migrants and the injustices of immigration detention infringing on their rights (Bosworth, 2008; Bloch and Schuster, 2005; Schuster and Solomos, 2004; Boswell, 2007), where mental health is often the focal point pertaining to health issues. This research focuses on the public health aspects and the wider SDH in order to reveal the barriers that may arise in accessing healthcare services for migrant detainees. This is in order to provide a more in-depth and holistic understanding of the problem that is immigration detention in the healthcare provision and access to healthcare services in IRCs as a result of the governance techniques and power relations and how they impact on the health and welfare of migrant detainees. I believe that undertaking this direction in research forms an integral contribution to the lack in scholarly papers to systematically assess the public health implications of immigration detention on the lives of migrant detainees.

1.1.3 Research Aims, Objectives and Question

Research Aims

My research aims to study the experiences of people detained in IRCs to understand the challenges they face in accessing healthcare services and how it impacts on their health. I aim to understand the role that workers and health professionals play in delivering or helping migrant detainees to access healthcare services. Due to the lack of systematic reviews which focus on assessing the implications that IRCs in the UK pose on public and migrant health, my research will seek to examine the challenges raised in IRCs for migrant detainees and the factors that cause challenges in accessing services within IRCs. This is a breakdown of the aims:

1. To critique the notions of biopolitics and governance and use them as analytical tools to help understand the relations of power in the access to healthcare in IRCs.

2. To conceptualise “detention” by explaining the differences and similarities between IRCs and prisons with regards to legislation, policies, practices, architectural design and conditions.

3. To support the conceptualising process of detention through adapting the CSDH (Solar and Irwin, 2007) model to help reveal the SDH of migrant detainees in identifying the inequities of health and healthcare access in IRCs.

4. To look into the legislation and policies of healthcare that govern both prisons and IRCs, including the systems of managing, reporting and recording cases of disease and vulnerability and assess the strengths and weaknesses of implementation in an IRC setting.

Research Objectives

This research project seeks to explore the barriers to the process of implementation of healthcare policies in IRCs and how these challenges affect the public health framework. The three variations of power which are formed as a result of the social production of space are examined which exists due to the governance techniques deployed within immigration detention. I also examine the economic, social and political determinants of migrant health which have an implication on public health and explore the challenges faced by detained migrants to accessing healthcare services in IRCs. The data sources are derived from both primary and secondary data, where the primary data is collected from interviews and the secondary data from written statements, public session from parliamentary committees, reports, letters, empirical studies, news coverage and blogs. The combining of this data set is integral to developing an understanding of the topic at hand and forming the basis of discussion for the research topic. Understanding the data is influenced by the various conceptual frameworks that help guide the analytical process of this research project.

The objectives of this investigation are:

- To investigate the kind of challenges migrant detainees, healthcare professionals, volunteers and or non-profit organisations (NGOs) and community support groups face in the accessing and delivering of healthcare

services and how the challenges impact overall on migrant and public health in IRCs

- To look into the systems of managing, reporting and recording new cases of disease in an IRC
- To help ensure that public health providers are better equipped to meet their responsibilities in providing services to the migrant population on a more equal level, where they will be informed about new pathways for tackling and reducing health inequities.

Research Questions

1. What impact does the governing strategies of immigration detention have on the healthcare delivery of detainees?
2. How do these strategies influence and determine the lifestyle choices and health outcomes of migrant detainees?
3. How is human rights impacted upon in light of these strategies?
4. What type of institutional system has been established which determines the power relations that exist between the service providers (the HO, the private companies, healthcare commissioners and professionals) and the service users (migrant detainees) of healthcare in immigration detention.

1.2 Theoretical Context

1.2.1 The purpose of the CSDH model in constructing a framework for migrant detainees

In constructing a conceptual framework for this research project that is supported by the CSDH model (Solar and Irwin, 2007), it assists in the work towards allocating the trajectories to the inequities of healthcare access for migrant detainees. The purpose of combining the conceptual framework of this project with the CSDH model (Solar and Irwin, 2007) is to be able to identify the SDH pathways which may result in the forming of barriers in the healthcare access of migrant detainees. This will enable the location of

ways of tackling the SDH based on assessing policy implementation, the impact of governance on access to healthcare services and the power relations that exist in immigration detention. In order to construct a comprehensive SDH framework, the following elements ought to be achieved: identification of the intermediary determinants of the inequities in health to show its association with the major determinants; making clear the mechanisms through which the structural determinants generate health inequities; providing a framework to evaluate which SDH needs to be addressed and to map the specific levels of intervention and policy entry points for action on the SDH (WHO, 2010). The key components of the CSDH framework that are examined in this research project is situated in a socioeconomic-political context (that is, governance, policies, culture and societal values) which impact on the socioeconomic position of the migrant detainee which influence the intermediary determinants (that is, the material circumstances, behaviours, biological and psychological factors of migrant detainees – please refer to Appendix E) (Solar and Irwin, 2007).

In assessing policy choices, the values that guide it may be implicit or explicit where the concept of equity in health pertaining to the work of the CSDH is an ethical foundation that is explicit. The framework for political leverage and social mobilisation is based on human rights to assist in advancing the equity agenda in the CSDH. In order to be mindful of health equity, there is the need to locate avenues in which to empower people particularly groups who are socially marginalised with a work towards increasing a collective control over the factors that shape their health (WHO, 2005). The previous Secretariat for WHO known as the Department of Equity, Poverty and Social Determinants of Health defined health equity – which is also referred to as socioeconomic health equity as:

> "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically" (WHO, 2005).

In a nutshell, health inequities are the differences in health that are produced socially and are systematically and unfairly distributed across the population (Dahlgren and Whitehead, 2006). In identifying a health difference as inequitable this may be perceived as an objective description, however the implication is rather that of an appeal to ethical norms (Braveman and Gruskin, 2003). National governments have the

primary responsibility of protecting and enhancing health equity, where the work of Amartya Sen has significantly contributed to building the foundation of contemporary moral and political philosophy in the linking of the concepts of health equity and agency for the implications for just governance to be made explicit (Sen, 1999). Sen Anand emphasises that health is a "special good" where its equitable distribution ought to be of utmost concern to the political authorities. There are two fundamental reasons that are to be regarded in health being a special good; firstly, health is directly constitutive of a person's wellbeing and secondly, health enables a person to function as an agent (Anand, 2001).

Hence, inequities in health is deemed as "inequalities in people's capability to function" which has a profound impact where freedom is compromised (Marmot, 2004). Governance is deemed to have failed its primary responsibility (in ensuring that there is fair access to basic goods and opportunities that effect an individual's freedom to make life choices that are of value to them) when systematic inequities arise as a result of an individual's social position (Rawls, 1971). It is argued by Ruger (2006) that achieving equity in health is a fundamental goal of public policy where health plays an integral role in individual agency. Having said this, the causal links between health and agency is not based on a single trajectory, thus health is a prerequisite for individual agency and freedom where better health outcomes is associated with people being provided with the social conditions that enable them to possess greater agency and control over their work and lives (Marmot, 2004). Hence, a mutually reinforced relationship exists - which is integral to policy-making where health not only enables agency but also, improves when there is greater agency and freedom. Sen's (1999) notion on "capabilities" is discussed only in this chapter and is not included as one of the overarching concepts. Sen's (1999) is used to introduce the idea of health, its importance and how inequities in healthcare contributes to the inability of a person to function as an agent. This process is fundamental in order to enable an understanding of the overarching concepts that frame the arguments in this thesis to be reached.

Frameworks that are based on policy development may assist analysts and policy-makers in identifying the various intervention levels and the points of entry for action pertaining to SDH which vary from underlying structural determinants being tackled by policies to strategies focused on the health system and the reducing of inequities that stem from adverse effects of ill health that different social groups suffer from (WHO,

2010). The mapping of entry points for policy action on SDH inequities is effective when aligned in conjunction with theories of causation (WHO, 2010) enabling the location of the trajectories to the inequities of healthcare access for migrant detainees for a more focused intervention to be achieved. Deploying the CSDH model (Solar and Irwin, 2007) to support the conceptual framework of this research project allows for an insight into the political and socioeconomic factors that arise within the space of IRCs that determine the level of opportunities available for the migrant detainee in their accessing of healthcare services. Gaining an understanding of the various SDH pathways of the CSDH model (Solar and Irwin, 2007) helps to reveal and enables an understanding of the type of barriers that are presented which cause inequities in the migrant detainee's accessing of healthcare services. The SDH pathways helps to provide a more streamlined understanding of how the governing techniques of IRCs influence the behaviours of the various actors involved causing their interaction with each other to be based on the power relations at work. This reveals how the actors use their power or non-power to influence the decision-making process of the migrant detainee in accessing healthcare services in IRCs.

1.2.2 Power relations and the role of fear

Power is a very necessary and prominent concept that has to be addressed within the institution of immigration detention. Power is what enables the decision-making process to take place where Hobbes' (1651) notion of "power" is based on the ability of an agent to affect the behaviour of a patient. This may refer to the idea of physical or mechanical power which involves being pulled or pushed against a person's will (Hobbes, 1651). Power is also viewed as the ability to set the political agenda where Bachrach and Baratz (1962) suggest in their essay, The Two Faces of Power, that there is a second face of power which is presented in non-decision-making or being unable to make a decision (please refer to section 2.2.2 on further discussion on the second face of power in context).. Non-decision-making power is often present in liberal democratic systems and operate in various ways. This research project focuses on the second face of power of this concept, where certain views and opinions may be denied or blocked as a result of the interest of the political party. The interests and the political agenda of the government or HO have led to the taking of actions through the coercing of the public – by recruiting frontline staff to becoming border guards (Corporate Watch, 2017)

(explained further in chapter two). The political agenda of the government and HO is further expressed through the employing of private contractors - who are driven by making profits and saving costs (Corporate Watch2, 2018a), thus providing a base upon which the "hostile environment"[1] may thrive within the space of healthcare in IRCs as the quality and rights to healthcare diminishes (please refer to section 1.3.8 on further discussions concerning the construction of the hostile environment). The findings of this research project identifies how the hostile environment conceives a space of intimidation for the migrant detainee thus influencing their decision-making processes which becomes blocked as they are deterred from accessing healthcare services and are unable to make a tangible decision about their healthcare. This conflict of interests enables the HO to exert its power over the human and healthcare rights of the migrant detainee, disregarding the moral and public health implications through their justification of securing the state against a perceived threat.

1.2.3 The tools of control and fear in deterring healthcare access

As this research project investigates the access to healthcare services in IRCs, the findings reveal that the need for detainees to access healthcare services is being used as a tool of control and discipline by the HO. Undocumented migrants are a particularly vulnerable population due to their precarious lifestyle pertaining to the conditions through which they enter the country, work and reside. Undocumented migrants have become fearful of accessing healthcare in the UK (Hiam, 2019). Due to their status and the hostile environment conceived within the space of healthcare, they have become fearful of arrest from the HO caused by the sharing of patient information between National Health Service (NHS) Digital and the HO (Department of Health (DH), Social Care (SC) and HO, 2017). The tracking of migrants in the UK by the HO has tripled in number since 2014, with figures of 8,127 data requests being made in 2016 for patient

[1] The UK Home Office hostile environment policy is a set of administrative and legislative measures designed to make staying in the United Kingdom as difficult as possible for people without leave to remain, in the hope that they may "voluntarily leave". Hill, A. (2017) 'Hostile environment': the hardline Home Office policy tearing families apart', *The Guardian* [Online]. Available at: https://www.theguardian.com/uk-news/2017/nov/28/hostile-environment-the-hardline-home-office-policy-tearing-families-apart (Accessed: 9 January 2020).

information by the HO to the Department of Health (DH) enabling 5,854 migrants to be traced (Asokan, 2017). This has led to the arrest of undocumented migrants in various locations in the UK, including hospitals (Corporate Watch, 2017). The use of this tool of control and discipline by the HO and managers of IRCs is mentioned in the findings of this research project through the accounts from both the professional workers and the ex-detainees. Undocumented migrants and migrant detainees are subjected to fear which is used to control and discipline them by the HO with regards to being placed on the "fast-track" – where they face immediate deportation or an extension is placed on their detention period within the IRC in the event of seeking further or specialist healthcare services (this is evidenced in the findings chapters of this thesis, particularly in chapter six). Undocumented migrants in the community are also fearful of arrest by the HO and are thus deterred from accessing public services such as healthcare. This enables a culture to become institutionalised within the space of healthcare as a result of border control strategies where the perception is created by the government and explicitly states that migrants do not have the right to healthcare services. The culture of discrimination, disbelief, mistrust, lack of transparency and accountability and diminished responsibility are thus given the opportunity to thrive within the space of immigration detention causing barriers to the accessing and the provision of healthcare services.

1.2.4 Non-power in the decision-making process of detainee health

Although Nikolas Rose's (1999) notion of healthism is more inclined to governable subjects who are free to make decisions for themselves concerning their health despite influences from the government, media and private companies, the notion healthism is also somewhat relevant to migrant detainees. Agamben's state of exception concept presents the case of the state excluding migrants from the law by denying them certain rights and privileges that a citizen would have and in doing so, have made the migrant an integral part of the law. This then ties in with Rose's (1999) healthism notion where although the migrant detainee may not be free to make a tangible decision about their health due to their limited rights, their decision-making processes are being influenced by the government and the organisational culture that is presented to them within the space of detention. Hobbes' notion of power is made evident where the migrant detainee's behaviour is being affected with regards to the decisions they make about

their health through fear, therefore placing the migrant detainee in a position of non-power (Hobbes, 1651; Bachrach and Baratz, 1962). The second face of power being the restrictive face of power of Bachrach and Baratz's (1962) concept on The Two Faces of Power (which is discussed in detail in section 2.2.2) is reflected in the restricting of the migrant detainee's decision-making process where they are blocked from being able to make a tangible decision about their health due to their limited or non-rights in accessing healthcare services. In this instance, the healthism concept – which is based on public health enables an examination into the life of the migrant detainee as to whether they are able to adequately govern themselves based on the level of healthcare they receive as a result of the resources, conditions, culture and the type of institution they have been detained in. This enables a better understanding of the reasons behind the health outcomes of the migrant detainee and the mechanisms involved that hamper their self-governing process.

Non-profit organisation (NGO) workers provide a channel through which undocumented migrants and detainees may have a voice through the representation and advocating of their discourse via the media, parliament, court and various forms of literature. An example may be found in the evidence given at the public session on 20th March 2018 led by the Home Affairs Committee on, The inquiry into asylum detention (Home Affairs Committee, 2018). Three managers from three different NGOs gave evidence concerning the risk that immigration detention poses to the health of undocumented migrants (Home Affairs Committee, 2018). The Home Affairs Committee comprising of members of parliament (MP) took the opportunity to reveal the injustices that are taking place within immigration detention by providing a platform for advocates of migrant detainees to speak publicly about what they have been told and experienced in working with migrant detainees in an IRC. The healthism concept in this respect reveals the extent through which the migrant detainee – who is perceived to have been silenced by the non-power caused by the restrictions placed on their decision-making process is now assigned with the power of making their voice heard as they use their advocates, that is NGOs, member of parliament (MP) and others from the world outside immigration detention as a mouth-piece to voice out their struggles and discourses to the public.

1.2.5 Human rights and dignity issues

The subject of immigration detention has become highly politicised over the years due to the stripping away of the basic human rights within immigration detention which has become symbolic of a contemporary camp in this modern era. It is necessary to understand the issues pertaining to the rights of the subjects of IRCs due to the fact that although an individual is not sentenced to detention through a judicial hearing such as in prisons, migrant detainees' rights are stripped away and their access to adequate care is restricted, preventing them from accessing the essentials of life.

Some human rights theorists hold the view point that every living thing, regardless of the form or quality of life they have been blessed with are entitled to rights (Jefferson, 1903; Locke, 1965). There are various laws pertaining to Human Rights that the UK has a legal obligation to uphold as a member of the European Council regardless of whether it is part of the European Union (EU) or not (Equality and Human Rights Commission, 2017). Immigration detention in the UK engages with some Human Rights laws such as Article 5 based on the right to liberty and security of a person (Campbell, 2017). Despite this law, it is not absolute where liberty may be deprived if a case can be made of a person once they have been convicted of a criminal offence by the court (Campbell, 2017). It is argued that the detention of asylum seekers for administrative purposes is deemed as a breach of their right to liberty under Article 5 (1) (f) (Campbell, 2017). However, the supreme UK court has ruled in favour of the detention of asylum seekers and undocumented migrants under Article 5 (1) (f) which states that, deprivation of liberty can be justified if it is done in order to prevent an unauthorised entry into the country or where action is being taken with a view to deportation or extradition (Ex Parte Saadi *et al.,* 2002). Human rights issues feature strongly throughout the data from the interviews with the participants of this research study. This re-asserts the notion of the state of exception where those with undocumented status have their rights undermined through the discretionary power of the government where immigration laws disregard human rights laws. The stripping of rights is amplified within the space of immigration detention of the migrant detainee, hence the camp paradigm is formed within the space of IRCs.

1.2.6 Agamben's camp paradigm concept and its relevance to the migrant detainee

The migrant population are being treated as criminals and are used as a scapegoat for the ills of society through the governing strategy of rejecting the other to protect the self' (Bigo, 2009; Butler, 2004) as also referred to by Agamben's state of exception (Agamben, 1998). The actions taken by the government and the organisations they employ to secure the nation's borders have become normalised due to the perceived threat that undocumented migrants pose on the welfare and security of the nation. This seems to have warranted the exclusion of migrant detainees from their political life thus, stripping them of their rights and political status as referred by Agamben (1998). Migrant detainees are therefore reduced to "bare life" and separated from political life where they are excluded from the political community and exposed to death (Agamben, 1998). This is made evident in the space on immigration detention, similar to Agamben's camp where action is taken to suspend civil liberties in the event of a social crisis where the government decides who can be included and who should be excluded (Agamben, 1998).

It may be perceived that undocumented migrants find themselves in a space of abjection which is intended for criminals and those who are labelled as second-class citizens of society due to their own actions and bad decision-making according to Rose (1999). Undocumented migrants are often coerced or forced into unfavourable situations often due to their struggles for a better life for their families and themselves which places them in a position of non-status. This position of non-status in immigration law places the undocumented migrant in a conceived space of abjection. This space of abjection is reinforced in immigration detention which is characterised by Agamben's camp paradigm.

In contemporary times liberal legality is argued by Schmitt (2004) that there is a crisis in the technique of governing where the government uses its discretionary state or decision-making powers to override the laws of the nation during a crisis situation (please refer to chapter two for further information on this theory). The use of discretionary power has become a prominent feature in our democratic society in the technique of governing that is evident in the institution of immigration detention. This technique of governing which enables the imposition of the will of the HO on the lives of its subjects impacts adversely on the health of the detainee population. There are

various ways through which detainees' health are impacted resulting from the challenges they are faced with in accessing healthcare services.

The culture of discrimination against race, nationality, religion, disability (including mental, physical and learning disabilities and difficulties), gender, transgender, sexual orientation and age has the potential of thriving within the space of immigration detention. This is often due to the lack of training and resources available in the IRCs to support people who require specialist care as the environment of such institutions are not designed to cater for people with special needs. This is particularly true for the elderly and those with disabilities (Shaw, 2016; Clarke, 2018). Also, a culture has been institutionalised within prisons and immigration detention that discriminates against black Asian and minority ethnic (BAME) groups, lesbian, gay, bisexual and transgender (LGBT) groups as well as women (Townsend, 2015; Merrick, 2018; Home Affairs Committee, 2018). On the matters pertaining to racism, this element of culture has been conceived and institutionalised within the space of immigration detention and is an attribute of one of the factors that impact on the healthcare access of migrant detainees.

The culture of discrimination is able to thrive in the space of immigration detention due to the normalisation of border control tactics which justifies the detaining of migrants, regardless of their circumstances and ailments where the government has set the precedent of making decisions that override the needs and human rights of undocumented migrants, which they state explicitly within the space of healthcare by constructing the hostile environment. This culture of discrimination marginalises undocumented migrants, beginning at the top level of authority (the government) descending to the next level of authority being that of the managers and workers of IRCs from private contractors. This enables the culture of discrimination to become rooted in the IRC system as a result of the governing techniques of border control where the wider healthcare systems in the community including other public services are not exempt.

The trafficking into exploitation and modern slavery of people in the UK has been noted by the government who have stated their commitment to identifying and providing protection for such victims based on regional and international law (Detention Action, 2017). This commitment was emphasised on in April 2017 by the then Home Secretary Amber Rudd stating her regret for "thousands of poor souls being exploited and abused"

in car washes, nail bars and brothels across the UK and expressed how the government was committed to "getting immediate support to victims when they are at their most vulnerable" (Gov.Uk, 2017a). The prime minister at the time, Theresa May – the predecessor of Amber Rudd (as the Home Secretary) reiterated this point and described human trafficking and modern slavery as "the great human rights issue of our time" (Gov.Uk, 2016). Despite the above statement being made by the former Home Secretary, during her administration the numbers in people being detained in immigration detention have steadily increased with targets set to reduce net migration below 100,000 a year which she denied and led to her resignation in 2018 based on an admission that the targets were set by her department which she claims to have been unaware of (Grierson, 2018).

The attempt in achieving a mass reduction in net migration is revealed in various cases in the UK including the detention of vulnerable women where The Guardian reports an increase of 46 Chinese women – who are victims of trafficking being detained towards the end of September 2016 to 112 at the end of September 2018 (Mohdin, 2018). This has contributed to the increases in Yarl's Wood IRC detaining of vulnerable women (Mohdin, 2018). The governing techniques of immigration control has thus enabled systematic discrimination to be formed in the wider public services of the UK where discrimination is being amplified in the space of immigration detention with the provision of ease in access for the HO to locate migrants (Corporate Watch, 2017; DH, SC and HO, 2017). The border control techniques of the government in the integration of the HO into public and some private services has led to the mass increases in migrants being tracked down, arrested and detained in IRCs (Mohdin, 2018). The rise in systematic discrimination has caused tensions to be formed in the provision of services, causing a neglect in the provision of due care for migrants in vulnerable situations (Shaw, 2016; Home Affairs Committee, 2018). These vulnerable migrants include victims of trafficking and human rights abuses, who are affected by the setting of targets to reduce migration flows (Mohdin, 2018). This has led to the coercion of workers into becoming border guards (Corporate Watch, 2017) as immigration status is being held with higher regard than the detrimental impact the system has on the condition of the migrant.

1.2.7 The space of abjection in the UK society

In the UK immigration laws are being created which marginalise migrants where the perception is created by the government and the media that migrants, particularly those with irregular status as a threat to the welfare and security of the UK society. Migrants are seen as a threat to jobs, housing, welfare, healthcare and are perceived as more likely to participate in crime. The migrant label has a stigma attached to it which causes an automatic prejudice to be formed, particularly against those with irregular status where the de-skilling of migrant workers takes place due to the lack of recognition of qualifications obtained from abroad causing barriers in the accessing of high-skilled jobs for migrants. The perception is thus created by the government that the vast numbers of migrants entering the UK are low-skilled workers or lacking in education. The new rules of the immigration law was confirmed on 2nd October 2018 by the present prime minister – Theresa May that high-skilled workers wishing to live and work in the UK would be given priority whilst the immigration of low-skilled people will be controlled (Fox, 2018). The three million citizens from EU countries presently residing and working in the UK will not be affected (Fox, 2018).

A great number of research studies have been carried out which analyses the effect of immigration on jobs and wages arriving at the conclusion that the huge increase in immigration in the UK has not impacted negatively on the prospects of jobs and wages for workers born in the UK (Wadsworth *et al.,* 2016; Wadsworth, 2015; Portes, 2016; Centre for European Reform, 2016; Dustmann *et al.,* 2005). The findings from the report by (Dustmann and Frattini, 2019) reveal that immigrants who entered the UK since 2000 have made consistent positive fiscal contribution regardless of country of origin. The report reveals that migrants outside the EU countries have contributed about 12 percent into the fiscal system, which is three percent more than what they took out, with a net fiscal contribution of about 5.2 billion Great British Pounds (GBP) between 2001 and 2011, whilst the natives contributed an overall negative fiscal contribution of 616.5 billion GBP (Dustmann and Frattini, 2019). EU migrants contributed a total of 15 billion GBP to the fiscal net payments during this same period, which was 64 percent higher than the transfers received (Dustmann and Frattini, 2019). A total 25 billion GBP has therefore been contributed to the net fiscal balance overall as a result of immigration to the UK between 2001 and 2011 during a period where the UK was running an overall budget deficit (Dustmann and Frattini, 2019).

Hence, the report suggests that immigrants entering the UK since early 2000 have rather made positive contributions to the country's public finances which is a great contrast to the perception that has been formed and maintained that migrants are a drain on the UK's fiscal system. The report further concludes that recent immigrants are 43 percent less likely to receive tax credits or state benefits where the comparisons with the natives from the same age, gender and educational composition resulted in 39 percent less likely of immigrants to receive benefits than the natives (Dustmann and Frattini, 2019). A further 16 percent is contributed to the total of public expenditure (such as defence) from immigrants reducing the financial burden of fixed public obligations for the natives to approximately 8.5 billion GBP between 2001 to 2011 (Dustmann and Frattini, 2019). Additionally, the majority of immigrants arriving in the UK have a discounted net value where their future fiscal payments have a potentially positive effect on the nation due to completing their education overseas where an estimated 6.8 billion GBP has been saved in education between 2000 and 2011 as a result of immigrants providing the UK with productive human capital (Dustmann and Frattini, 2019). Therefore, the hostile environment and the goal of reducing low-skilled migration are irrational and not backed up by the evidence which shows that migrants make huge economic contributions to the UK.

The stigmatising of migrants is further evidenced in the perception of migrants as "health" or "medical tourists"[2] conceived by the government in using migrants as scapegoats for the NHS "crisis" causing them to be targeted for the regaining of funds to resolve the budgetary crisis. However, a report by Doctors of the World in 2019 revealed that migrants with irregular status are less likely to access healthcare until the later stages of their health condition where 89 percent of undocumented migrants who attended their clinic were not registered with a GP, causing two in five of undocumented migrants being refused registration at the GP due to lack of; address, proof of identification or immigration status (Hiam, 2019). The average level of time is six years before a migrant makes an attempt to access the services of such clinics provided by NGOs for migrants with irregular status (Hiam, 2019).

[2] Medical tourists are tourist who travel for the purpose of receiving medical treatment or improving health or fitness. Dictionary.com (2020) 'Medical Tourism', [Online]. Available at: https://www.dictionary.com/browse/health--tourism (Accessed: 21 January 2020).

Measures put in place include a national surveillance or monitoring system set up by the HO to enable them to gain access to people's personal information which is obtained through the integration of systems via the NHS, Driver and Vehicle Licensing Agency (DVLA), schools, landlords, employers, births, marriages and various other public systems (Corporate Watch, 2017). The purpose of an IRC is for administrative purposes, however, IRCs are being used for punitive measures to detain refugees, asylum seekers, undocumented migrants and migrants who are going through the process of securing their legal status (Taylor *et al*., 2018). Migrant detainees are placed into detention without having committed or not been suspected of committing a crime, who have not gone through a judicial process therefore are not given a time limit for detention, often do not have legal representation, face uncertainty about their fate and are subjected to the conditions and hostile treatment of immigration detention (Taylor *et al*., 2018; Shaw, 2016). This is only a portion of the challenges that migrant detainees face in the UK which hampers their access to healthcare services (Shaw, 2016).

1.3 The control of aliens – the inception of camps and detention centres in Britain

An insight into the historical background of how IRCs were formed and established in the UK will help bring about an understanding of the concept of immigration detention. The following discussion informs on the pioneering of strategies in containing, imprisoning and expelling aliens as a technique of national security in the government's work towards building the nation. The history begins at the first and second World Wars, from the year 1914 to our present time.

1.3.1 The provision of camp facilities and the public responses (World War I)

During World War I, between 1914 to 1918 laws and policies were created concerning the control of aliens into Britain. The peacetime in 1905 led to the introduction of the Aliens Restriction Act in 1914 where the laws pertaining to the British state's response to alien immigration included deportation and internment for the first time (Taylor *et al*., 2018). The Aliens Restriction Act (1914) was enacted as a result of Britain's entry into World War I which enabled the Crown to possess the powers to protect the home front from enemy aliens in times of national danger or great emergency (Taylor *et al*., 2018). German and Austrian nationals were required to register with the police with limitations placed on their travel, restrictions on their entry into certain areas and being

subject to deportation and internment when deemed necessary (Taylor *et al*., 2018). The sinking of the passenger ship named Lusitania in 1915 resulted in the British government ordering all German and Austrian men of military age living in the UK to be placed in internment (Taylor *et al*., 2018). This led to the repatriation of 28,000 people where the majority included German nationals who were a well-established people in Britain with a population of 57,000 Germans during the course of World War I (Taylor *et al*., 2018). By the month of November in 1915, 32,400 people of German and Austrian nationality were detained. Those detained during this time were mainly held in the camps on the Isle of Man as civilian detainees rather than prisoners of war with others dispersed into camps located on the mainland such as Stratford in London, Alexandra Palace and LoftHouse Park near Wakefield (Taylor *et al*., 2018). Britain ensured that the rules of their treatment set out in the Hague Conventions of 1899 and 1907 pertaining to the section on the Laws and Customs of War on Land were adhered to, which also permitted international observers from countries such as the United States (US) and Switzerland to visit and inspect the camps (Taylor *et al*., 2018).

Civilian internees, unlike prisoners of war were not required to work and were provided with food and accommodation standards at an adequate level which also allowed internees to organise activities pertaining to education, sports and religion. Despite this, the defining feature of the camp life was boredom as a result of enforced inactivity. Paul Cohen-Portheim (1880-1932), an Austrian internee stated how time had to be killed and everyone did their best to achieve this as it was the arch-enemy. In some locations such as the Cunningham Camp in November 1914, riots would take place due to the poor conditions and overcrowding in the camps. Lord Kitchener felt compelled and thus ordered the release of as many internees as was possible to ease the problem of overcrowding after the inquiry into an incident of the shooting of protestors.

The attitudes and responses that were voiced from the various observers began with The Red Cross who spoke of "barbed-wire disease"[3], which was reiterated by Adolf Vischer

[3] The Swiss physician Adolf Lukas Vischer described a psychiatric syndrome among prisoners of war, the 'barbed-wire disease' that follows a long-term incarceration and which involved boredom, confusion, clouding of consciousness and amnesia. Vischer first identified this as an important clinical issue. Ohry, A. and Solomon, Z. (2014) 'Dr Adolf Lukas Vischer (1884-1974) and 'barbed-wire disease', *ResearchGate*, [Online]. Available at: https://www.researchgate.net/publication/260446856_Dr_Adolf_Lukas_Vischer_1884-1974_and_'barbed-wire_disease' (Accessed: 9 January 2020).

– a Swiss observer that this was as a result of the inactivity, the ignorance as to the length of captivity, the absence of privacy and irregularity of communication from home of the camp life (Taylor *et al.,* 2018). Organisation that advocated for particular groups such as the Society of Friends Emergency Committee for people who had restrictions placed on them termed enemy aliens which included the British women who had lost their nationality as a result of marrying German or Austrians (Taylor *et al*., 2018). Despite there being some voices and regions who opposed the treatment of enemy aliens, with some describing it as anti-British in newspaper, letters and public forums, the media and opinion poles were generally in favour of internment which caused its use to increase (Taylor *et al*., 2018).

1.3.2 Groups affected by the laws and policies (World War II)

During the Second World War, on 28th September 1939, the HO's Aliens Department set up 120 internment tribunals around the UK for the purposes of examining all adult enemy aliens that were UK-registered (Taylor *et al*., 2018). The HO divided the aliens into three categories; Category A - were those to be interned, Category B – were those to be exempted from internment but subject to restriction and Category C – were those to be granted exemption from both internment and restrictions (Taylor *et al*., 2018). The people who were not interned remained subject to restrictions where they had to obtain police permits to be able to travel, change residence or even own a car. Foreigners living in the UK were also subjected to a curfew (Taylor *et al*., 2018). After the fall of France, Belgium and the Netherland to the Nazis in May 1940, Britain feared that an invasion was fast approaching which resulted in the British government authorising approximately 8,000 German and Austrian nationals living along the southern coast of the UK to be interned (Taylor *et al*., 2018). Italy declared war in June 1940 which caused 4,000 Italian nationals living in the UK who were known to be members of the Fascist Party or those aged between 16 to 70 years who were resident in the UK for less than twenty years to be detained (Taylor *et al*., 2018). On September 1939 when war was declared, 70,000 Germans and Austrians who had obtained UK residency were classified as enemy aliens (Taylor *et al*., 2018). This led to the HO granting the Category C status to 66,000 German and Austrian enemy aliens in the UK causing them to be exempted, with 6,700 classified under Category B – subjecting them to restrictions and 569 classified under Category A who were instantly interned (Taylor *et al*., 2018).

Despite this, the British government's sweeping approach to internment caused the internment of vast numbers of people who were placed in Category C, particularly Jewish refugees fleeing Nazism (Taylor *et al*., 2018). The HO published clear guidelines in July 1940 concerning those who are exempt from internment (Taylor *et al*., 2018). A scandal followed after the S.S. Arandora Star sank 75 miles west of the Irish coast en route to Newfoundland whilst carrying 1,150 internees and 374 British seamen which caused the death of half of the people on board (Taylor *et al*., 2018).

The people who were exempt from internment included; the elderly, those under 16 years, medical professionals who were permitted to practise in the UK, pioneer Corps members, key workers in industry, workers in agriculture and refugee organisations and those whose sons were in the British armed forces (Taylor *et al*., 2018). Leading up to March 1941, 12,500 interns had been released which continued to increase causing less than 5,000 people to remain interned by 1942, particularly on the Isle of Man (Taylor *et al*., 2018).

1.3.3 The provision of camp facilities and the public responses

Schools, unfurnished housing estates, army barrack and race tracks were often converted into camp sites which were makeshift due to the mass internment of people in short spaces of time, particularly during the mobilisation periods of the armed forces causing a strain on the location of spaces to hold internees (Taylor *et al*., 2018). Between June and July 1940, the Canadian and Australian governments volunteered to take on internees where 7,500 people were shipped overseas (Taylor *et al*., 2018). Holloway Prison or the camps on the Isle of Man often interned women and children where internees described the camps as dilapidated, dirty, drafty, cold and stripped of all furnishing (Taylor *et al*., 2018). The camps' facilities at most sites were limited to providing essentials with the majority of camps permitting internees to cook their own meals with the food being described as "adequate if unexciting and repetitive" (Taylor *et al*., 2018). Britain once again followed treatment of internee according to the Hague Conventions of 1899 and 1907 in the provision of basic board and accommodation and not permitting them to work (Taylor *et al*., 2018). The camps, although fenced around by barbed wire were not run as prisons in line with the Hague Convention however, internees freedom was restricted whilst maintaining a level of autonomy for the

internees through the participation into education, music, art and other creative tasks (Taylor *et al*., 2018). In the camp on the Isle of Man named Hutchinson camp, a majority of the internees were highly educated and published journals named The Camp and Camp University which included regular discussion groups and lectures that covered topics focused on history, chemistry, Greek philosophy and subjects relating to agriculture and town and country planning (Taylor *et al*., 2018). Despite, the trauma of imprisonment and separation from families in combination with enforced inactivity leading to boredom, frustration affected internees causing some to suffer from mental illness (Taylor *et al*., 2018).

The attitude and responses of the public varied during this period however, the Mass Observation reporting on public opinion in April 1940 revealed feedback from a detailed interview held in London and West Scotland on the low level of support for mass internment (Taylor *et al*., 2018). The defeat from the war of France, Holland and Belgium in May 1940 caused an increase in fear of the uprising of groups working for the enemies of Britain, commonly termed as a Fifth Column (Taylor *et al*., 2018). This resulted in the press supporters of the right-wing advocating for increases in internment with various town and city councils calling for a blanket internment of enemy aliens (Taylor *et al*., 2018). Political and public disapproval regarding internment was based on the indiscriminate and chaotic internment that occurred in May 1940 including the poor communication, overcrowding and the poor judgment in policy implementation which led to the shipping of internees overseas (Taylor *et al*., 2018). The HO were condemned and highly criticised for holding Jewish refugees and Nazi-sympathisers in the same accommodation along with the bureaucracy that people were faced with which caused communicating with family members and challenging the HO's decision to intern them quite difficult (Taylor *et al*., 2018). The issue of internment was raised on several occasions in the House of Commons by MPs such as Eleanor Rathbone highlighting individual cases whilst criticising the implementation and the conditions of the policy in its entirety (Taylor *et al*., 2018). A six-hour parliamentary session concerning internment was held on 10th July 1940 due to the sinking of the S.S. Arandora Star causing MPs to call for a swift review of individual internee cases who were likely to have been imprisoned unfairly and also for the improvement of conditions in the camps (Taylor *et al*., 2018). Newspapers, including The Times on 11th July 1940 received letters stating their opposition to internment and referring to it as

"clouding the national honour", along with the launching of various petitions by members of the community (Taylor *et al*., 2018).

1.3.4 Groups affected by the laws and policies (after World War II)

At the end of the Second World War there was no longer the need for large size detention facilities, thus causing their numbers to decline (Taylor *et al.,* 2018). A small proportion of aliens were deported each year which was often as a result of committing crime, but were held in the local police stations before being deported (Taylor *et al*., 2018). Prior to 1962, aliens entering the country were required to register at their local police station whenever they changed their address but did not have any restrictions placed on them concerning their movements during this peacetime, they were only required to prove that they had sufficient funds to support themselves and that they were not suffering from any particular medical illnesses or infectious diseases (Taylor *et al*., 2018). However, in 1962, a significant change to immigration law in the UK came about due to the introduction of the Commonwealth Immigration Act (Taylor *et al*., 2018). Prior to the passing of the Act, every person that lived in the British empire and a Commonwealth country automatically possessed the right to enter and remain in the UK where restrictions were placed only on people attempting to enter Britain who were from outside the empire and Commonwealth therefore being classified as aliens (Taylor *et al*., 2018). The HO were given the authority by the introduction of the 1971 Immigration Act to detain people based on the administrative acts of examination, removal and deportation (Taylor *et al*., 2018). A decade after the Act was introduced, the power to detain was mainly used as a short-term measure in cases of refusal of leave to enter as the holding facilities and camps were often used as a place of welcome, reception and orientation for refugees arriving in Britain in large groups (Taylor *et al*., 2018). The nationalities that were often detained in Britain under the Immigration Acts were Hungarians in 1956, Ugandan Asian expellees of 1972 to1973, Vietnamese refugees in the early 1980s, Sri Lankan refugees in the late 1980s and others (Taylor *et al*., 2018).

1.3.5 The provision of IRC facilities and the public responses

All the refugee groups were initially held in temporary reception centres, which were often at the ex-Royal Air Force (RAF) bases as they were able to cater for hundreds of

refugees until they were found housing and work due to the large size of the bases (Taylor *et al*., 2018). The holding facilities in the airports became inadequate to hold the vast numbers of Commonwealth immigrants that needed to be processed after the enactment of the 1969 Immigration Appeals Act, thus causing the opening of Harmondsworth Detention Centre in 1970 (Taylor *et al*., 2018). In the early 1980s, there were some temporary centres which were used as a reception and welcome for immigrants, particularly Vietnamese refugees after being used for something else (Taylor *et al*., 2018). Morton Hall in Lincolnshire as an example, initially started running as a temporary centre, became a prison until 2011 when it was reopened as an IRC (Taylor *et al*., 2018). The HO made use of various alternative holding facilities in the late 1980s due to the inadequacies of the detention capacity to cope with the rising numbers of asylum seekers, with examples such as the using of abandoned car ferries (Taylor *et al*., 2018). The attitude and responses in the late 1960s from political and public debates were centred on immigration being a problem to society rather being of any benefit with the solution being that of deterring entry (Taylor *et al*., 2018). This attitude to immigrants during this period was being conflicted by opposing opinions to detention resulting in anti-deportation campaigns that took place regularly and were successful, which were often participated by people who came from communities that were affected by the changes in the law pertaining to the migration of Commonwealth citizens (Taylor *et al*., 2018).

1.3.6 The effects of the end of the war on immigration detention

The end of the cold war led to a more consistent movement of people across the borders as a result of the rise of nationalism, the collapse of states as well as the struggles of post-colonial states, civil war and economic instability, which was a contrast to the government-sponsored arrival of large refugee groups between the 1950s to 1980s (Taylor *et al*., 2018). In the late 1970s, the number of individual asylum applications increased from 300 a year to 71,160 by 1999 with immigration law making the application process of individuals applying to enter and remain in the UK who did not have strong family links to Britain quite difficult (Taylor *et al*., 2018). The existence of detention centres became formalised as a result of the 1999 Immigration and Asylum Act, which were re-named officially in 2001 as removal centres (Taylor *et al*., 2018). The introduction of the Act resulted in Britain shifting from using detention as an

exception and a temporary measure during periods of experiencing a major crisis, to using detention for administrative purposes as a measure to support the refugee and asylum system of Britain, causing 13,636 asylum seekers to be detained in 2014 (Global Detention Project, 2019). During this period, the powers governing detention were extensive and not limited by any automatic independent scrutiny regarding the lawfulness, appropriateness or length of detention (Taylor *et al*., 2018). By 1990, 1,304 Commonwealth citizens had been detained which was the first year that the figures for this group of people detained rose above 200 (Taylor *et al*., 2018). The detention estate expanded rapidly in its total capacity in 1993 from 250 places to 2,644 in 2005 where detention procedures are routinely applied to both men and women, including victims of human rights abuses, pregnant women and children (Taylor *et al.,* 2019). Despite claims by the government to have abolished the detention of children, 42 children entered immigration detention in 2017 (Association of Visitors to Immigration Detainees (AVID), 2019).

1.3.7 The opening of IRCs

It is necessary to get the basis of immigration detention which the longer history of camps and detention centres provides. During the earlier stages of immigration detention (World War I and II) laws were initially enacted to protect the British country against immigrants who originated from or were refugees of the country at war with Britain (Taylor *et al*., 2018). The laws changed over the years where immigration laws are made to suit the present situation – which is usually to deal with a "crisis" or a "state of emergency" (Taylor *et al*., 2018). When the crisis has been averted, the laws that were used in the emergency situation lie dormant and are not used until a similar crisis arises again. After the war, immigration laws such as the Aliens Restriction Act (1914) were no longer needed (Taylor *et al*., 2018). However, it was revived and enacted in its evolved state from the early 1990s to enable the government to detain migrants in IRCs on a mass scale with the intention of deportation due to the political shift and the intentions of controlling migration (Taylor *et al*., 2018). This has resulted in the production of an arbitrary regime where migrants are detained indefinitely, unlike their European counterparts who have a time limit on the detention of migrants (AVID, 2019). The huge rises in the arresting and detaining of migrants has led to the increase in the number of IRCs and holding facilities in the UK in order to cope with the

numbers of people being detained which raises questions pertaining to human and healthcare rights and whether or not IRCs are fit-for-purpose.

Campsfield House was initially used as a young offenders' institute, but was re-opened as an IRC in 1993. In 1996, Tinsley House was opened as the first purpose built IRC in the UK (Taylor *et al*., 2018). In 2001, the two only existing IRCs in Scotland – Yarl's Wood and Dungavel opened followed by Dover IRC and Haslar IRC in 2002, Colnbrook IRC at Heathrow airport opened in 2004 and Brook House IRC at Gatwick airport opened in 2009 Taylor *et al*., 2018). The Oakington reception centre opened in Cambridgeshire in 2000 as an IRC purposely for people whose asylum claims were considered as "fast track" by the HO however, the centre was closed in 2010 (Taylor *et al*., 2018). The attitude and responses of the UK public in 1994 resulted in a campaign to close Campsfield which led to monthly demonstrations taking place outside of the IRC and continue to take place until this day (Taylor *et al*., 2018). Further attitudes and responses of the public in 1997 resulted in 50 people demonstrating against an attempt of the HO to move two migrant detainees being held in Campsfield House to a prison (Taylor *et al*., 2018). Various disturbances and fires took place in February 2002 in Yarl's Wood IRC resulting in the destruction of a section of the centre, causing the centre to be shut down until it was reopened in September 2003 (Taylor *et al*., 2018). Detention was deemed by the United Nations High Commissioner for Refugees (UNHCR) in 1995 as an undesirable solution to immigration control, suggesting that alternatives should be considered at every turn however, as the UNHCR's demands for states to put an end to detention were not solid, the UK's immigration law has done little to change its policy (Taylor *et al*., 2018).

1.3.8 The hostile environment laws and policies of 2010 until today

There was a normalisation in the British immigration policy in the use of detention which was extended by the HO in 2010 to the hostile environment policies (please refer to section 1.2.2) and were mainly implemented as part of the Immigration Acts of 2014 and 2016 (Taylor *et al*., 2018). In 2015 the HO increased the number of people they detained, achieving the highest figure of 32,447 of detained migrants, including members of the Windrush generation as a result of the hostile environment policies (Taylor *et al*., 2018). In 2017, almost half of the detained population in the UK had claimed asylum with over 5,000 EU (AVID, 2019) nationals being detained in IRCs in

the UK – leading to a 600 percent rise since 2009 (Taylor *et al.,* 2018). The top five ranking nationalities that were detained in immigration detention in 2017 were Indians, Pakistanis, Bangladeshis, Nigerians and Polish (AVID, 2019). The average cost of detaining someone in a UK IRC according to the HO's statement is 92.67 GBP detainee per day, which is almost 34,000 GBP per detainee per year of the tax-payers' money (Shaw, 2016).

Numerous inspection in IRCs report that they are being run like prisons due to inadequate management and a lack of regulation, where detainees do not feel safe along with inadequacies in the legal and mental health that is provided in IRCs (Taylor *et al*., 2018). Research has demonstrated that depression, anxiety, posttraumatic stress disorder (PTSD), suicide and self-harm are commonly suffered by migrant detainees where there is an association between the length of stay in detention and the increase in distress and severity of the illnesses (Taylor *et al*., 2018). The uncertainty in the length of time being detained before removal from the country along with difficulties in communicating with legal advisors and family members, including challenges faced when going through the process of an appeal are all part of the experiences of immigration detention that causes significant stress (Taylor *et al*., 2018).

In Europe, the UK is the only country that holds people in detention indefinitely where the processing period for their release from detention ranges from several weeks to years with hundreds of immigrants also being detained in prisons under immigration powers (AVID, 2019). To date, there are nine long-term IRCs in the UK, namely; Brook House (London Gatwick Airport), Tinsley House (London, Gatwick Airport), Cedars (Pease Pottage, Crawley – closed down on 21st July 2016 and moved into Tinsley House IRC), Campsfield (Killington, Oxon), Dover (Western Heights, Dover), Dungavel (Strathaven, South Lanarkshire, Scotland), Harmondsworth (Harmondsworth West Drayton), Colnbrook (Harmondsworth West Drayton), Yarl's Wood (Clapham, Bedfordshire), Morton Hall (Swinderby, Lincolnshire) and Haslar (Haslar, Hampshire) (NHS England, 2015; The Detention Forum, 2016). Other types of holding facilities in the UK for the purposes of immigration enforcement come in the form of residential short-term holding facilities, police cells and holding rooms at airports (Taylor *et al*., 2018). The growing detention estate and normalisation of immigration detention has resulted in various groups from human rights organisations, civil society and political lobbyists in the UK to run numerous campaigns in their protest against immigration

policies (Taylor *et al.,* 2018). These groups and their campaigns include; Movement for Justice's "Shut Down Yarl's Wood", Right to Remain's "These Walls Must Fall" and Detention Action's "Time4ATimeLimit" among various others. In 2015, the very first parliamentary inquiry into immigration detention took place where a report was issued introducing a twenty-eight day maximum time limit on detention which was a cross party inquiry requesting that the government uses wider ranging alternatives to detention (Taylor *et al.,* 2018).

Through the course of time detention has become normalised and acceptable in the UK due to the government creating a perception to the nation that there is a crisis. The intended purpose of detention from the inception of camps was initially to secure the nation against threats and during a state of emergency to contain and control the mass flows of refugees. The methods used for containing, imprisoning and the expelling of migrants has evolved over the years into the form of IRCs which carry the same message as that of the war era where the government maintains the perception that the nation is under attack. This fuels the government's action to deploy security techniques on a mass scale at the detriment of the lives of people who enter the UK for various reasons and become criminalised due to their legal or non-legal status. The intended purpose of IRCs in this modern era for administrative purposes has evolved into a regime of punishment and control which is kept hidden by the HO and physically removed from society in order to prevent knowledge or the true atrocities that take place within the walls of IRCs.

1.4 Private companies and the profits gained in managing IRCs

In the UK the private companies that manage IRCs, including the managing of prisons gain huge profits due to their contracts and outsourcing techniques (Corporate Watch2, 2018a). An analysis on the detention industry reports that the standard rate that IRCs in the UK gain in profits overall, is 20 percent or more (Corporate Watch2, 2018a). Four private contractors run seven of the IRCs in the UK namely; Serco, G4S, Mitie and GEO Group (Corporate Watch2, 2018a) whilst the other IRCs are run by Her Majesty's Prison and Probation Service (HMPP) (HMPP, 2017).

The analysis made based on the accounts of the GEO Group by Corporate Watch2 (2018a) reveal that they are receiving 30 percent of the profits through the running of

the Dungavel IRC in Scotland whilst G4S has been gaining 20 percent profit from running Brook House IRC and over 40 percent from running Tinsley House IRC (Corporate Watch2, 2018a). Private companies, such as COMPASS, Serco and G4S run housing for asylum seekers (Corporate Watch2, 2018a). These private companies have been complaining greatly that government policies have been preventing them from gaining much profit from running housing for asylum seekers (Corporate Watch2, 2018a). Private contractors have also been struggling to make their huge profits from outsourcing in other industries such as healthcare and transport where such companies as Mitie have resulted in selling off its entire home care business at a loss (CorporateWatch2, 2018a). The latest annual report based on Mitie's accounts also reveal tight margins in various other areas which include cleaning and engineering maintenance (Corporate Watch2, 2018a). In light of the small profit margins that private companies are making from outsourcing contracts in other industries, they have been able to devise techniques that enable them to maintain increases in profits from detention contract by taking such measures as employing migrant detainees to work for one GBP an hour which saves them the cost of contracting cleaners (Corporate Watch2, 2018a). The GEO Group is an example of such an instance where they are reported to have saved in less than three years more than 727,000 GBP by employing migrant detainees at Dungavel to work in the IRC for much less than the minimum wage (Miller, 2018). The report of 2014 by Corporate Watch (2014) reveal that detention contractors have saved on costs between them of approximately three million pounds a year through the employing of migrant detainees to work for less than the minimum wage to clean, cook and maintain their own detention centres.

This technique of the cutting of costs through the reducing of IRC facilities to the bare minimum and under-staffing by private contractors of IRCs is rarely subjected to scrutiny (Corporate Watch2, 2018a). The further advantage the private contractors of IRCs have to enable them to deploy techniques to cut costs, is that they are allowed to audit their own performances with minimal scrutiny from the HO (Miller, 2015). This enables unlawful actions to be deployed in the techniques of the private companies in the managing of IRCs who escape scrutiny and are rarely labelled as illegal in their actions due to a lack of accountability whilst they govern migrant detainees who are stigmatised as illegal. In addition, an oligopoly is formed in the bidding process for deals on contracts by private companies which tend to be quite large deals involving a

handful of specialist bidders who tend to maintain prices at a high rate (Corporate Watch2, 2018a). The private companies have further advantage by knowing the business of immigration detention quite well with Securicor, which is now part of G4S managing the first purpose-built IRC in the UK – Harmondsworth since it opened in 1970 (Corporate Watch2, 2018a). The Blair government introduced private finance initiative (PFI) funding of IRCs where contracts were handed directly to the management of private companies (Corporate Watch2, 2018b).

The current austerity conditions applied by the government has caused many service contracts to feel squeezed however, contracts involved in the business of detaining people do not feel the impact and are rather thriving as expected of businesses involved in security in general in a society where inequity, insecurity and xenophobia is on the rise (Corporate Watch2, 2018a). Based on this notion forms the basis to why outsourcers such as, G4S and GEO Group mainly commit to security and imprisonment causing them to thrive and generate healthy profits (Corporate Watch2, 2018a). This drives the outsourcers to persistently bid for prison, IRC and other detention contracts whilst promoting the private prison industry (Corporate Watch2, 2018a). Government deals in other sectors such as transport, housing and others tend to experience financial difficulties yet, the industry that locks people up –immigration control and prison continues to thrive (Corporate Watch2, 2018a). An annual report from Serco stated that, "we can be very confident that the world will still need prisons, will still need to manage immigration … a prison custody officer can sleep soundly in the knowledge that his or her skills will be required for years to come" (Serco, 2017).

1.5 Structure of thesis

This thesis progresses onto six further chapters. In the second chapter, I begin by reviewing the literature on virtual borders and it's contentions with healthcare access in the wider UK healthcare system and IRCs. I proceed to discuss the main overarching frameworks of this thesis which are, biopolitics and governmentality along with the supporting concepts of, the second face of power and the trialectics of space and how it relates to IRCs and the healthcare access of migrant detainees. This is to help bring about an understanding of the three variations of political power, the restrictive face of power of the migrant detainee and the social production of space within immigration

detention. This leads the discussion further onto the legality, rights and policy issues of healthcare delivery in IRC and prisons – as a result of securitisation of immigration in Europe and the UK. I then elaborate on the final supporting concept of the CSDH model in explaining the importance of the SDH pathways in using it as a tool to locate possible barriers to the implementation of health policies in IRCs.

In the third chapter, I present the methodology and discuss about the research design, which involves; the method, the participants and sampling design used, the sources of data collected and a reflection on the data collection process. A reflexive account of the data collection process and data analysis is made based on my experiences, challenges and techniques used in accessing the participants and managing the data. The management of the data involves an explanation of the type of approach and process used in applying the techniques of interviewing, coding and the overarching concepts in the categorising and structuring of the two groups, that is, the service user and the service provider. The two groups are formed to emphasise on the type of data that is being collected to enable a clear distinction to be made in the forming of themes. This is in order to create ease in the process of analysis and to enable the distinction between the two groups to be highlighted in the discussion of the findings. The methodological considerations and reflection on my position in the research process are discussed based on the validity and reliability of the research study, ontological, epistemological and ethical considerations and the limitations of the research method.

The fourth, fifth and sixth chapters are based on the data collected from my fieldwork. The fourth chapter named, Border enactment in its convergence with the standardising of healthcare systems in IRCs is based on policy and practice. In this chapter I call upon the theoretical concepts of biopolitics and governmentality to bring about an understanding of the factors that impact on the assessment processes of healthcare delivery and the effects of standardising healthcare systems based on my fieldwork. This chapter is heavily reliant on the data collected from the two senior healthcare professionals to help inform on policy and practice in IRCs.

The fifth chapter named, Immigration detention: a new penal system and the crisis of liberal legality focuses on professional workers, particularly health professionals. Here I begin by unpacking the type of factors that impact on the ability of health professionals

to perform their duties in IRCs based on the findings of my fieldwork. The governance and culture of IRCs are examined in this case through the use of the theoretical concepts of Agamben (1998; 2005) on biopolitics where migrant healthcare rights are undermined. Rose's (1999) concept on new public management, is used to examine the effects of the neoliberal techniques of governing through the integration of privatisation in IRCs. Schmitt's (2004) governance concept supports the above mentioned overarching concepts on the use of discretionary power where immigration laws supersede health and social care and human rights laws. I assess the factors that contribute to the lack of compliance to HO policies with a final examination of this chapter focusing on the doctor-patient relationship and how it has become fragmented.

The sixth chapter named, The mechanisms of disempowerment: migrant detainee health and the inequities in accessing healthcare in IRCs emphasises on the variations of power and space within the context of immigration detention. A critical examination into the experiences of migrant detainees enables a discussion to be formed within the socioeconomic and political context of the CSDH framework based on the findings of my fieldwork. This chapter finalises its examination by focusing on the impact of IRC systems and the material circumstances of migrant detainees on their health and how the mentioned factors contribute to the inequities in healthcare access.

I conclude with the final and seventh chapter by drawing on the main points of the thesis which focuses on my contribution to knowledge and the implications for the migrant detainee in the accessing of healthcare services. The implications of the power relations between the migrant detainee, the HO and the healthcare professionals in the accessing of healthcare services is outlined at the individual, institutional and societal levels to conclude on the inequities in healthcare access for migrant detainees. A final note emphasises on the potential of resistance and agency of migrants and their advocates with a brief discussion on a possible direction for future research.

Chapter 2
Literature Review

This chapter aims to point to the "virtual borders" that challenge undocumented migrants' access to healthcare within the space of immigration detention. As this is an interdisciplinary project of immigration and health, I situate my theoretical framework on the biopolitics concept of Agamben (1998; 2005) including the governance and healthism concepts of Rose (1999). This framework will be supported by Schmitt (2004) concerning liberal legality and Bachrach and Baratz's (1962) on the two faces of power to form the basis of my analysis for this research project.

2.1 Virtual borders in its contentions with healthcare access

The exploring of the link between the virtual borders and the healthcare access of migrant detainees is central to addressing the research questions and the aims of this project. My attempt to investigate this link begins at my research questions which ask; what impact does the governing strategies of immigration detention have on the healthcare delivery of detainees?, how do these strategies influence and determine the lifestyle choices and health outcomes of migrant detainees?, what role does human rights play in light of these strategies and what type of institutional system has been established which determines the power relations that exist between the service providers (the HO, the private companies, healthcare commissioners and professionals) and the service users (migrant detainees) of healthcare in immigration detention. Addressing the SDH in this research project enables the public health pathways of migrant detainees to be located. The pathways locate where health inequities may arise as a result of the structural determinants of health, which is based on a socioeconomic and political context and is linked to the intermediary determinants of the migrant detainee that impact on the opportunities available in accessing health services.

The "border" – in the context of this research project implies to the act of controlling and managing immigration. "Virtual borders" as implied by Bloch and Schuster (2005); Bosworth (2008) and Schuster and Solomos (2004) have been created particularly in the European system through legislative laws and policies where border enactment

strategies leading to deportation, detention and dispersal are being termed as "normal" by the UK government. "Virtual" is a term used in this context whereby the controlling and managing of immigration is achieved through the use of electronic and biometric systems where data-sharing mechanisms may take place. One of the ways this is evidenced in the UK is through the Memorandum of Understanding (MoU) between the DH and the HO (DH, Social Care (SC) and HO, 2017). The MoU is an agreement made by NHS Digital (previously the Health and Social Care (HSC) Information Centre) and the DH to share patients' personal information with the HO, implemented publicly since 16 January 2017 (DH, SC and HO, 2017). The MoU enables the access to patient's date of birth, last known addresses, GP details and the date registered with a GP (DH, SC and HO, 2017). This is justified on the basis of public interest by,

> "maintaining effective immigration controls" and protecting "limited UK resources and public services (including the NHS, jobs, schools, housing) … from unnecessary financial and resource pressures", stated in the agreement which relies on section 261(5)(c), (d) and (e)of the HSC Act 2012 policy to conduct this strategy (DH, SC and HO, 2017).

The creation of this virtual border strategy is devised for the purposes of monitoring and tracking people for potential arrests to be made leading to detention, possible deportation and dispersal. This has led to an increasing rate of detained migrants where border enforcement strategies attribute its success not solely to the recruitment of immigration officers to conduct raids and the arresting of people in their homes, work places, hospitals and other public spaces – often through patient information, tip-offs and other sources of information, but also through the recruitment of the local people (Corporate Watch, 2017). These local people include; employers, landlords, doctors, administrative staff at: general practitioner (GP) surgeries, hospitals, schools, universities, banks, registry offices, police and security companies (Corporate Watch, 2017). The enactment of this virtual border in the UK society has created a perception that states implicitly that migrants do not have the right to access services unless they have purchased it. However certain services, particularly with regards to healthcare (which is free to all at the point of delivery irrespective of residential or legal status for certain UK health services), persistently denies access for migrants who hold undocumented status which is reaffirmed more aggressively upon those detained in IRCs. The establishment of this virtual border has conceived a hostile environment

within the space of the UK's healthcare service (which was introduced by the then Home Secretary – Theresa May in 2012) causing a kind of tension to be impressed upon healthcare staff creating a conflict between the duty of care to the patients and the disclosing of patient information to the HO (Mahase, 2018).

> "All detainees must have available to them the same range and quality of services as the general public receives from the NHS" (NHS England, 2015, p.7-8).

I believe that comparing IRCs and prisons in terms of legality and rights – which is a focal point that is limited in scholarly studies, will allow questions to be addressed as to why the government's attempt to manage the border allows or denies a person to access healthcare services primarily based on their residential status. The comparing and contrasting of healthcare legislation and policies that govern both the IRC and prison setting enables an emphasis to be made on the issues in policy implementation caused by legality and rights that impact on the outcome of the detainee's health and wellbeing. I draw from literature based on reports from NHS England (2015), PHE (2014, 2018), The Detention Centre Rules (2001) and the Shaw Review (2016) to inform on the issues pertaining to legality, rights and policy in the IRC, prison and healthcare service setting. The reports provide insight into systematic failures attributed generally to ineffective implementation of procedures (of which some are intended for the prison setting), weak implementation of policies due to a lack of compliance stemming from institutional culture and other underlying factors which present challenges on the access and provision of healthcare services in IRCs. This reinforces the notion of the challenging of virtual borders to the healthcare access and provision of undocumented migrants and migrant detainees.

2.2 Contextualising biopolitics and governance in IRCs and healthcare access for undocumented migrants

To conceptualise the challenges of access to healthcare as virtual borders, I will rely on the concepts of biopolitics and governance. This will help to work towards achieving an understanding of the reasons why the structures of society and the institutions of detention which have been established in a society centred on democracy and human rights undermines the well-being of undocumented migrants and places them at health

risk whilst under-going the process of determining their residential and legal status. My first approach will be to attempt to understand the concepts of biopower and governmentality and its relevance to my research study.

2.2.1 The governmentality, security and camp paradigms in context

Agamben (2005) deals with the concept on the State of Exception by giving us an insight into the problems generated by authoritarianism, sovereign exception and state violence. Hence, it does not focus on the socio-political and institutional structures that are impacted on by the normalisation of actions in the attempt to securitise the state which relate to public health and human rights issues. I draw from aspects of Agamben's concept on biopolitics based on the two volumes of his project; The Homo Sacer and The State of Exception which focus on the camp paradigm and the security paradigm respectively (Agamben, 1998, 2005). This will give insight into the impact on undocumented migrants of the governing strategy in normalising exclusion and the power relations that exist between the various actors of immigration detention.

Agamben's theory of biopolitics was a progression of Foucault's biopower theory. Foucault was able to form the term biopower by developing strategies that focused on institutions such as, hospitals, schools and prisons and the kind of power that manages them. As Foucault's work progressed, biopower developed into the term biopolitics as the focus shifted from institutions onto populations and the power that governs or manages them. Foucault observed that the state power which governs the life of populations has been assigned the duty to protect the welfare of its population. This has presented itself in the form of the state securing the welfare of the society which has given rise to the notion of the "other". The other, by the explanation of Foucault implies that, "if you want to live, the other must die" (Foucault, 2003, p.255). This means that killing someone for the benefit of societal security, is not seen as murder. Based on this notion, biopower in present times is referred to as the politics of security. This politics of security is centred around the categorisation of "us" and "them", the "normal" and "abnormal" that is, who is a legitimate citizen and who is not. Immigrants of undocumented status are categorised as them or abnormal thus seen as not deserving to live whilst those that fall into the category of us or normal are seen as deserving life.

Agamben's (2005) biopolitics progresses further to combine the life of people in the community along with the political involvement and effects of the state. This is in order to devise interventions and strategies that examines the processes people undertake or are subjected to in the interactions and decision making of the state system on their daily lives. Agamben's concern was that contemporary politics which is regulated by sovereign power often excludes the life of people to the extent that some people must die. This is achieved by the removal of their rights, nationality and political status, as illustrated in Agamben's (1998) first biopolitical project of the Homo Sacer camp paradigm. Agamben examines and questions the strategies the state deploys in containing migrant and refugee flows. This strategy seems to be backed-up by the ideology of the war on terror, presented in Agamben's second volume on biopolitics; the state of exception (Agamben, 2005) where terror may be referred to undocumented migrants and the perceived threat they pose on the nation's security. This has been hyped-up to a state of emergency which has resulted in incredibly increased numbers of people going through court processes relating to their immigration status concerning where they will be placed or displaced residentially. This is the point where the space of abjection in its relation to the administration of bare life, referred to by Agamben's (1998) camp comes into play where migrants' lives are laid bare and subjected to the mercy of the powers that govern immigration laws and IRCs.

The concept of the space of abjection in the camp paradigm of Agamben's (1998) Homo Sacer portrays this space as a state of non-being or muted-being. This relates to the contemporary space of IRCs where its subjects (migrant detainees) are perceived to be in a state of non or muted-being due to their undocumented status and limited rights. There is a danger of illustrating the subjects of the space of IRCs as inaudible, invisible and unable to make decisions for themselves concerning their health. The camp is designed to produce fear which is also depicted in an IRC. Migrants of undocumented status in the community fear to be located by the authorities and then detained in an IRC where the environment is hostile despite it being deployed for administrative purposes by the government.

Agamben's (1998; 2005) biopolitical view on the abandonment of space as an exercise of power leads on from Foucault's paradigm of governmentality. Foucault (2003) expresses that the type of governmentality at work today is the neoliberal form which restricts the action of the state and allows the market mechanisms to play a predominant

role. This means that there is a de-centralising of power where the government delegates authority to each state to govern themselves and allows the market to take the leading role. The market mechanism encourages competition to take place where the private sector and non-state organisations take on duties and functions in areas that the state would have been responsible for. This is evidenced in the delegation of managerial responsibilities to the private security companies to run the IRCs in the UK, which has encouraged the market mechanisms in immigration detention to take place. This is such to the effect that the private companies are typically interested in generating profit, thus are driven by the increased numbers of people that are detained. Resources (food, clothing, medicine and others) and services (healthcare, catering, domestics and others) in IRCs are provided at the bare minimum as the private companies' interest is to retain as much profit as possible by limiting the amount of money they spend on detainees (Shaw, 2016; Silverman, 2017). This technique of governing is what Rose (1999, p.16) referred to as "new public management" which has become the normative image of governance. The term governance has become the preferred terminology of government as it has a positive vibe to it and is often used in the context of governance being good. Good governance is said to exist when the government reduces its level of involvement in the management of social and economic affairs and the establishing of policies. IRCs may be seen as the construction of abandoned spaces within the nation where they are constituted at arm's length from the state.

Healthism, which is an expression of a kind of commodified self-care conceptualised by Rose (1999) in this instance refers to migrant detainees to the extent that they are the subjects of the space of institutions, such as IRCs and are governed by the powers managing IRCs. Hence their health outcomes are determined by the type of health systems that have been put in place with regards to the type of facilities and resources that are available and the level of access they may obtain. These factors determine the extent of which migrant detainees may make decisions about their health. Healthcare access to services are extremely limited in IRCs thus presenting migrant detainees with less than the bare minimum of healthcare provision which provides them with limited options regarding decisions about their health. Migrant detainees have been made subject to a system within the institution of immigration detention that is governed by sovereign power which seeks to undermine their healthcare rights. The institutional space of immigration detention has conceived a culture of disbelief, mistrust, dual-

loyalty, falsehood, discrimination, lack of transparency and accountability which have produced barriers in the adequate provision and access of healthcare services. This however, does by no means place migrant detainees in a position of absence or without a voice but rather enables a narrative to be formed based on the discourses of their struggles in their health and in accessing health services during their time in detention.

Carl Schmitt's case for the technique of governing is that liberal legality has been adopted by democratic states as the administrative form of governing which has become more prevalent since the first and second World Wars (Schmitt, 2004). Liberal legality is a belief that politics should be constrained by legal constitutional boundaries (O'Brien, 2011). Schmitt argues that there is a crisis in this technique of governing (that is, liberal legality) in its use of discretionary state or decision-making powers. Discretionary state power is analysed through the relationship between law, state and the emergency situation. Schmitt argues that for the law to be effective, there needs to exist some level of order which is achieved through establishing norms by the state or parliament. The norm cannot be applied in a situation of chaos as the law cannot function effectively where there is an absence of order. Where an extreme emergency situation occurs, a decision may be made to suspend the application of the law to enable measures to be deployed to restore order so that the law may be reapplied after dealing with the crisis situation (Schmitt, 2004).

I make reference to the liberal legality concept of Schmitt (2004) in my research project in the case where border enactment and the right to healthcare converge, resulting in the government exercising its discretionary power by causing immigration laws to override health and social care and equality laws. Carl Schmitt's (2004) concept is another way of viewing the exercising of power which is presented in an apparent chaotic context. Schmitt's legality concept in his emphasis of the prevalent use of discretionary state power in contemporary times (post-war era) coincides with Foucault's and Rose's neoliberal era. The three concepts of Foucault (2003) on governmentality, Rose (1999) on governance and Schmitt (2004) on legality work together to help develop an understanding of how governments use their sovereign power to perform actions at their discretion in the name of securitising the state against a set population of people (undocumented migrants and migrant detainees) who are perceived as a threat to

society. Such actions may be evidenced in the MoU which allows the HO the right to access patients' personal information for immigration purposes.

The private security companies play their part well in the neoliberal-contemporary era where new forms of governing are at a rise, such as the delegating of power to the private sector to encourage market mechanisms to take place. The stakeholders of the market are primarily driven by profit – in this context profit is achieved by the continuous detention or increased numbers of migrants detained. The government thrives on the private companies' thirst for driving up profit which provides the assurance of migrants being detained in vast numbers. As the managerial power has been delegated to the private companies, the government may take the opportunity to evade responsibility of the arbitrary and inhumane treatments of the people detained in immigration detention. The use of discretionary power in linking with the governance concept of Rose (1999) also relates to the governing technique of delegating some level of responsibility to the local people by enforcing border control via the various institutions of the UK. This has conceived a culture of hostility within the various institutional spaces of the UK society, particularly that of healthcare that affects the decision-making power of the migrant population on their health due to their limited rights. The aspects pertaining to non-power in decision-making from Bachrach and Baratz's (1962) concept is relevant to the position of the migrant detainee, which I emphasise on in this research project.

2.2.2 The second face of power in context

Bachrach and Baratz's (1962) Two Faces of Power argues that political scientists and sociologists view power from different perspectives. They refer to the sociologist's perspective of power (that is, the second face – more hidden) as being highly centralised and unrecognised while political scientist's view of power (that is, the first face – more visibly active) is more widely diffused (Bachrach and Baratz, 1962, p.947). The first face of power deals with the exercising of power on issues that are critical – which the authors believe is recognised by political scientists. Bachrach and Baratz are on the view point that political scientists do not hold any regard of the second face of power which is "the restrictive face of power" (Bachrach and Baratz, 1962, p.952). The second form of power is viewed by the authors as enabling an understanding of the first face

where the dynamics of non-decision making in the restrictive face of power is involved (Bachrach and Baratz, 1962, p.952). In this case, influence is utilised in the limiting of the scope of discussion or in the prevention of conflicts from being brought forward where Bachrach and Baratz believe that the restrictive face of power may be used as a tool for analysis as it is able to set the standard for determining the differences between "key" and "routine" political decisions (Bachrach and Baratz, 1962, p.952). Although Bachrach and Baratz (1962) recognise that identifying the restrictive forces of power involves a subjective act suggest that it is a useful way of constructing the power concept.

The premise of Bachrach and Baratz's (1962) concept is based on five core areas namely; behaviour, decision-making and control, conflict, interests and moral orientation. Bachrach and Baratz argue that behaviour is a critical component to be considered in understanding power in its restrictive form which involves studying the relationships between individuals in their exercising of power. In the restrictive sense of power, the behaviour of an individual in exercising their power takes place when they limit the scope of discussion or make a decision that affects the other individual (Bachrach and Baratz's, 1962).

Decision-making and control is another component which Bachrach and Baratz (1962) consider as vital in determining who makes the decisions and who has the control. Those who are able to manipulate the issue at hand are said to be in possession of control and not those who make the concrete decisions. Bachrach and Baratz contend with this notion as they argue that decision-makers may be merely acting on items of an agenda that are perceived as "safe issues" that were raised by those coming from the restrictive form of power (Bachrach and Baratz's, 1962, p.948). This situation is exemplified in the situation between principals and teachers, where committees are often formed with teachers with the intention of making decisions based on non-offensive issues whilst dealing with more crucial matters without having a discussion, causing power to be assigned to those performing these actions.

Bachrach and Baratz's (1962) concept goes further to suggest that the restrictive sense of power is also based on avoiding conflict. In "limiting the scope of the political process to public consideration of only those issues which are comparatively innocuous" is considered by (Bachrach and Baratz's, 1962, p.948) as an individual

possessing power. The authors assert the notion that the extent to which barriers are constructed – as a result of conflicts in policy by an individual or group (regardless of whether this action was performed consciously or unconsciously) in public determines that the individual or group is the possessor of power (Bachrach and Baratz's, 1962). It is important to note that power exists regardless of whether it is recognised or not, where an action that is not recognised as power may pose a significantly greater threat as it may not be questioned nor challenged (Bachrach and Baratz's, 1962).

Another component Bachrach and Baratz consider in the concept is where an individual who is possessing power has his or her interests advanced or protected due to their ability of preventing issues being brought up by others which may result in making decisions that conflicts with their preferences. In view of those individuals who do not or possess less power, their interests are blocked from advancing in order to protect themselves from harm (Bachrach and Baratz's, 1962). Moral orientation is the final component considered in Bachrach and Baratz's (1962) idea of power where power is exercised through the maintaining of the norm whereby the rules of the game are determined by not addressing matters that are deemed as unsafe.

2.2.3 The trialectics of space in context

The trialectics of space is used in order to bring clarity to the data discussed and to define in the data between what are assumptions, beliefs, attitudes, ideas and behaviours that form the culture and approach of the service users and the service providers within an IRC. The space of immigration detention and healthcare access of undocumented migrants relating to the lived, perceived and conceived spaces of Lefebvre's (1980) trialectics of space concept will be defined to assist in emphasising on the production of the power relations involving the actors of immigration detention and healthcare services (please refer to Appendix F). The relationship between the three spaces are continuously unstable where the lived space is expressed in social interactions, the perceived is an expression of the real material space of geographical locality and the conceived expresses the imagined space of representations. Please refer to Appendix F which helps to bring an understanding of the trialectics of space as it demonstrates how the three compartments of space interrelate and overlap (Pugalis, 2009). During the analytical process, it is necessary to define the type of space of IRCs where the lived

space will be based on the data produced from the primary source; interviews with participants, the conceived and perceived spaces will be based on a combination of primary and secondary. The three compartments of space do not function separately as they exist and work alongside each other, but are distinguished in order to understand the complexities of how they interact with each other (Pugalis, 2009).

2.3 Securitisation of immigration in Europe and UK

In order to be able to tackle the idea and issues surrounding the governance and power relations of migrants in UK, particularly within the institutions that detain them more critically, I begin by outlining the mechanisms that cause human insecurity as a result of border enactment strategies formed within the context of migration flows and management into Europe and UK.

Human insecurity, particularly for undocumented migrants in the UK have been evidenced firstly, through the instilling of fear to discourage undocumented migrants from seeking healthcare (Asokan, 2017); secondly, by the undermining of their human rights through immigration laws over-riding human rights laws (Lousley, and Cope, 2017; Gentleman, 2018); thirdly, the setting up of complex immigration laws that are not easy to follow or understand (Carr, 2017; Dugan, 2017); fourthly, migrants perceived as a threat to the security and welfare of the nation in terms of terrorism, crime and the scarcity in the allocation of resources (for example, health service, housing and jobs) (Roberts, 2012; Coporate Watch, 2017) and fifthly, migrants being used as scapegoats for NHS budgetary crisis (Milne, 2014).

These myths have been formulated and hyped-up by the government and the media which has given ground to the normalisation of actions by the government to enforce the war on terror where migrants – who are categorised as undeserving or the other – referred to by Foucault (2003), are perceived as a threat to the security and welfare of society (Roberts, 2012). This has warranted further actions in the last couple of years to take place where the responsibility of securing the UK's borders and controlling of migration flows has been delegated to local people following the Brexit (departure of the UK from the EU) through various institutions, namely; schools, hospitals, police, detention centres, workplaces, banks, housing and marriage (Corporate Watch, 2017). Passport and identification checks are being integrated into these institutions for the

purposes of recording and allowing the HO access to people's location and immigration status. This is evidence of the attempt of establishing a form of governance that involves the delegating of authority to the local people over the lives of others, where people in various front-line roles are coerced into participating in the enforcement of border control.

The tragic event of the 11 September 2001 bombing of the twin towers in the USA has provided the platform for debating on the issues and the securitisation of immigration in Europe (Berthelet, 2002; Zucconi, 2004). This has led to the revising of strategies to securitise the nation and reduce the potential of threats. The strategy focuses on free movement and immigration controls in the UK and Europe which are based on the Pact system devised by the Council of the EU and Member States since 2005 by adopting the Global Approach to Migration (Council of the EU, 2008). The vision of the Council of the EU and Member States is to maintain its image abroad whilst working on settling mutual concessions of expulsion strategies between states and their impact on human rights (Council of the EU, 2008). The desired goal is to reduce the powers of the European Commission by enabling the Council of the EU and Member States to undermine the principles of free movement whilst working towards establishing a system of surveillance in Europe (Council of the EU, 2008). This system controls the Union's territory over foreigners and citizens alike of people who wish to enter and those who are inside the Union's borders. The stated rationale behind this is to fight against terrorism and prevent illegal immigration whilst preserving their good image with regards to human rights (Council of the EU, 2008). The Pact system is designed to target people who have legally acquired a three-month tourist visa and have overstayed (Council of the EU, 2008).

An IRC which may be categorised as an institution that operates under a closed system creates a clearer picture of the type of regime and powers that govern the space of detention in an IRC. Although it is typical that institutions of detention limit the rights of its subjects, even more so for IRCs, it is debatable what the intended purposes of IRCs are and its effectiveness in managing migration and refugee flows due to the implications on public health through the undermining of the human rights of migrants.

Immigration detention was initially used in response to a war related crisis at the start of the 20th century to manage alien spies and refugee flows (Bloch and Schuster, 2005).

The UK has ten IRCs which hold people for long-term, four residential short-term holding facilities (RSTHFs), one non-residential short-term holding facilities (NRSTHFs), one pre-departure facility for families, 19 holding rooms at ports and 11 at reporting centres (Silverman, 2017, p.6). The UK immigration detention estate is one of the largest in Europe and the only nation that detains people indefinitely (Silverman, 2017). In 2009 until the end of 2016, 2,500 to 3,500 migrants have been in detention at any one time (Silverman, 2017). In 2016, 81 percent of the total migrant detainees released from detention had been held for twenty-eight days to two months, 16 percent were held for two to four months, two percent held six to twelve months, and one percent held for more than a year or 4.5 years (Silverman, 2017). In 2016 28,900 people entered immigration detention compared to approximately 32,400 in 2015 (Silverman, 2017). In 2005 to 2006 the weekly cost per detainee held in immigration detention ranged from 511 GBP (Lindholme IRC) to 1,344 GBP (Colnbrook IRC) with the average cost per day at 86 GBP in 2016 (Home Office, 2017). Under immigration control purposes, over 1,000 children were detained in 2009 and reduced to below 130 in 2011, increased to 242 in 2012 and fell to 71 in 2016 (Silverman, 2017).

Detention practices are similar and widespread across Europe in countries such as Italy, Greece, Spain, France and others where a common European legal framework enforces the restriction of migrants' movements (Del Grande, 2014). The EU legal framework also supports integration policies for regular migrants, and this is where Italy distinguishes itself from many other countries (Del Grande, 2014). The UK's integration and immigration policies are similar to that of Italy which are outlined in the following points: Italy's recent laws greatly stress criminality and focus much less on rights as does the UK. The fact of being detained simply for being an immigrant, without any law-breaking, is in itself mostly exclusive to the Italian legal code which reflects that of the UK's immigration system. The situation can become difficult given that Italian law recognises as Italian only those individuals born to two Italian citizens, which is also the case in the UK concerning the recognising of UK citizenship. If one of the parents is a non-EU citizen, the individual must achieve citizenship while risking detention in a centre for identification and expulsion (CIE) which is relevant to the IRCs of the UK. The risk is even higher for those who have been living in Italy for many years and whose visa renewal depends on a regular job contract, which is also the case for migrants in the UK.

In 2004, Doctors Without Borders, an NGO in UK described the structures as inadequate and denounced the frequent cases of self-mutilation of the prisoners (Del Grande, 2014), where such incidences of self-harm due to the frustrations of indefinite detention and arbitrary treatment are common-place in the IRCs of the UK (Shaw, 2016). It has been argued – based on the evidence in this thesis and supported by the findings of this research project, that IRCs in the UK are deployed as a securitisation tool for the controlling of immigration. IRCs are used as a deterrent to discourage migrants from entering or remaining in the UK illegally, as well as for administrative purposes during the process of determining their legal status (AVID, 2019). For this reason, IRCs are conducted in such a manner that criminalises the detained migrant population where the act of not possessing the legal papers to reside in the UK is deemed as a criminal offence (Corporate Watch, 2017).

2.3.1 Legality, rights and policy issues of healthcare delivery in IRCs and prisons

Healthcare legislation and policies that govern the IRC setting are often designed similar to that of the prison setting as they are constituted as similar institutions. Comparing and contrasting the two settings based on healthcare legislations, legality and rights will help uncover any similarities or disparities that may have the potential to impact on the health of detainees. These institutions operate under a closed system which reveals the type of culture that has been conceived within the institution of immigration detention thus allowing a critique to be formed around the effects that such a system has on the health of migrant detainees.

Legislation and policy of prisons, particularly those pertaining to healthcare are often used to govern the IRC setting. This often causes issues in the implementation process in IRCs as prison practices and procedures are transposed onto the IRC set-up which functions differently due to the vulnerability and the limited rights of the migrant detainee (Shaw, 2016). An instance of similarities between the two institutions may be found in the health checks, although the protocols differ and are tailored to suit the setting (IRC versus prison), the outcomes are similar in implementation. The implementing of NHS Health Checks and associated preventive services in all prisons and detained settings is obligatory according to specification 29 of Section 7A in the NHS England's commissioning of public health functions (PHE, 2014). NHS England under the Health and Social Care Act (2012) are required to commission and deliver

these services in prisons and detained settings to the same level as that of the community (PHE, 2014). NHS England and Public Health England (PHE) established a joint advisory board in 2013 to oversee implementation of NHS Health Checks in prisons where an audit took place in 2014 informing on the extent and quality of roll out of the health checks in prisons (PHE, 2014). The summary of outcome from the audit revealed that; implementation of the service was slow, the quality of the NHS Health Check was poor, the availability of health promoting lifestyle services was poor with inconsistencies in continuity of care (PHE, 2014).

The initial health assessment in immigration detention in the UK however, is known as the Rule 34 procedure which is obligatory in immigration detention and is fundamental to establishing the health conditions and health needs of the detainee upon arrival at the IRC (Detention Centre Rules, 2001). The Rule 34 procedure enables the identification of human rights abuses in detainee patients where referral is made to proceed onto the Rule 35 procedure for medical examination, documentation and healthcare treatment by a doctor for victims of torture, trafficking, modern slavery, female genital mutilation (FGM), gendered based domestic and sexual violence (Detention Centre Rules, 2001). Policy implementation and legality issues arise here as there is a lack of compliance to the Rule 34 and 35 procedures in IRCs and is thus deemed not fit for purpose as cases such as mental health linked to torture are disregarded (Shaw, 2016). Despite physical and documented evidence, the HO persistently maintains its decision to continue the detention of these vulnerable detainee patients (Shaw, 2016).

The Shaw Review (2016) reports on constant inconsistencies in the judgment of medical staff and numerous rejections by caseworkers despite evidence in the medical reports of mental health conditions as a result of torture and other human rights abuses (Shaw, 2016). There is also a lack of experienced readers of Rule 35 reports in IRCs which also contributes to the discrediting of Rule 35 in letters to detainees on grounds that the doctor was not independent in his or her diagnosis of the patient's condition (Shaw, 2016). The lack of compliance and weak implementation of healthcare policies, particularly with regards to the Rule 34 and 35 procedures has impacted on the space of healthcare in immigration detention resulting in; a fragmented doctor-patient relationship, lack of staff training to equip health professionals to be able to identify and treat victims of human rights abuses, communicable diseases and mental health conditions (Shaw, 2016). Similarities regarding weak implementation of healthcare

service policies in IRCs particularly, concerning health checks is also an issue in prisons in the UK (PHE, 2014).

Another similarity of healthcare legislation and policy that is shared between the two settings of IRCs and prisons is the system for the managing and reporting of new cases of infectious diseases (NHS England, 2015). The Public Health in Prisons (PHiPs) was originally named the Prison Infection Prevention (PIP) team which is part of the national Health and Justice team within PHE and carry out work in prisons and other places of detention relating to public health (NHS England, 2015). It is unclear however, the extent of which IRCs are complying with the operating procedures of the PHiP's team (NHS England, 2015). The minimal reporting of a dataset from Health Protection Teams to PHiPs must be reported by IRCs and prisons by using the operating procedure templates for outbreaks and single infections (NHS England, 2015). The minimum reporting on outbreaks should include; acute respiratory infection, gastrointestinal infection and unexplained skin rashes (NHS England, 2015). There is a full list for single infections and a list for any other major infectious diseases for prisons which is recommended by NHS England to be used for reporting cases in IRCs (NHS England, 2015). The role of the Consultant in Communicable Disease Control (CCDC) is to manage incidences of infectious disease by controlling and preventing infection that occur in prisons and other detention settings with the provision of expert advice, facilitating laboratory testing and hospitalisation where necessary (Department of Health, 2007). It is required that doctors notify the local CCDC of any cases of serious infectious disease (NHS England, 2015).

The disparity in legality, rights and policy pertaining to healthcare in both IRCs and prisons are presented in the following cases: A time limit is placed on detention in prisons, but is indefinite in IRCs in UK (Shaw, 2016). All those detained in IRCs are vulnerable or potentially vulnerable which is enhanced by the situation of being detained (Shaw, 2016). Hence, greater emphasis is laid on the injustices of the detention of people who have not been sentenced as criminals by the judicial system but have been perceived as such rather by the action of being detained. Pregnant women may be detained in both prisons and IRCs however, the detaining of pregnant women in an IRC has human rights and health implications to be considered as well as for the fact that they have not gone through a judicial process to be sentenced to imprisonment. The report by NHS England (2015) and Sturge (2018) reveals a predominance of BMEA

population that are detained in the UK IRCs as compared to the prison population that detains predominantly white or European people. Affirmation is made by the statement of a participant I interviewed in this research study - Participant I (please refer to chapter 6, sections 6.2.1 and 6.2.2), supported by the accounts by the participants from the report by Inegbenebor and Saga (2012) that people detained in UK prisons are treated much more fairly than those detained in IRCs. Hence, the reason for the significant differences in treatment between prisons and IRCs is attributed to the institutionalised culture of discrimination in detention against the BMEA population. White foreign nationals and non-EEA European nationals comprise of a total of 21 percent of the UK prison population and do not necessarily hold a legal status, but are exempted from discrimination and from being detained in an IRC (Sturge, 2018). The treatment of white prisoners is in contrast to the treatment of the people from the BMEA population who are detained in prison due to a criminal conviction and do not have a legal status as they are placed in an IRC to continue their detention after completing their full sentences in prison, rather than being released back into the community like their fellow white cell-mates.

The physical care given to pregnant women in IRCs is inadequate with lack of consideration for their welfare (Shaw, 2016). In contrast, some prisons provide a unit for pregnant women and a mother and her baby where it is permitted for the baby to remain with her mother in prison up to 18 months after birth of the child before they are separated (Gov.Uk, 2018a). Based on these reasons, the HO is unable to justifying the grounds for detention where the vast majority of pregnant women that are detained in IRCs are shortly released back into the community (Shaw, 2016).

The Assessment, Care in Detention and Teamwork (ACDT) is a protocol devised for the protection of detainees in both prisons and IRCs against suicide and self-harm (Shaw, 2016). In IRCs, Shaw (2016) reported that there was a much higher reliance on the ACDT process in IRCs than that of prisons where IRCs used it as “defensive medicine” with emphasis made on the process rather than achieving a good outcome for detainees. This was due to contractual implications should the IRC fail to comply with the required process and as a result of transposing prison practices into an IRC regime leading to negative outcomes and misuse of the protocol (Shaw, 2016). The cases outlined above highlight the weakness in policy implementation based on the failure to recognise IRCs as an institution that holds people that are not criminals and typically

come from a background of vulnerability or are made vulnerable as a result of being subjected to the conditions of immigration detention. In order to secure the welfare of migrant detainees, it is fundamental that the issues pertaining to the legality and rights of this marginalised population is addressed. Hence, the majority of IRC policies ought to reflect that of its own environment to meet the needs of its population rather than attempting to meet the standards set by prisons and IRC contractors.

2.4 The SDH in its location of pathways where barriers to the implementation of health policy in IRCs may arise

To put into context the impact and relevance of the State of Exception for this research project, the addressing of the public health implications for the migrant detainee population provides an extension to Agamben's work as his project focuses on what is happening as a result of the normalisation of the State of Exception, but not on why this is the case (Colatrella, 2011; Huysmans, 2008, p.7; Neal, 2004, p.373, 2006, p.31-46). Addressing the SDH will help to locate the various pathways associated with public health that identify potential barriers to the healthcare access for migrant detainees and the reasons behind them.

The pathways I have identified in this section streamlines the discussion based on elements generated from the CSDH model (Solar and Irwin, 2007) (please refer to Appendix E) and how undocumented migrants and migrant detainees are placed into context. In the CSDH model (Solar and Irwin, 2007), the formation of structural determinants of the SDH are based on; socio-economic and political context of the UK government and society which has a bearing on the socioeconomic position of the undocumented migrant and migrant detainee in the generating of health inequities (Solar and Irwin, 2007). The structural determinants form the intermediary determinants involving; material circumstances, behaviours, biological factors and psychosocial factors which all impacts on and is affected by the extent to which health and wellbeing opportunities are presented to the individual (Solar and Irwin, 2007; WHO, 2010). I have included geographical factors as an intermediary determinant to tailor the CSDH (Solar and Irwin, 2007) model according to the location IRCs are placed as this affects the migrant detainees' health and wellbeing opportunities.

2.4.1 Socioeconomic and political structural factors of SDH for undocumented migrants and migrant detainees

The report by NHS Commissioning, Direct Commissioning Change Projects Team (2016) Strategic direction for health services in the justice system: 2016-2020 states that the burden of illness is disproportionately higher for people who are in or are at risk of being placed in temporary detention, custody or secure and detained settings. Such illnesses include; long term conditions, infectious diseases, mental health problems, alcohol, tobacco and drugs misuse where access to treatment and prevention programmes are inadequate (NHS Commissioning, Direct Commissioning Change Projects Team, 2016). These particular health issues are often compounded by social issues with regard to; deprivation, homelessness, unemployment and poor levels of education (NHS Commissioning, Direct Commissioning Change Projects Team, 2016).

IRC buildings are typically built to conform to prison-like categories with regards to the level in security and the ability to contain huge numbers of people at any one time (Clarke, 2017, 2018). According to Basu (2011) the prison setting is a high-transmission institutional amplifier where communicable or infectious diseases may be easily contracted. IRCs are similar to prison settings with regards to their vulnerability to outbreaks of communicable diseases (NHS England, 2015). The risk of contracting and transmitting communicable diseases in IRCs may be as a result of the following; the nature of the environment with regards to the architectural design, healthcare facilities and the varying in age of many IRCs which were originally built for prisons (NHS England, 2015). The conditions with respect to sanitation of the facilities provided on the premises of the IRC also plays an integral part in the spread of communicable diseases.

There are geographical issues pertaining to the physical exclusion and the creation of a physical distance between the inhabitants of immigration detention and the community has a detrimental impact on the health and wellbeing of the migrant detainee. IRCs are typically situated on the outskirts of towns and states as a technique of the government to re-assert its sovereign power and emphasise on the notion of them and us where it becomes difficult to have or maintain contact with the community. The location of IRCs makes the migrant detainee feel disenfranchised as contact to and visits from family and friends become strained and lost, NGOs and lawyers have to travel extremely long

distances to get to the IRCs, which is one of the factors causing lack of legal representation for migrant detainees (Home Affairs Committee, 2018). The distance in location is a contributing factor of IRCs not reaching out to the local GPs and hospitals (Shaw, 2016).

The governing strategy argued by Agamben (1998) in the attempt to protect the security and welfare of state is evidenced in various instances, particularly by the persistent detaining of women, children and vulnerable people found in various reports by NGOs, HMIP and other enquiries of immigration detention. The purpose behind the detaining of women seeking asylum, where 15 percent of these women were deported out of the UK in 2016, whilst 85 percent were released back into the community to resume their asylum claim proceedings is put to question in the report by Lousley and Cope (2017). In total, asylum detainees accounted for 46 percent of the immigration detainee population in 2016 (Silverman, 2017).

The Shaw review (2016) which reports on the welfare and detention of vulnerable people reveals the extent to which prolonged immigration detention has a detrimental impact on the detained population. The public health implications are made explicit based on the quality of care provided in IRCs with recommendations made on ensuring the welfare and healthcare needs of the subjects of immigration detention are met. The adults at risk in immigration detention policy was devised by the HO in 2016 shortly after, in response to Mr Shaw's report however, gross failings of the subjects of immigration detention continue to take place. The deploying of strategies to control migration through the normalising of immigration detention whose primary purpose is to; detain, deport and disperse (Bloch and Schuster, 2005) has caused immigration legislation (Immigration Act (2014), (2016)) to undermine legislations pertaining to; Health and Social Care (2012), Equality Act (2010) and Human Rights Act (1998).

Migrants are being used as a scapegoat for the ills of society and are perceived as a burden on the NHS and as contributors of the NHS budgetary "crisis" through health tourism and misuse of the healthcare system (George *et al.*, 2011). The reported cost to the NHS due to the misuse of health services by the migrant population, which is to be recovered through government strategies account for a mere 0.3 percent of the NHS budget (George *et al.*, 2011). Migrants are expected to pay 54,000 GBP for an NHS treatment per patient, including an immigration health surcharge (HIS) of 150-200 GBP

on a yearly visa or 1,000 GBP for a five-year visa (dependent on what category visa you apply for, for example a student or Tier 5 visa) for NHS care prior to a migrant travelling to the UK from abroad (Gov.Uk, 2018b). This perception of migrants burdening the healthcare system contributes to the hostile environment conceived within the space of healthcare for undocumented migrants, which is re-affirmed in immigration detention causing their rights to be stripped away.

Over the last two decades, there has been a monitoring of the deaths of 508 individuals held in custody from the black minority ethnic (BME), migrant and refugee community by the Institute of Race Relations (IRR) Athwal (2015). Their deaths have been treated as suspicious with implications placed on the police, prison authorities and detention officers. No one has been convicted for their part in these unlawful killings. Young black men are usually stereo-typed as “bad” and not “mad” where erratic behaviour or asking for help is manifested (Athwal, 2015). In this instance the young black men are associated with being violent and dealing with drugs which is believed is to be met with violence (Athwal, 2015). Although changes have been made to policies as well as revising guidelines, including evidence produced from investigations and narrative warnings of dangerous procedures, lessons are still not being learnt. IRC officers’ stereo-typing migrant detainees seem to be a tool often used to prevent detainees from seeking healthcare (Athwal, 2015). The existence of institutionalised racism of migrant detainees in IRCs has established a level of mistrust between the officers of IRCs and the detainees which acts as a barrier to the access to adequate healthcare services (Athwal, 2015). In a period of time where there is a prevalence of deaths, particularly as a result of suicide, IRCs shift contracts to avoid scrutiny and accountability which also causes standards to drop within the centre therefore impacting on the health and well-being of detainees (Athwal, 2015; Lewis, 2016; Bacon, 2005).

2.4.2 Behaviours, biological and psychosocial intermediary factors of the SDH for undocumented migrants and migrant detainees

There are various reasons and routes by which people migrate abroad from their country of origin to their host country. People commonly migrate for the purposes of visit, work, study or seeking refuge from war at their country of origin (Jayaweera, 2010; Bloch and Schuster, 2005). They may travel to their host country via route of normal or treacherous conditions. Migrants may have either acquired an illness before travelling,

en route of their journey or after arriving at their host country. The conditions by which migrants leave their country, travel and arrive at their host country plays a huge role in determining the state of their health and the entitlements available to them on accessing healthcare services. There are various routes that the detention population come from on entering an IRC such as; from the community, police cells or entering the country through illegal or hazardous routes (NHS England, 2015; Institute for Public Policy Research (IPPR) 2005; Health Protection Agency, 2006; Johnson, 2006; Piachaud *et al.,* 2009). Many of the detainees tend to have a poor record of access to healthcare services on arrival at the IRC as a result of their undocumented status causing them to fear seeking healthcare (NHS England, 2015; Jayaweera, 2010).

The exposure of the various ethnic and national groups of the detainee population to particular diseases in their home country or during transit to their host country, compounded by the conditions of an IRC places them at risk of contracting certain diseases. The lack of childhood immunisations is prevalent in tropical countries and makes the detainee population more vulnerable to contracting communicable diseases (NHS England, 2015). An example may be derived from the guidance outlined by the Health Protection Agency in 2012 on the increased risk of foreign-born prisoners and other detainee populations to chickenpox (NHS England, 2015). Detainees tend to originate from tropical and subtropical regions which increases their susceptibility to contracting chickenpox in their adulthood by six-fold than that of adults form temperate zones, as they are less likely to be infected as children than people from Western Europe (Department of Health, 2001). Infants and children are detained at some IRCs and are a group that are most likely to be infected with chickenpox which may also spread to others (Department of Health, 2001).

This causes an increased prevalence of vulnerability to the detained population where serious illnesses may be caused by chickenpox infection for such people as; pregnant women, HIV or AIDS sufferers, immune-suppressed people and others (Department of Health, Health Protection Agency, 2012). There is an increased risk of the prevalence of opportunistic diseases, such as tuberculosis (TB) where those infected with HIV are most vulnerable and may even result in death (Basu, 2011; Jayaweera, 2010). This risk is not exclusive only to IRCs but also to prisons where public health is at risk due to overcrowding and unsanitary conditions which increases the risk of the spread of HIV and TB. WHO have reported that access to medical technologies, standards of medical

treatment and healthcare determine the key outcomes of TB as well as social factors (WHO, 2015).

Adults and children with chronic diseases suffer with their conditions being exacerbated due to lack of medication and treatment and long periods of stay in the IRC. Particular cases reported are infants born under the age of six months to mothers who are HIV positive but are un-diagnosed and untreated for infection. Children are deported back to their country of origin and contracting malaria as inadequate provision of prophylaxis is administered despite the high incidence of malaria in that country. Children who are sickle-cell are not treated with analgesia despite being in pain, suffering from high fever and unable to take in fluids. Inadequate education or activities are provided for children in the IRCs along with indefinite detention, in some occasions, separation from their families to another centre, back home or foster care causes exacerbation of illness, mental problems and difficulties in integrating with the community they are released into (Marmot *et al.,* 2008; Lorek *et al.,* 2009; NHS England, 2015).

In the study by Inegbenebor and Saga (2012) the key findings revealed that the detainees experienced mental health conditions, including depression, stress, anxiety and suicidal tendencies which were not dealt with by a mental health professional or counsellor during detention. Others experienced interruptions or disruptions to their treatments for health conditions such as HIV, asthma, high blood pressure, diabetes and so on or attempts were made to deport them. Concerns were raised on violence and verbal abuse and excessive force, particularly from escorts. There was a general atmosphere of uncertainty, fear and anxiety amongst the detainees due to being detained indefinitely. The participants expressed that detention in prison was much more preferable to that of IRCs (Athwal, 2015; Inegbenebor and Saga, 2012).

2.4.3 Healthcare entitlement and access opportunities for migrants in UK

The following section of this chapter makes emphasis on the legality and rights of migrants revealing the opportunities presented to them concerning the access of healthcare services in the UK. It has become necessary to reveal the type of environment that has been constructed within the space of healthcare where border enactment and healthcare converge. There is conflict between the lived and the perceived spaces of healthcare access for migrants and those with undocumented status

which impacts particularly on migrant detainees, as the healthcare provided in immigration detention should resemble that which is provided in the community (PHE, 2014; Shaw, 2016). This provides insight into the political agenda of the government as well as the biological and psychosocial factors of SDH that effect the migrant and detainee population. NHS entitlement is determined by categorising individuals who are not ordinarily resident in the UK as not being eligible for free NHS care at the point of delivery (PHE, 2018). This has caused the space of healthcare in the UK to evolve drastically since the inception of the NHS in 1948 by Aneurin Bevan (Labour Party Health Secretary from 1945-51) who created it for the purpose of providing free healthcare services for all at the point of delivery (NHS Choices, 2015). This was made possible due to the paying of taxes which contributed to the NHS funds, which is still the case until today.

The majority of migrants and EU nationals travel to the UK for the purpose of earning a living, where they are taxed with their tax codes being unique to that of the citizens of the UK, hence being charged a higher rate of taxes. Despite this, given the instance of the Windrush generation[4], many of whom are from the Caribbean and Commonwealth countries are now pensioners facing health conditions who seek healthcare from the NHS are being turned away due to inability to produce identification and payment for their treatment (Gentleman, 2018). These individuals were promised citizenship after the Second World War as their parents from the Commonwealth countries fought with the British army and cannot produce their identification either due to their documentation being misplaced as a result of it being attached to their parents' passports or for other reasons (Gentleman, 2018). The majority of this generation have worked for four decades or more and have paid into the UK tax system yet are being denied of free healthcare and are rewarded with evictions from their homes under

[4] The Windrush Generation: In May 1948, HMT *Empire Windrush* was en route from Australia to England, via the Atlantic and docked in Kingston, Jamaica, to pick up servicemen who were on leave. Whilst the *Windrush* was crossing the Atlantic the 1948 British Nationality Act, which would grant all Commonwealth citizens free entry into Britain, was being debated by the British government. Even before the act – which would reaffirm their pre-existing rights of travel and residence – had been passed, Commonwealth migrants began to arrive in Britain with the first of these travelling on board the *Empire Windrush*. The History Press (2019) 'Windrush: A landmark in the history of modern Britain' [Online]. Available at: https://www.thehistorypress.co.uk/articles/windrush-a-landmark-in-the-history-of-modern-britain/ (Accessed: 10 June 2019).

ownership of the council and left destitute as well as cases of arrests and imprisonment in IRCs for immediate expulsion (Gentleman, 2018).

Up-front charges and the producing of identification checks before receiving NHS treatment was introduced last year in the UK on 23rd October 2017 following the EU membership referendum – known as the "Brexit"[5] where migrants and non-EEA (European Economic Area) nationals are required to pay for healthcare (DH and SC, 2017). Primary healthcare such as GP consultations and treatments remain free to everyone at the point of delivery regardless of whether or not an individual is able to produce identification and proof of address or not (DH and SC, 2017). However, lack of information and training of front-line staff causes hostility towards individuals who are unable to produce the documentation with demands being made for them else denial of registration for those who fail to meet their demands. This culture of lack of training of staff in providing access to healthcare service pertaining to the migrant population has become prevalent over the years and is magnified in the space of immigration detention.

Free access to NHS secondary care or hospital services is based on an individual being permanently resident in the UK (PHE, 2018). Some secondary healthcare services are free regardless of country of normal residence as long as the visitor has not travelled for the purposes of seeking healthcare treatment (PHE, 2018). These services apply only to: accident and emergency services pertaining to A&E; diagnosis and treatment of the vast number of communicable diseases such as, HIV, TB and Middle East Respiratory Syndrome (MERS); sexually transmitted infections (STIs) (PHE, 2018). Also included are: family planning (excluding termination of pregnancy or infertility treatment); mental or physical conditions resulting from human rights abuses, such as female genital mutilation (FGM), torture, sexual or domestic violence; registered palliative care with a charity or company and the NHS111 telephone advice line services (PHE, 2018). The categories of people who are exempt from paying for the services stated above include: asylum seekers and their dependants; refugees and their dependants; those

[5] Brexit is an abbreviation for "British exit," referring to the U.K.'s decision in a June 23, 2016 referendum to leave the European Union (EU). The deal Theresa May negotiated with the EU has been rejected by the House of Commons three times. The new Brexit deadline for Britain to ratify the withdrawal agreement is October 31, 2019. Kenton, W. (2019) 'Brexit' [Online]. Available at: https://www.investopedia.com/terms/b/brexit.asp (Accessed: 10 June 2019).

receiving support from the HO (under section 95 of the Immigration and Asylum Act 1999); failed asylum seekers receiving support by the Home Office (under section 4(2) of the Immigration and Asylum Act 1999) or a local authority (under section 21 of the National Assistance Act 1948 under Part 1 (care and support) of the Care Act 2014) and children that are looked after by a local authority (PHE, 2018). Those also exempted are: victims and suspected victims of modern slavery; human trafficking including their children (under 18 years old), spouse or civil partner (who are lawfully present in the UK); immigration detainees and prisoners (PHE, 2018).

Following the Brexit in the UK and the governing strategies to reduce migration flows, border enactment has resulted in the creation of a hostile environment within the space of healthcare services. Although the free access of certain NHS care stated above are available to categories of people irrespective of residential status in the UK, including the undocumented and detainee migrant population, these people are being deterred from accessing healthcare services (DH and SC, 2017). Migrants are being deterred through ID checks and up-front charges for those not ordinarily resident in the UK (Corporate Watch, 2017; DH and SC, 2017) and inadequate provision of healthcare services in IRCs that ought to reflect that of the community (Shaw, 2016; PHE, 2018).

2.5 Summary of chapter

Overview of the variations of power and its influences and effect on migrant healthcare access

In conclusion, the three variations of political power are used in context of this research project based on concepts derived from the paradigms of governmentality, the camp and security. These paradigms help support the argument based on sovereign or state power in relation to decision-making techniques to securitise the nation against perceived threats. This technique is assisted by the strategies of governing through the delegating of power and responsibilities to the local people with the inclusion of market mechanisms. The delegation of responsibilities by the government has become evidenced in the deploying of strategies to coerce people, particularly front-line staff, managers, practitioners, agencies and contractors in the various institutions of the UK, as border guards in the attempt to control migration. The use of electronic and biometric systems combined with the recruiting of people as border guards assists the virtual

border control of migration on a massive scale. The variations of power in governing, securitising and delegating, including the imposition of state will on its subjects in the context of immigration detention has led to failures of practice and weak implementation of policies which proves detrimental to the public health and rights of migrant detainees. This has been achieved through the institutionalised culture of discrimination against migrants fuelled by border enforcement.

Healthcare in Europe and the UK is a basic human right which is recognised by all the Member States that regardless of status, ethnicity, age, gender and others, everyone has the right to access and receive healthcare. Due to the absence of rights in accessing healthcare as a result of the migrant's legal status, they are used as a scapegoat for the ills of society and are seen to be a threat to the security and welfare of society where stigma is placed on migrants who attempt to access healthcare services. Migrants being perceived and treated as criminals has led to the conception of a hostile environment within the space of healthcare. This has repercussions for public health on both citizens and non-citizens alike. Delays in detection and treatment of illnesses have the potential of increasing the prevalence of disease and causing a financial strain on the NHS in the long-run. Deploying public health pathways enables the location and streamlining of structural determinants and factors that lead to barriers in healthcare access. This will allow for effective allocation of interventions that would result in early detection and treatment of diseases and provision of information on ways to navigate the system to increase confidence and access so as to reduce inequities in healthcare access.

The government must also regard the need to reduce health inequities for everyone who wishes to access healthcare services in England according to the Equality Act (2010) and Health and Social Care Act (2012). This means that migrant detainees have the right to receive healthcare that is equivalent to that which is available to the general population within the community, which is also in line with the Detention Centre Rules (2001). Health and wellbeing services are responsible for dealing with health inequities and the wider determinants of health in IRCs by seeking to improve the health and wellbeing of migrant detainees (Home Office Enforcement, NHS England and Public Health England, 2015). The DH, NHS England (NHSE) and Clinical Commissioning Groups (CCGs) are also responsible for regarding the need to reduce inequities in access to and outcomes from healthcare as a priority (Allen, 2016).

Chapter 3

Research Design and Methodology

In this chapter, I begin with a break-down of the research design to bring insight into the purpose of this research project which is based on a compelling need to fill-in the gap in literature concerning immigration detention and the public health implications. The approach and strategy of my research study follows; informing on how the theoretical framework was chosen along with how it will be used, what is being examined and how the data will be collected to provide information on answering the research questions. The following section provides an explanation of how I arrived at deciding on the type and size of the group to be interviewed and the technique used for sampling that would assist in the selection process in providing the best possible outcome in the accessing of the participants. This study is based on two sources of data; primary and secondary that both inform this research about immigration detention, thus an explanation is provided concerning the type of data collected and how they were collected.

3.1 Research design

3.1.1 Research Purpose

The lack in scholarly studies that focus on systematically examining the public health implications of people who are being detained under immigration laws and denied healthcare and human rights whilst going through the process of determining their legal status was of great concern to me. My professional background stems from ten years of providing administrative support to two NHS Trusts in addition to qualifications obtained pertaining to migration and public health, which have played an integral role in bringing me to the point of embarking on this PhD research project. The growth in migration globally, particularly in the UK, including media coverage, scholarly papers and having ties with the BME community has peaked my interest and driven me to bring to the forefront the discussions based on the stories derived from people whose health are being affected by the governing techniques as a result of border enforcement. Hence, the drive to undertake this research project to help bring about an understanding

and to provide one of the very few sources of information and critical understanding of the matters of immigration detention that impacts on public health.

My research project embarks on a phenomenological approach as it seeks to investigate healthcare access and delivery in immigration detention. This is achieved by providing a subjective account of the experiences and perceptions of the actors of immigration detention which allows for an examination of the power relationships that are formed between the actors and how it impacts on public health.

The research project aims to fill the gap in literature and to develop further Agamben's (1998) and (2005) biopolitical theory on the notion of power by applying it to IRCs and its subjects with regards to healthcare access and delivery. This is systematically examined through a public health framework so as to be able to identify the pathways that potentially lead to the inequities of healthcare access for migrant detainees. The governance concept of Rose (1999) also forms a significant part of the theoretical framework and is applied to help guide the analytical process in examining the mechanisms of power which is influenced by legality, decision-making, autonomy, coercion and fear (please refer to Appendix D).

3.1.2 Research Approach

The developing of a theoretical framework in this research is based on examining the notion of power at an individual, institutional and societal level. Migrant detainee power – at the individual level focuses on their ability or non-ability to make decisions about their healthcare and how it is impacted upon through culture at the institutional level against migrants through the coercion of workers into becoming border guards. The societal level focuses on the social exclusion of migrant detainees pertaining to the undermining of their human rights and the lack of healthcare access as a result of their non-legal status which may lead to their detention in an IRC, being deported out of the UK or dispersed back into society.

3.1.3 Research Strategy

The basis of my research is to gain a better understanding of the phenomena - which is immigration detention and healthcare by examining the governing strategies of immigration detention in the UK and the power relations that are formed between the actors of immigration detention. These are analysed by the two main overarching concepts of biopolitics and governance. The overarching concepts of this research project are supported by additional underlying concepts which are, liberal legality (Schmitt, 2004) and the two faces of power (Bachrach and Baratz, 1962). Data is collected through interviewing participants in order to develop an explanation that would address my research questions:

1. what impact does the governing strategies of immigration detention have on the healthcare delivery of detainees?
2. how do these strategies influence and determine the lifestyle choices and health outcomes of migrant detainees?
3. what role does human rights play in light of these strategies and what type of institutional system has been established which determines the power relations that exist between the service providers (the Home Office, the private companies, healthcare commissioners and professionals) and the service users (migrant detainees) of healthcare in immigration detention.

Central to answering my research questions are the people who have themselves been detained and hence, have lived experience of immigration detention. I realised that I needed to capture the opinions and perceptions of people who had lived experiences in immigration detention to help understand the issues pertaining to governance in its relation to the implementing of IRC policies pertaining to healthcare. This would have a bearing on the rights and legality of the users of healthcare services in IRCs as well as the autonomy and ability of the providers of healthcare services to perform their role effectively, thus revealing the kind of power relationships that have been formed between the subjects of immigration detention. I used semi-structured interviews because they are best suited for collecting the kind of data needed to answer my research questions. This ensures that categories are set within the interview schedule to help guide the discussion and allow probing into statements made by the participant to take place that are confined to the category of the topic.

Ethical approval was sought and gained through the University Ethics Committee to ensure that the safety of the participants and myself have been taken into account, with the necessary procedures adhered to. Consideration was taken into the methods that were appropriate and effective in approaching the participants to gain their response and participation.

3.2 Participants and sampling design

3.2.1 Participants

It became necessary to split the participants into two groups; the service user and the service provider. The service user group consisted of migrant ex and present-detainee participants consisted of; nine men and three women – a total of 12, of the ages ranging from 25 to 50 years. The men's ethnic origin was derived predominantly from Nigeria, where others came from the countries of Jamaica, Ghana, Sri Lanka and Pakistan. The women's ethnic origin was from Nigeria and Uganda. Both the men and women participants of this group had entered the country due to fleeing war or oppression or on tourist or visit visa. All the participants had over-stayed their visas and were either seeking asylum or were in the process of applying for their legal status. Participants had experienced being arrested by the HO or the police either on the street, in their homes or at work. Participants had experienced being detained between one to four occasions in an IRC in the UK. Interviews with the participants were conducted predominantly over the phone with one done face-to-face.

The service provider group consisted of five workers; a detainee support worker, an immigration lawyer, the head of Her Majesty's Inspectorate of Prisons (HMIP) and IRCs a senior NGO doctor and the lead consultant doctor of an IRC. Interviews with three of the participants in this group were conducted face-to face whilst the other two workers were interviewed over the phone. In order to achieve saturation of the data I was collecting, some aspect of purposive sampling led me to select the service providers based on the following reasons: the immigration lawyer - based on his experiences in legally representing migrants without a legal status as well as dealing with the HO and the staff of IRCs in the UK in representing his clients; the lead HMIP and IRCs - based on his role which involves advocating for human rights within IRCs through inspecting, reporting and providing recommendation for IRCs; the senior NGO doctor with

extensive experience in treating and advocating for undocumented migrants who are victims of torture, trafficking, modern slavery and other human rights abuses and the lead mental health doctor whose background and experience stems from treating migrants with extreme mental health conditions. The selecting of these individual key workers I believed would provide a more complete picture from the worker's perspective of the provision of services within IRCs.

3.2.2 Recruitment techniques

In order to ensure ease of access to the participants the snowballing procedure was the technique used to recruit the type of people that I believed would provide information relating to the research topic centred on public health issues and healthcare in IRCs. I thus decided that it would be necessary to collect the data from a healthcare provider's perspective and from a healthcare user's perspective which led me to approach ex-detainees from IRCs and doctors who have worked in IRCs. I approached ex-detainees as access to people presently detained proved difficult due to the tight restrictions placed by the HO in accessing IRCs in the UK. I believed that it did not make any difference in the quality of data being produced pertaining to whether the participants were present or ex-detainees, but perceived the content of the data to be rather richer coming from an ex-detainee as they were released from the IRC and thus less fearful of the HO. My initial intention on embarking on this research was to gain access to the IRC grounds to retrieve the data from the participants however, after conducting my fieldwork and encountering the various challenges, I now realise that the data that I might have collected from the IRC, if I had been successful in gaining access to the IRC grounds may not have been as rich and as open as the data that I retrieved from the detainees who had been released from the IRC. This is due to the element of fear and mistrust placed within migrant detainees due to their status. I had the opportunity of speaking to one man over the phone who was presently being detained in an IRC in the UK and his responses to my questions during my interviewing him seemed quite guarded, short and lacking any expression in comparison to the responses from the interviews I held with the eleven ex-detainees. I deemed it necessary to approach an immigration lawyer and the HMIP to include their responses in the data I was collecting to ensure a more holistic approach is achieved in providing a more rounded insight into the aspects pertaining to healthcare delivery and access in IRCs.

I realised that in order for me to achieve the best possible outcome from the gathering of data, it would be necessary during the selection process to identify the samples as belonging to one of the two categories either; the service user or the service provider. This would encourage a more streamlined collection of data which would focus on healthcare service access and delivery respectively to provide an insight into both spectrums of healthcare in IRCs in order to create a full picture relating to the research topic.

3.3 Source of data collection

3.3.1 Primary sources of data

The data gathering method of this research relies on the subjective accounts of participants, thus one-to-one interviewing was conducted. A qualitative technique is used to collect the data which is based on the experiences of migrant detainees or ex-detainees who have attempted to access healthcare services in an IRC, including healthcare professionals and workers who have delivered or assisted detainees to access healthcare services within an IRC. My research project seeks to investigate on the factors that impact on public health through the type of healthcare access and delivery presented within IRCs.

The accessing of primary data was necessary as it became clear that the basis of my research project would fundamentally rely on the first-hand information of people at the grass-root level who had been subjected to the conditions of being detained within an IRC and had suffered from health conditions during their detention. This would help to yield information from a service-user's perspective regarding access to healthcare services in an IRC.

The service providers were accessed by invitation to participate in my research study through the provision of flyers, information leaflets and consent forms emailed, posted and distributed by myself during meetings through NGOs and doctors. Informed consent was sought and provided either written or verbally by the respondents prior to participation. Initially, participants were to be accessed on-site at the IRC, but this was changed (please refer to 3.6.5 in this chapter).

3.3.2 Interview schedule

The interview schedule was based on a semi-structured technique in order to achieve the best possible outcome in extracting in-depth and detailed information. The same set of questions were devised according to which category of people were being interviewed that is, a set of questions for the service providers and another set of questions for the ex-detainees. The questions for the workers were tailored according to their area of work, but were structured under the four main themes:

1. Type of health services provision and the problems in accessing the health services that are needed
2. Health policy implementation
3. Training and health promotion of staff working with detainees and of health service provision
4. Monitoring, evaluating and reporting

(Please refer to the interview schedules in Appendix A and Appendix B).

The interview questions for the HMIP and IRCs did not follow strictly according to the four themes devised for the healthcare professional workers due to his nature of work, but was rather centred on following-up on feedback from the ex-detainees with no strict structure (please refer to Appendix A). The immigration lawyer who was my first professional worker interviewee followed the four themes mentioned above that was devised for the healthcare workers, but the questions were asked based on his experiences and encounters with the IRC, the staff and his clients. The detainee support visitor worker was also asked questions in the interview that followed the same four categories however, the majority of questions asked were the probes to her responses.

The questions were not set in stone where probing into particular statements made by the participants were made during the course of the interviewing to gain more detail and a better understanding of the topic under discussion.

This same method of devising and asking the interview questions was applied to the ex-detainees and tailored according to their living experiences of the conditions in IRCs that impacted on their access to healthcare services and that affected their wellbeing. The interview questions for the ex-detainees were structured under three main themes:

1. Health conditions of detainees and access to healthcare services in IRCs,
2. Conditions of IRCs and its effect on detainee health
3. HO policies and its effect on detainee health & wellbeing

(Please refer to Appendix B).

3.3.3 Secondary sources of data

Secondary data is used to support and inform on the interpretation of some aspects of the interview data I collected from the participants. The combination of the two data types; primary and secondary enables greater insight and validation of the findings (Yin, 2003). The secondary data is derived from information retrieved from blogs on social media such as, twitter, facebook, NGO websites, newspapers, public sessions from committee hearings at parliament and healthcare associations, written statements, letters, reports, reviews, articles and toolkits.

I deemed it necessary to include the secondary data within the empirical chapters in order to fill-in the gaps in information provided from the interview data. This was particularly the case on matters pertaining to HO and IRC policies including reviews and reports made concerning their policies by NGOs and healthcare professionals. I believed that in utilising this approach in combining primary and secondary data, it would help to form a stronger argument and enhance the validity of my research project.

3.4 Reflexivity in the data collection process

3.4.1 My experiences in the accessing and collecting of data and reflexivity of this process

It is a fundamental element of the research process to state my positionality as a researcher which is known as reflexivity (Holmes, 2014). Reflexivity is thus described as an on-going process of self-analysis involving an in-depth reflection of the experiences encountered during the research (Cohen and Crabtree, 2006; Patnaik, 2013). Bourke (2014, p.2) states that

> "reflexivity involves a self-scrutiny on the part of the researcher; a self-conscious awareness of the relationship between the researcher and an 'other'".

During the data collection process, I found it difficult and awkward to remain impartial to the experiences that the ex-detainee and detainee participants were going through and sharing with me. I believed that I would have come across as lacking empathy to the plights through which they have been experiencing under a nation and government they anticipated would provide refuge or betterment of life. It would have also gone against my professional and ethical beliefs concerning the marginalisation of migrants in the UK. I believed that this needed to come across to some extent due to the background I am coming from, that is, public health and my African origin, even though I was birthed and brought up my whole life in the UK. It is argued by social theorists that researchers are part of the social world they are investigating hence they are unable to step above it to gain an "Olympian perspective" or move outside it to get a "view from nowhere" (Hammersley, 2004, p.934) causing reflexivity to become an integral feature of the research process. Reflexivity allows the researcher to become self-aware of the personal effects their own values, beliefs and attitudes have on the settings they are studying thus enabling self-criticism to take place with regards to the choice and application of their research methods to assist in the facilitation of an enhanced evaluation and understanding of their research findings by both themselves and their audience (Payne and Payne, 2004). Based on this understanding, this section provides a reflexive account of what was experienced during the processes of accessing and collecting the data for this research study.

3.4.2 Pilot study

The data collection process began with a pilot study which involved interviewing someone who had experienced being detained in a police cell by immigration officers. I used this method to help me to get a sense of the interview questions in order to develop them further if necessary. This also helped me to work on my approach in asking the interview questions to help build my confidence and to allow me to align the questions more closely to what I want to investigate. I decided to do a pilot study with someone I was familiar with who is also a member of my community with a BME background.

3.4.3 Experiences and challenges with recruiting migrant ex-detainees

Trust is described by Miller (2004) as an element that causes barriers to researchers accessing respondents of refugee communities. There were issues of trust between myself and the ex-detainee participants, including the NGOs who were the gate-keepers to the ex-detainees. The majority of NGOs I contacted were reluctant to put me in-touch with the ex-detainees whilst other NGOs decided to invite me to their events to provide me the opportunity to mingle with the attendees to seek for myself those I deemed to be potential participants. The reason the NGOs had for not putting me in contact directly themselves with the ex-detainees is due to issues they said they have experienced in the past with orchestrating such connections between researchers and ex-detainees.

I found myself with no other choice then to experiment with the method of snowballing, which I found to be effective to a certain extent. This began with a detainee visitor worker I interviewed who put me in-touch with an ex-detainee who agreed to be interviewed. After interviewing this ex-detainee, I asked him if he knew of fellow ex-detainees I could speak to. He was keen to put me in-touch with those he knew and was able to connect me with another ex-detainee whom I did an interview with shortly after exchanging phone numbers with him. After these initial interviews with the participants, I spent my time looking up events on social media organised by NGO groups and attended some of them hoping to meet ex-detainees or leaders of NGO groups who could help to connect me with ex-detainees and those who work in IRCs. I found this method to not yield much result in the recruiting of participants. I found that approaching a potential participant in person was more fruitful, even more so if a previous participant would spread the word whilst I was present. In my experience of this, fortunately for me a participant I had interviewed at the earlier stages of my research happened to be present at one of the NGO events I was attending at the time and he began to approach fellow ex-detainees and brought them over to me to so we could exchange details for me to contact them to arrange an interview with them for a date after the event. Others were migrants that were part of different NGOs who knew of ex-detainees within their groups. This enabled me to get in-touch with one other ex-detainee. All interviews with detainee and ex-detainees were carried out over the phone as this was the much preferred approach due to the issues of travelling long distances to have the meeting which proved to be inconvenient as they tended to live within the region of where they were previously detained – based outside of London. I seemed to

establish a general kind of trust with the ex-detainee participants however, there were a few that were apprehensive.

At the initial stages of my research, I decided to join an NGO group who advocated for refugees as I believed that this would help me keep abreast with the issues effecting migrants. I attended their meetings on a regular basis and got involved in their campaigns. I seized the opportunity to deliver a short message which I did a couple of times during or after the meetings in my call out for participants for my research. I networked with the aim of accessing potential participants which enabled me to approach a number of attendees and members. The members of this NGO were professional workers whom I approached and exchanged contact details however, when I tried to contact them they were not forthcoming. I was able to arrange an interview with two workers – the immigration lawyer and the senior NGO doctor who were visiting speakers at one of the meetings held at this particular NGO group that I was a member of. One of the workers I interviewed provided me with some names of other potential professionals I could look up and approach to participate in my research.

Overall, I felt a sense of the professional workers' need to guard the ex-detainees by denying me or any other researcher access to them directly. I believed that this was attributed to their aim in preventing any breaching of confidentiality from taking place, which I did not take personally and understood that it was essentially a case of trust and possessing limited time for building their confidence in me. Another person I approached who was also a visiting speaker at a different time and is one of the leads in an NGO group agreed to advertise my flyers and post on their intranet my call-out for participants who were volunteer visitors and professional workers of IRCs. This caused one detainee volunteer visitor to contact me whom I was able to interview and also put me in-touch with my first ex-detainee interviewee. During the process of recruiting participants, I also placed a call-out for people to contact me to participate via the university's intranet directed at the post-graduate students as I was not allowed access to the undergraduates. This caused an ex-student to communicate with me via email and put me in-touch with the lead for one of the NGO groups I had previously attempted to contact who now invited me to their yearly social event attended by their members of whom some were ex-detainees. I was able to contact two of the ex-detainees I approached at this event which enabled me to interview one of them. These two ex-detainees, one was a man and the other a woman. I sent out emails to both the man and

the woman ex-detainees and after about three months later, I received a positive response from the man who apologised for his late response due to some issues he was experiencing and that he was eager to help to take part in the interview. The interview with this man took place shortly after his response to my email. Some weeks after I had sent the email to the woman ex-detainee requesting her participation onto my research, I decided to call her as I had not received a response. I was able to speak to her over the phone but was not able to arrange a date for the interview as she was making certain monetary demands from me as a condition to allowing the interview to take place which I did not accept.

The men that I had to approach generally took me on board, once I broke the ice with them through small-talk and discussing about life in the UK and the situations they were facing which allowed me to lead the conversation into talking about myself and the project I am doing and why I think it is important to carry out my research. This inevitably led to the exchanging of phone numbers to arrange an interview time and date. Accessing women participants proved to be quite challenging in the two different groups. I decided to register and join with another NGO that runs once a week which is based on inviting migrants from the community to come and eat, socialise and participate in various events. I believed that becoming a familiar presence there by offering my services to volunteering during the summer would be an ice-breaker that would allow the women to trust me and open up to me. The majority of women from the community who attend this gathering are asylum seekers hence they would be going through some immigration issues which I believed may have caused them to have experienced some period of detention. I saw this as an opportunity to mingle with them and establish a level of trust by serving with the volunteer workers (half of whom were also migrants and asylum seekers) before seizing the moment to discuss about my project and asking them to participate.

3.4.4 Experiences and challenges with recruiting professional workers

I spoke with a fellow student after she presented her work at a symposium who had a friend that worked at the HO. She gave me the contact details of the lady working at the HO who I tried contacting on a number of occasions as well as the friend encouraging her to call me, but to no avail. I perceived her unwillingness to respond to my calls to be based on the fact that she works for the HO of whom I was told have restrictions on

providing information to members of the public. I somehow anticipated that she would be reluctant to talk to me, but decided to give it a try anyway as I believed that having the opportunity to talk to a member of the HO staff would yield first-hand data from their perspective that may bring insight into the governance experiences of immigration detention and the challenges they face in dealing with migrant detainees.

I reached out to an NGO that recruits doctors from the NHS to work in IRCs. One of the doctors that I communicated with initially from this NGO who was a head consultant lead of the doctors in one of the IRCs near one of the UK airports was extremely helpful and offered to inform his fellow doctors about my research and put me in-touch with them to encourage them to take part in my interviews. Although he initially did the interview with me and also made it a point to reach out to the doctors in his department at the IRC during their morning meetings along with the bunch of participant information leaflets I designed and posted off to him, the doctors seemed apprehensive about responding and did not contact me. I perceived the apprehension of the doctors of the IRC an issue of trust, as they did not know me and had not met with me due to the tight restrictions placed on the public in accessing IRCs in the UK. This apprehension I experienced from the doctors was also confirmed by the lead consultant doctor during his querying of me in conversation prior to the interview I had with him about the nature of the questions I would be asking in the interviews and if the questions would implicate anyone as opposing the HO as the HO are their employers.

3.4.5 Reflecting on my approach in conducting the interviews

My approach to asking the interview questions with the migrant ex and detainee population was done in a way so as to enable the obvious questions as well as the not so obvious details of the detainee experiences to come to light. I broadened my scope of questions slightly, not focusing only on questions pertaining to health, but also on certain conditions of the IRC that may directly or indirectly affect their health.

My approach to asking the interview questions held with the lead of HMIP and immigration detention, knowing that his job is based on challenging the human rights aspects of immigration detention and prisons was brought forward by revealing areas not only that would help answer areas of my research questions, but that were centred on prevalent issues that the migrant participants had shared with me which I deemed

important to query. My approach in devising the interview questions for the healthcare professional doctors who are NHS staff recruited to work in IRCs was a delicate matter. I had to, in a way come across as neutral as possible in order not to implicate any of the staff who were wary of the HO's disapproval of any comments that may show a sense of disloyalty as the doctors were employed by the HO. Despite my efforts, I felt that this did not allow me to gain or extract as in-depth a data as could have been possible.

3.5 Data analysis

3.5.1 Approach and process

The data was analysed by applying the overarching concepts of biopolitics and governance channelled through the various public health pathways relating to the SDH of the CSDH (Solar and Irwin, 2007) model adapted for the context of immigration detention (please refer to Appendix C and D). In order to arrive at analysing the data, the semi-structured technique of interview questioning was prepared in advance with the use of probing. The coding process also enabled the data to be structured and placed into categories pertaining to the pre-designed themes.

3.5.2 Data categories and structure

The data collected from all the participants were transcribed and coded by myself alone. I initially had prepared four categories within the interview schedule concerning the areas I wished the interview questions to follow in order to cover the areas relating to my research questions. However, it soon became clear that the questions needed to cover a wider scope, not just focusing on health service access in IRCs, but the conditions and experiences of the participants' time in detention which also proved to have a bearing on the health and wellbeing of the detainee (please refer to Appendix B). The data retrieved from the health professionals remained within the initial schedule design of the four categories set in the interview schedule (please refer to Appendix A).

To enable the coding process to take place, the text produced from the interview data were colour-coded according to the topic in question. The colour-coded text was then placed into groups of similarity in topic of discussion and given labels or headings that summarised the various groups, thus forming themes. Four themes for the health

professional workers' data were created namely; 1. Type of Health Service Provision, 2. Health Policy Implementation, 3. Training & Health Promotion and 4. Monitoring, reporting and evaluation. Three themes were derived from the data namely; 1. Conditions of IRCs and its effect on detainee health, 2. Health conditions of detainees and access to healthcare services in IRCs and 3. HO policies and its effect on detainee health & wellbeing. The break-down of the codes I used in each of the themes to help make sense of the data retrieved from the interviews may be found in Appendix A and B.

3.5.2.1 Explanation of the codes and themes for the migrant detainee group

Theme 1 focuses on the health conditions of detainees and access to healthcare services in IRCs. The purpose of this section is to give a brief view into the types of backgrounds the participants are coming from and how it led to their encounter with the HO and their detention at the IRC. A total of 12 participants – nine men and three women were interviewed who had been detained previously in an IRC at least once, if not multiple times in the UK. This theme may be divided into three sections. The first section focuses on demographic information which consists of ethnic origin, age, the dates of and number of occasions they had been detained in an IRC and the location of the IRCs. The second section includes data concerning the purposes of the participants arriving in the UK, the conditions that led them to being arrested and detained by the HO and their initial experience of arriving at the IRC to ascertain whether or not they received an initial health check. The final section consists of any existing health conditions they had upon arrival at the IRC and the type of care that was administered, health conditions acquired during their detention at the IRC and if they were able to access healthcare services, their experiences in attempting to access healthcare services and if there was any evidence of health record-keeping to assist in the continuation of their care during or post-detention.

Theme 2 focuses on the conditions of IRCs and its effect on detainee health. Questions were formed around the detainee's experiences in residing in an IRC which generated information based on their economic situation, sanitation and health and safety issues. These questions included probing where the discussion also brought out information on the detainee's type of relationship with and their perceptions the IRC and HO staff.

Theme 3 focuses on HO policies and its effect on detainee health and wellbeing in IRCs. The questions asked in this theme is based on drawing out information on how the HO's rules and regulations including those that govern IRCs impact on the health and wellbeing of detainees and undocumented migrants who are subjected to arrest for the purposes of detention. Questions were asked concerning how detainees were able to access their medical records, if the detainees were approached and how they were informed about health promotion and legal aid at the IRC. These preceding questions mentioned were mainly followed by some level of probing which led some participants to discuss further about their experiences in being placed in solitary confinement, prison or and deterioration of their health due to the conditions and the length of stay at the IRC. These questions enabled an insight into how the detainees' experiences affected their ability to make decisions concerning their health and wellbeing.

Before drawing the interview to a close, I prompted every participant to give a closing statement. This allowed the participant to say whatever was on their mind without further questioning from me. This technique often yielded information from the participant of how immigration detention made them feel, the impact it has had on their lives and their concern about the negative perceptions they believe have been adopted by society concerning migrants' impact on the nation's welfare. The nature of the statements made at this point brought out the underlying perceptions of the detainees regarding the government and how they cause migrants to feel disempowered and disenfranchised.

3.5.2.2 Explanation of the codes and themes for the healthcare professional group

Theme 1 focuses on the type of health service provision in IRCs. The purpose of this is to ascertain what the participant's professional role is at the IRC and how they came about becoming a worker at the IRC. This enables the discussion to progress onto asking questions pertaining to the type of population they treat and to establish what type of health conditions the worker is assigned to treating or if there is a varied mix of conditions they have to treat at the IRC. The mix of questions asked under this theme ranged from gaining information on such things as; if the worker has had any involvement in the initial health assessment process, how many patients are referred, how much time is allocated to treat a patient, if the worker has had to communicate with a detainee's GP, what the model of care is for their department, what type of procedures

are put into place for the continuation of care for the detainee, if they liaise with other health professionals external to the IRC and at what point the worker liaises with the HO concerning the health conditions of the detainee.

Theme 2 on health policy implementation seemed to overlap Theme 4 which focuses on monitoring, reporting and evaluation in IRCs. A few questions were prepared prior to the interview under these themes in order to make allowances for more probing to take place. The prepared questions were mainly; if there is a system in place which flags up the prevalence of health conditions, how efficient the record-keeping system is in the IRC, if annual reviews and appraisals take place of the healthcare staff and how effectively the healthcare team are able to work with the HO. Very detailed information was retrieved under these themes which was heavily based on probed questioning.

Theme 3 –focuses on training and health promotion in IRCs. If there are any opportunities presented to the workers to promote healthy lifestyle to the detainees and if the HO gets involved in the organising of health sessions for the detainee. Response to these questions were direct and informed and much less lengthy as the information provided from the other themes.

A lengthy closing statement was provided by all the participants which was prompted by myself. The information provided at this point was detailed in expressing mainly a grave concern for the immigration detention system in the ways in which people are detained regardless of their health conditions and the need to have the NHS as the main provider of healthcare in immigration detention.

The four themes remained the same for the NGO doctor, the immigration lawyer and the HMIP however, the type of questions asked within those themes were tailored according to their field and professional background. The general feedback received from all the workers generated information on how their ability to do their job is impacted upon through HO policy implementation, governance and systems in the IRCs.

3.6 Methodological considerations and reflecting on my position in the research process

3.6.1 Credibility, dependability and transferability of the study

Quantitative research traditionally applies generally the concepts of validity and reliability. In qualitative research these concepts are inadequate in describing trustworthiness, thus the concepts of credibility, dependability and transferability are deployed (Denzin and Lincoln, 2000; Lincoln and Guba, 1985) and are relevant to this research study. Achieving credibility is based on how well the data and analysis are able to address the focus of the research project. It is observed in the research process that the researcher and those who are researched are objective instruments of data production. Hence there ought to be an awareness that significant bias due to personal involvement may form as a result of people getting to know each other and admitting others into their lives (Oakley, 1981). Various meanings and interpretations of the data and text may be formed due to the influences of the researcher's background and ontology, thus it is necessary to maintain one researcher to conduct the collection and analysis of the data (Kugelberg, 2013). This is in order to avoid inconsistencies being formed by the involvement of additional researchers during the collecting of data where the asking of the interview questions is concerned. In addressing the issue pertaining to bias, the transcripts were viewed by two senior academics who provided feedback also during the data collection and administration stages. Dependability takes into account the factors of instability and the factors that causes alterations to be made in the phenomena or the design of the research study during the data analysis process (Lincoln and Guba, 1985). In my attempt to avoid inconsistencies being formed during the data collection process, the interviews were all performed by the use of a semi-structured interview schedule. Transferability is based on the findings of the data and the extent to which it may be transferred into another context (Lincoln and Guba, 1985). Consideration has been taken into the context of this research study and the characteristics of the participants to ensure that the type of data being retrieved is relevant to informing on the research questions.

The researcher's failure to identify their philosophical position in informing on the connections between the data collected and the theory adopted is not deemed as a fatal action however, the quality of the research results become affected (Bryman, 2012). There are two prominent philosophical underpinnings that form the basis of social

science; positivism and social constructivism, which are associated with qualitative and quantitative research methodologies (Bryman, 2012). Qualitative and quantitative methods may be used in both constructionist and positivist epistemologies thus causing considerable levels of confusion as they may also be underpinned by both nominalist and realist ontologies (Bryman, 2012). Hence the defining of the terms epistemology and ontology become necessary to enable me to identify the positioning of this research project.

3.6.2 Ontological considerations

Bryman (2012) describes social ontology as focusing principally on the nature of reality of social entities. The basis of the argument in social science regarding the social ontological stance refers to considering whether the social entities and phenomena are external to the social actors – including the researcher, or whether the social actors are internal to the social entities and phenomena (Khalil, 2018). This means that either the social entities and phenomena are taking place and developing independently and externally from the social actors or that the reality of the social entity and phenomena depends on the experiences and perceptions of the social actors (Khalil, 2018). Objectivism and constructionism or subjectivism respectively, are the terms that are used in referring to the two positions just mentioned. However, it is important to note that these two ontological perspectives on social entities are not to be often forced to the extreme (Bryman, 2012).

In light of this, a critical realistic ontological stance has been adopted for this research study as the focus is based on the nature of causation, structure, people's interactions with each other and agency (Bhaskar, 1989). This is in order to be able to distinguish between the real world and the observable world (Bhaskar, 1989). This is due to the belief in critical realism that observable or explicit events are caused by unobservable or implicit structures, thus the social world may only be understood if people understand the structures that create these events (Bhaskar, 1989). Based on this understanding, this study investigates the participants' experiences in accessing and delivering healthcare services in the context of immigration detention, how they make sense of the challenges they face and how it affects their rights as service users and their practice as service providers. Being the sole researcher, the type of data collected and analytical process are focused on informing on the type of power relations that exist on an individual,

institutional and societal level which are formed as a result of political constructions and a form of governing in the context of immigration detention. Strong social constructs rely not only on the existence of human knowledge and perspective but also on what is constructed by society (Sinn, 2016). Social constructionism's main focal point is centred on uncovering how individuals and groups participate in the construction of their perceived social reality (Khalil, 2018). This comprises of the ways in which social phenomena are developed, known, institutionalised and formed into tradition through human involvement (Gale, 2008). This demonstrates that human perceptions – regardless of how large or small the impact create the social world. Thus social constructionism emphasises on the knowledge produced as a result of social interchange.

3.6.3 Epistemological considerations

Progressing on from the ontological discussion, epistemology is the philosophical stance whereby social researchers make informed decisions on how to examine and explore the form of their chosen reality (Khalil, 2018). Epistemology thus is concerned with the basis of how we know the world, where the phenomena is examined with the use of techniques in the collecting of data, combined with the methods to be selected in the interpreting of the data. There are three primary epistemological positions in social science research; positivism, realism and constructionism (Bryman, 2012). I believe that adopting the social constructionist stance enables me to deploy the methods that are most effective in retrieving knowledge to inform on the research questions to develop an understanding of the phenomena that is immigration detention.

3.6.4 Ethical considerations in the collection of data

3.6.4.1 Migrant detainee participant group

As stated in my ethics forms and application which was approved by the university's Ethics Committee, my research study is deemed to be of minimal risk to the participants as the probability and magnitude of harm or discomfort anticipated in this research is no greater than any ordinarily encountered in daily life, including during the performance of routine physical or psychological examinations or tests.

In my approaching of the participants of the migrant detainee group, the university's Ethics Committee required clarification on why I did not consider this group of people as "vulnerable" participants before they would permit me to conduct my fieldwork. I presented my case accordingly:

a. The concept vulnerable according to research terms refers to the barriers or any potential hurdles that may be encountered in the attempt to obtain informed consent. The participants that fit the criteria for the migrant group may possibly hold an irregular status in the UK and may therefore be placed in a position of vulnerability. This position of vulnerability is brought on by the state which places them at risk to violence, exclusion and incarceration. They will not be impeded in anyway in their ability to decide whether or not to provide informed consent to participate in my research project.

The promotion of and reliance on the notion that migrants pose a threat to the state are brought on by the so called crime complex (Garland, 1996) or governing through crime (Simon, 2001) brought about by the government labelling migrants as criminals. Migrants have become the target of state intervention through the securing of the nation's borders in an attempt to control immigration. This is done with the aim of obtaining national, economic and social security however, mistrust and fear have been generated through these means.

In so doing immigration laws have formed a reliance on state interventions and the power of prisons to construct and secure the nation's borders – presented in its various forms; concrete walls, barbed-wire fences, e-borders for entry points which is true of the nation of Britain. This has led to the undermining of freedom in all its forms including basic human rights of migrants and the citizens. Where research is concerned, migrants are therefore placed in a position of vulnerability mainly when they are exposed to the authorities or confidentiality of their personal details have been compromised.

b. The migrant group will be acquired through NGOs, therefore they will have the protection of the NGO in case they are unsure or uneasy about participating. They will also be protected by the regulations of the university (UEL) as I will provide them with the contacts outlined in the participant information sheet and other forms/leaflets before, during and after the interviews. Not all migrants will have an unsettled status, others may have successfully acquired a secured status in the UK.

3.6.4.2 Health professional participant group

Due to the position of the HMIP of IRCs who is a participant from the professional group, I realised that it would be difficult to conceal his identity in the research findings. I discussed this issue with the HMIP to confirm whether or not he would wish to go ahead with his participation on this research of which he agreed.

3.6.5 Limitations of the research method

The observational participatory method may have offered an additional approach to the data collection process that may have been an effective solution to retrieving data. However, due to tight restrictions on access to IRCs in the UK an alternative method (stated in the Research Design) had to be deployed. The 100 percent response rate of informants participating in my study was not achieved due to the tight restrictions placed on gaining access to the IRC sites.

3.7 Final reflection and direction

Writing this chapter has enabled me to reflect on why I am doing this research study, why I need to answer the research questions and how I went about obtaining the answers. This chapter has allowed me to be clear on what my positionality is and how and what ways this impacts on the entire research process. This has proved beneficial as it assists in the evaluation process and understanding of the research findings in painting a clearer picture of the story being told in this research study.

The following three chapters are based on the findings from my fieldwork. Chapter four discusses practice and policy relating to the professionals of healthcare services and systems of IRCs. Chapter five focuses on healthcare professionals in IRCs and the factors that cause risks and tensions in carrying out public health duty. Chapter six is focused on the pathways that lead to the inequities in healthcare access of the migrant detainee. These three chapters are based on the primary data I collected and illustrate the key concepts of this study. These are the power relations that exist in immigration detention between the service users and the service providers as a result of Agamben's (1998; 2005) camp and security paradigms of biopolitics in the government's deployment of border enforcement techniques. The main conceptual framework also

includes the governmentality concepts of Rose's (1999) governance and healthism notions in revealing the impact of the government's governing techniques in their aim to maintain state security.

Chapter 4

Border enactment in its convergence with the standardising of healthcare systems in IRCs

This chapter forms an analysis by assessing the data that is produced mainly from the healthcare professional workers of the IRC. A focus is placed on the healthcare systems of IRCs based on the accounts of the doctors I interviewed, supported by some of the accounts from the migrant detainees I also interviewed. Migrant detainee voices are included at the initial stages of this chapter to bring about an understanding of the service users' perspective through the lived experiences of accessing healthcare services in IRC. This allows for an insight into the level of provision of healthcare services in IRCs which determines the level of access for the service users with the intention to prepare towards a more in depth discussion of the public health implications supported by Rose's (1999) healthism concept in the following chapters. Bachrach and Baratz's (1962) notion on the second face of power contributes particularly to the initial stages of this chapter in highlighting how migrant detainees are rendered powerless as they are unable to make a tangible decision about their health as a result of the level of provision and access to healthcare services in IRCs.

The findings of this chapter are used in order to gain knowledge and an understanding of; what type of procedures are put in place to assist in the assessment of the healthcare needs of the migrant population in IRCs, the factors that impact on the effectiveness of systems in the reporting, monitoring and analysing of patient information and its association with the standardising of healthcare systems. This helps to gain an understanding of the governing techniques of IRCs and to what extent policies are implemented in the improving of healthcare services for the migrant detainee population. This allows for an examination to be made of the impact the governance techniques of IRCs have on the healthcare of migrant detainees in accordance with Schmitt's (2004) concept on liberal legality and the government's exertion of sovereignty in the use of its discretionary power.

Various measures are put in place to ensure that monitoring and accountability in IRCs take place. However, despite this, other reports and the accounts of the professional workers I interviewed suggests that the implementation of policies are weak in IRCs and is therefore hampering the ability of healthcare professionals to do their duty thus causing a detriment to the health and wellbeing of the subjects of immigration detention. The HMIP and IRCs is an independent inspectorate responsible for inspecting and reporting on the conditions and treatment of people detained in prisons, young offenders' institutions and immigration detention centres in England (HMIP, 2014). They report on the conditions of prisons and detention centres in the UK often in partnership with Office for Standards in Education (Ofsted) or Education Scotland, the Care and Quality Commissioners (CQC) and the General Pharmaceutical Council (GPhC) arriving at the centres either announced or un-announced (HMIP, 2014). Their reports often reveal extremely shocking truths about the state of centres of immigration detention, for example the report on Brook House and Harmondsworth IRCs (Clarke, 2017, 2018) amongst others.

It is presumed that the reporting of the conditions of gross negligence by the authorities would be respected and dealt with immediately with steps taken to improve on the quality of the conditions and care of the subjects within the space of immigration detention. It is at this point that the HO exercises legality in its liberal form where immigration laws supersede the rights and entitlements to healthcare and human rights of the migrant population in immigration detention. NHS England under the Health and Social Care Act (2012) are required to commission and deliver healthcare services in prisons and detained settings to the same level as that of the community (PHE, 2014). NHS England and PHE established a joint advisory board in 2013 to oversee implementation of NHS Health Checks in prisons and detention centres where an audit took place in 2014 informing on the extent and quality of roll out of the health checks (PHE, 2014). The summary of outcome from the audit revealed that; implementation of the service was slow, the quality of the NHS Health Check was poor, the availability of health promoting lifestyle services was poor with inconsistencies in continuity of care (PHE, 2014). This may give an indication of the level of care that is provided in IRCs based on how strongly policies are implemented through the monitoring of the commissioners over healthcare services in IRCs and the measures put in place to ensure

that the healthcare providers are able to deliver quality services to the migrant detainee population.

4.1 Key points of the impact of governing practices on healthcare access and provision in IRCs

This section focuses on providing the key points of this chapter pertaining to the impact of governing practices on healthcare access and provision in IRCs. The following table (Table 1) also produces an overview of the key findings from the healthcare professionals concerning the impact of IRC governance as a result of systems and culture on their ability to perform their duties in the provision of healthcare services in IRCs.

Table 1

The factors that impact on the assessment processes of healthcare delivery in IRCs and the effect of IRC healthcare systems on the ability of workers to do their job

The factors that impact on assessment processes of healthcare delivery in IRCs		
FACTORS	PRACTICAL EFFECT	THEORETICAL IMPACT
Lack of consistent recording of health conditions	Difficulty for commissioners to assess the health needs of the detainee population and to ascertain the appropriate resources needed	Disempowering of the detainees as discrepancies in the documenting of their health conditions does not enable them to access the adequate healthcare
People typically arrive at the IRC very late at night or extremely early in the morning	Detainees are unable to think clearly to answer questions about their health due to their state of shock and exhaustion upon their arrival at the IRC Staff are also keen to push through the new arrivals to their various cells due to large numbers	Disempowering process of migrant becomes amplified upon arrival at the IRC in their swift transition to becoming a detainee
Lack of specialist staff available to identify victims of torture, trafficking and other human rights abuses	Lack of documentation thus denying the detainee patient of the necessary healthcare access and treatment required.	The space of abjection and non-rights is amplified as HO uses its sovereign power to deny adequate healthcare by neglecting to perform its duty in providing the necessary training of staff

Lack of the use of interpreter and advocacy services Migrant detainees are used to interpret for their fellow migrant detainee despite cultural and political tensions between detainees	Communication becomes strained and broken, detainees feel disrespected and disenfranchised as their rights and cultural beliefs are disregarded. Diminished responsibility and negligence of health conditions and the denial of adequate health treatment	The space of abjection and non-rights is reasserted causing fear and disempowerment of the detainee
Ambiguous and miscommunicated IRC rules and procedures	Lack of compliance of healthcare staff to HO procedures, eg. Initial health assessment, Rule 35, etc. Gives HO the upper hand to dismiss medical reports and prolong detention, incl. people classified as vulnerable under the HO's AAR policy	HO utilises discretionary power possessing the sovereign power in decision-making
The effect of IRC healthcare systems on the ability of workers to do their job		
FACTORS	PRACTICAL EFFECT	THEORETICAL IMPACT
Constant creation and revising of HO policies	Difficulty in adhering to HO policies	HO uses the strategy in the constant changing of the rules to maintain its sovereign authority over the workers and detainees
Lack of training of healthcare staff	High staff throughput due to predominant recruiting	Disempowering of healthcare staff as they lack

	of agency staff	the knowledge to comply with HO procedures – which in-turn disempowers the detainee in the denial of adequate healthcare
Predominant employment of contracted staff	Dual-loyalty has become prominent where staff place their loyalty and responsibilities in the HO before considering the welfare of detainees	HO is empowered to coerce contracted staff, thus undermining their autonomy
Lack of transparency	Due to lack of accountability causing diminished responsibility	HO is empowered to maintain detention and denial of adequate care of the detainee through the weak implementation of policies
Lack of trust	Doctor-patient relationship becomes fragmented	Detainees have become fearful of healthcare staff, including doctors and nurses as they perceive them to be agents of the HO
Disbelief	HO disbelieves detainees of health conditions Undermining of professional medical judgement/reports due to lack of compliance to HO	HO exercises its sovereign and discretionary power over a medical report – disempowering the doctor which in-turn disempowers the detainee denying them of the due care.

	rules	
Inconsistencies in IRCs utilising the routine collection of data	Lack of an organised collection of populated data-sets to inform on disease prevalence and how it is associated with specific groups of people Unable to make informed decision to device strategies in tackling disease prevalence	HO is empowered to maintain the denial of adequate care for detainees as a result of negligence.

The above table shows the impact of governing practices on healthcare access and provision in IRCs and the effect of IRC healthcare systems on the ability of workers to do their job.

4.2 The factors that impact on assessment processes of healthcare delivery

4.2.1 Risk assessment procedure

The recording and reporting or the clinical auditing of the detainees' health conditions is a requirement in IRCs where routine assessments take place on an annual basis at IRCs conducted by auditors who are external to the on-site team from NHS England (NHS England, 2015). However, there is a lack of consistent recording of health conditions, particularly long-term illnesses in IRCs making it difficult for commissioners to assess the health needs of the IRC population and to ascertain the appropriate resources required (NHS England, 2015, p.21). The senior NGO doctor emphasises on the various factors that are presented in an IRC setting which prevent adequate auditing to take place based on identifying victims of torture, trafficking, modern slavery and other human right abuses in the following excerpt:

> First, the IS91RIA – the lay risk assessment is never in the medical notes and is not at all clear that it is ever seen by a nurse….(senior NGO doctor).

In the event of deciding whether or not to detain a person, the caseworker is required by the HO after consulting with their manager to follow the risk assessment procedure to identify any risks associated with the detaining or transporting of an individual. The IS91RIA is a risk assessment form which is to be filled out by the caseworker as a policy of the HO to ascertain whether or not it is appropriate to detain the individual. When a decision has been made to detain the individual, they are then transported to the IRC. The IS91RIA risk assessment form is a standard procedure carried out on every individual that is to be detained based on the account of the senior NGO doctor. It is believed that he completed IS91RIA risk assessment form is attached along with other documentation concerning the detainee and transported along with them to the IRC. The completed IS91RIA risk assessment form would then be produced at the initial health screening with the nurse to ascertain the level and nature of vulnerability pertaining to the health conditions of the detainee patient. However, in the same token if any risks had been flagged up in the initial stages by the caseworker, the standard procedure would be to arrive at a decision not to detain the individual due to detention posing a risk to their health. This decision would not have been in the interest of the HO as they reserve the right to detain the individual in question for administrative purposes to give them time to determine the fate of the individual.

4.2.2 Initial health assessment procedure

The lived space of the migrant detainee participants is revealed through the recounting of their individual experiences in having an initial health assessment or health screening at the IRC. The HO policy stated in the Detention Services Operating Standards (DSOS) (2002) (which is derived from the Detention Centre Rules, 2001) under Standard 14 of the section on Healthcare that an initial health assessment or screening is to be carried out on every person who enters the IRC on the first day of their arrival which involves a medical assessment by a nurse, which must include an assessment for risk of self-harm or suicidal behaviour within two hours of admission at the IRC (Pollette, 2002). This policy is conceived within the space of IRCs by the HO for the purposes of creating order and fairness – which is a perception that is sold to the public that there is no discrimination within the services of our democratic society. However, there is a lack of initial health assessment on the day of arrival at the IRC which is re-iterated by the majority of ex-detainees I interviewed. Participant K expresses how he received his initial health assessment two days after his arrival at the IRC instead of the first day. He further explains that the assessment was inadequate as the IRC staff failed to ask him if he had any health conditions so they were unaware that he was a diabetic. He also did not mention that he was a diabetic and thus had to result to controlling his diet by being careful with the food that he ate until he was able to speak to a doctor to explain his health condition in order to get medication for his diabetes. The following excerpts are further examples of detainees' experiences of an initial health assessment at the IRC:

> I went to detention centre the 1st time, cos you get to be put in the short-term and then you spend like a 3 days there, 4 days there and then like I do remember seeing the healthcare and I do remember telling them about my issues.. (Participant I).

Participant I in the excerpt above explains how he received some form of an initial health assessment three or four days after arriving at a STHF and was asked about his health conditions. An initial health assessment does not appear to have been done on Participant I upon his arrival at the IRC he was transferred to as he does not mention receiving an initial health assessment there. The HO may have had a record of his

previous health assessment done at the STHF however despite this, Participant I should have received another initial health assessment on his arrival at the IRC along with the documentation that should have accompanied him in his transferal from the STHF to the IRC. It is HO policy that every person who arrives at an IRC – as stated in the DSOS is to receive a medical health assessment (Pollette, 2002).

Four out of the twelve ex-detainee participants I interviewed who believed that they received some form of an initial health assessment recount the experiences they had at the IRC. An example can be found in the following excerpt by Participant D who recounts that they asked him some basic health questions:

> It's only the few questions they ask you... They don't do any health assessment, it's only a few questions …they won't come for any medical or, it might take 2 or 3 days before they could come and they send a screen called "GP appointment" (Participant D).

Another participant - Participant H explained how upon his arrival at Morton Hall IRC - the first IRC he was detained in, a nurse asked him questions about his health such as, do you have any allergies, what is your weight and height, have you attempted suicide before, any self-harm history. Participant H expressed how he felt that they asked these questions to protect themselves and not for the welfare of the detainee. As there were several procedures to follow when he arrived at the IRC he had to wait about an hour before being asked the health questions. Participant N explains in the following excerpt that she did not have an initial health assessment when she arrived at the IRC in Yarl's Wood and was asked some questions about her health by the IRC staff. Participant N decided to seek healthcare during her detention, sometime after her arrival at the IRC when she became ill and was eventually able to get an appointment and be seen by a doctor. This is expressed in the following excerpt:

> Not at all. No nurse nothing except when I was sick.. (Participant N).

Participant J also expresses in the following excerpt how he was not asked any questions about his health but rather if he was on medication and a check of his personal details and NHS number by the reception staff on arrival at the IRC:

> No, they don't assess you, they don't do anything like that. They will check your details and NHS… they have their doctors down there which is if you're at

> home and you're taking medication, they will start giving you back your medications... but they don't check that if you're fit to be there or if you're not fit to be there (Participant J).

The factors that constitute as an initial health assessment based on HO policy (Pollette, 2002, PHE, 2014) is re-iterated in the following excerpt by the lead consultant doctor of an IRC and the senior NGO doctor I interviewed in the following excerpts:

> … when somebody comes into the detention centre when they're received is irrespective of the route which they come from, from an immigration perspective … they get a primary healthcare screening which is carried out by a member of the nursing team (lead consultant doctor).

> On arrival, they are required to be seen by a nurse within two hours. Among other things, the nurse is required to find out whether they've got any dangerous health problems, whether they are vulnerable persons within the meaning of policy, namely; victims of torture, trafficking or other related human rights abuses (senior NGO doctor).

The above two excerpts from the two medical doctors explains that an initial health assessment involves a detainee being assessed by the nurse within two hours of arrival at an IRC. As the senior NGO doctor explains that the purpose of the initial health assessment is so that the nurse may find out if there are any existing serious health conditions and if any of the new arrivals fall under the vulnerable persons of the HO policy. Various factors may have contributed to the initial health assessment not taking place for Participant I. The lack of initial health assessments taking place has been reported by eight out of the twelve ex-detainee participants I interviewed.

The absence of an initial health assessment affects the decision-making process of the detainee relating to Bachrach and Baratz's (1962) notion on the second face of power as they are position within the space of disempowerment where the detainees are not presented with the opportunity to reveal their health conditions thus hindering the accessing of the healthcare services they require. Participant I, as is the case with the majority of participants I spoke to took the decision to not mention his health conditions in the initial stages of his arrival at the IRC as he had not received a health assessment or been asked about his health conditions. The will of the government in exercising its sovereign-discretionary power, re-iterating Schmitt's (2004) concept on liberal legality

enables the HO to take actions that is against the wellbeing of the migrant, thus disregarding their health conditions and making the decision to detain them.

4.2.3 Early arrival times

The NGO doctor raises the second factor which prevents adequate recording and reporting of the detainees' health conditions to take place based on the identifying of victims of torture, trafficking, modern slavery and other human right abuses in the following excerpt:

> Second, patients often arrive in the middle of the night. They are confused, they've been travelling for a long time (senior NGO doctor).

People typically arrive either very late at night or extremely early in the morning at the IRCs which are located on the out-skirts of towns beside airports and harbours. The nature in which the detainees arrive initially places them in a state with which they are unable to think clearly to answer questions about their health. The new arrivals to be detained are often tired, disorientated, confused and afraid – as reiterated by the NGO doctor in the excerpt above, causing the detainee to take the decision to manage their health conditions until they are ready to seek healthcare at the IRC in the future. The staff are also keen to push through the new arrivals to their various cells as nurses who are available to carry out the initial health assessment are not specifically trained in identifying victims of torture, trafficking and other human rights abuses. The lacking of the skills and competencies to identify such patients causes the lack of documentation thus denying the detainee patient of the necessary healthcare access and treatment required.

A vast number of people also arrive at the IRC in handcuffs, which adds to the disorientation and trauma of the detainee upon arrival causing them to recall a few details of their experience of an initial health assessment. Participant Q who is one of the female ex-detainee participants I spoke to recounts her experience in the following excerpt:

> …like I told you when I entered Yarl's Wood, I was in handcuffs, so you can only imagine… I remember the nurse that came, but I don't remember most of the things she said to me cos I was in shock, just as I walked into the

> building….everything was just too much to take in because I just walked in and stayed for a little bit and then a nurse came she was asking me some questions about, I don't know family sickness and other problems you've got and things like that, but I don't remember the rest…I remember she brought some paperwork with her (Participant Q).

This reveals that there is weak implementation of policies within IRCs as the resources needed to ensure that procedures are adhered to are limited which makes it difficult for IRC staff to comply to HO policy. Liberal legality mentioned by Schmitt (2004) in his argument of the government's use of their discretionary power is evident here where the will of the HO precedes over that of the policies set in IRCs. The establishing of the kind of conditions that detainees are suffering from upon arrival is fundamental to enabling access to the required healthcare service. The lack in the provision of this initial health assessment pushes detainees into a position of non-ability (Bachrach and Baratz, 1962) in the decision-making process about their health and rendering them powerless in taking control of their health. The power assigned to migrant detainees is perceived as that of non-power as the level of healthcare services are restricted due to the reasons mentioned in this section hence, evidencing Roses' (1999) healthism concept where their healthy lifestyle choices are influenced predominantly by the provision of healthcare services in IRCs.

4.2.4 Interpreting services on arrival

The senior NGO doctor raises the third factor which prevents adequate recording and reporting of the detainees' health conditions to take place during the initial health assessment based on the identifying of victims of torture, trafficking, modern slavery and other human right abuses. There is a great lack of interpreters being used in the IRCs causing issues in provision of the necessary care for detainees. Language was thus one of the major barriers in communication between the IRC staff and the detainees accessing the necessary care to treat their health conditions. The senior NGO doctor I spoke to expressed this in the following excerpt:

> Third, very often where the use of an interpreter is essential to facilitate communication, one is not employed (senior NGO doctor).

Barriers occur quite frequently in detainees accessing doctors and specialist care in IRCs. The accounts of detainee participants re-iterates the kind of challenges mentioned by the senior NGO doctor in the excerpt above concerning the accessing of a doctor or the necessary healthcare they required. The lack of the provision of interpreters during the health assessment process is a major issue that causes barriers in detainees accessing the necessary healthcare. This example may be found in the following excerpt expressed by Participant K:

> I know a lot of people weren't able to explain correctly because of the language that they spoke, the dialect that they spoke. (Participant K).

A significant proportion of the population detained in the IRC do not speak fluent English causing communication between some of the detainees and the IRC staff to be quite strained. Based on the excerpt above by Participant K, it seems that interpreters were not used on a regular basis as he expresses how he believes that he was placed at an advantage due to being able to speak English fluently which enabled him to explain to the staff the illness he had and the medication he had been prescribed and how it had to be administered.

IRCs detain people from diverse cultural and ethnic backgrounds and should have a system in place that categorises and keep record of the type of backgrounds of the people it receives. Dismissing the importance of utilising the services of an interpreter or advocacy service (which should be a prominent feature, particularly where healthcare services are provided in every IRC) allows mental barriers to be built up between the detainee and the staff. The space of abjection becomes ever more real for the migrant detainee as communication becomes strained and broken causing detainees to feel disrespected and disenfranchised as their rights and cultural beliefs are disregarded. The disregarding of the migrant detainees' rights and cultural beliefs also extends to the level where the IRC staff assign migrant detainees to interpret for their fellow migrant detainee. Often is the case and recounted by one of the ex-detainees I interviewed – Participant H (from Sri-Lanka) that they are asked to interpret unknowingly by the IRC staff for a fellow detainee who speaks the dialect of the oppressors they were fleeing from in their country. This causes the interpreting migrant detainee to recount their experiences and re-live the trauma once again – even on multiple occasions.

Seeking to establish a common ground between the detainee and the staff is the first step to building a mutual relationship of acknowledgement and respect integral to achieving compliance to IRC rules and regulations. It is also paramount where healthcare is concerned to utilise the services of interpreters or advocacy to help through the processes of health assessments and screening in the establishing and documenting of health conditions. A lack of interpreter or advocacy services during healthcare procedures results in diminished responsibility and negligence of health conditions and the denial of adequate health treatment being administered. Interpreter and advocacy services help to facilitate a smoother transition from the community into immigration detention where the detainee is often placed in a position of bewilderment, confusion and fear, particularly for those who do not speak English fluently or at all causing the lines of communication to become strained. This re-affirms the presence of liberal legality where the implementation of policies is weak due to the imposition of the will of the HO's primary purpose; to detain, deport or disperse regardless of public health concerns where border enactment and the right to healthcare converge.

4.2.5 Identifying victims of torture and human rights abuses

The NGO doctor raises the fourth factor which prevents adequate auditing to take place based on the identifying of victims of torture, trafficking, modern slavery and other human right abuses in the following excerpt:

> Fourth, in a very large proportion of cases that I have seen where the person claims to be a victim of torture, although they are required to be asked about that on arrival, that often does not happen or is not recorded yes or no (senior NGO doctor).

One of the HO procedures according to the Rule 34 process requires that an initial medical assessment takes place within two hours on arrival at the IRC of the detainee by a nurse (Detention Centre Rules 2001). At this point the nurse will establish what the health conditions are, particularly as to whether or not the detainee is a victim of torture or any other related human rights abuses. If the detainee has been established as falling within this category, the protocol is to refer the detainee onto the next process known as the Rule 35 where the manager is alerted and an appointment is made to see the doctor. A full medical examination and assessment pertaining to the nature of the physical and

mental human rights abuses experienced by the patient takes place where certain protocols are to be followed such as, the Istanbul Protocol Compliant Medical Legal Report which is an international standard legal report devised by the United Nations (UN) that has to be documented by the doctor who carries out the Rule 35 examination on the patient in identifying them as a victim of trafficking, torture, slavery or other human rights abuses (Detention Centre Rules, 2001). The HO is then notified of the adverse effects that detention poses on the health of the detainee (Shaw, 2016). According to the NGO doctor's statement above, there are issues in the implementation of these processes in IRCs. This suggests that the monitoring and implementation of this healthcare process in identifying a migrant detainee as a victim of trafficking, torture, slavery or other human rights abuses by the commissioners is weak as the ensuring of doctors to meet the standards of the healthcare process in order to be compliant is lacking.

Weak implementation of policies may instantly suggest non-power however, the governing techniques of the HO who are joint commissioners with NHS England and PHE (in the provision and overseeing of healthcare services in IRCs) in this instance use their sovereign power in the dismissing of medical reports produced by the IRC doctors as a result of not complying with the procedures such as the Istanbul Protocol Compliant Medical Legal Report during the Rule 35 examination. This assigns the HO with an authority in decision-making that often has a greater influence than that of the healthcare professionals over the lives of migrant detainees. The HO in neglecting to provide training to doctors to enable them to be compliant to this healthcare service procedure provides leverage for them to refuse applications containing the medical reports that would support the case of a migrant detainee concerning immigration detention posing a detriment to their health, which would have otherwise presented a strong case for their release. The discretionary power argued by Schmitt (2004) in his liberal legality concept is exercised by the HO in its entirety in such instances where they maintain the decision to continue the detention of migrant detainees despite the evidence produced in medical reports based on the lack of compliance to procedures.

4.3 The importance of standardising healthcare systems in IRCs

4.3.1 Inadequate use of tools and routine processes

The lead consultant doctor informed me in the interview that the IRCs are part of a national reporting system where data on detainee patients are recorded from primary care and sent to NHS England. This second doctor I spoke to is the lead consultant doctor of the mental health team of an IRC and recognises the importance and lack of standardising a routine collection of patient data as he emphasises that it may be used to improve on the care plans that may be devised for detainee patients. The lead consultant doctor further explains that this kind of data collection is limited in IRCs as compared to prisons and although the data exists in IRCs, it is not being researched and used effectively to improve on services within the IRC healthcare system. Very few standardised systems have been established in IRCs' healthcare services which contributes to the weak implementation of healthcare policies in IRCs, thus hampering the smooth running of the auditing process and rendering the process ineffective.

The lead consultant doctor in his knowledge of data collection suggests that data is being collected on a routine basis without people realising it with the instance pertaining to demographic information that is populated during health screening. He affirms that there is a screening tool that effectively collects data when the nurses do their assessments and would use this tool called the PHQ9 for assessing migrant detainee patients suffering from depression which is a health questionnaire that is frequently used in such cases. This assessment tool is also used in the community in primary care for the purposes of keeping a register of certain types of conditions which are nationally set in a system named the Quality Outcomes Framework (QOF) in order to inform on what model of care would best serve the type of population being treated. Although this is a requirement from the commissioners of the NHS for primary care in all types of healthcare settings, it is not clear how effectively it is being implemented in all the IRCs of the UK, despite the fact that the lead consultant doctor mentioned that engaging with the QOF produces incentives for GPs where they are paid extra for filling in these questionnaires. As GPs and nurses are predominantly contracted out by private companies in IRCs, it is not clear whether they benefit from this incentive or not and if they are encouraged to engage in the QOF which has the potential of being one of the major attributes of the lack in data being routinely collected and monitored, thus

hampering the benefits of acquiring and analysing data that may improve on healthcare services in IRCs. This system is being implemented in the department of mental health at the IRC where the lead consultant doctor gives an example in the following excerpt of how the data reporting system for his department works:

> The way that QOF works is if GPs fill it in, they get paid extra…it could be collected by the primary care nurses, it could be collected by the GPs when they do their assessment and they put in a diagnosis and that forms something called a code so you'll, say I write schizophrenia in the electronic patient record, that will come up highlighted as green and that record automatically records that as a code and then that code can be our data, there's a data person who does a lot of the data-reporting stuff and that he can run a report and look for all the people that've got schizophrenia on the record and code and he can come up with a list of names for example, or a number of people and that's the kind of thing, the way it gets reported (lead consultant doctor).

The lead consultant doctor re-iterates that there is a huge amount of information that is being routinely collected that may be constituted as data which is being either systematically collected and being reported on or may be merely the information that is being provided within the patients' notes such as, medical notes that may not have been coded properly and would require searching through in order to find the particular data needed. The lead consultant doctor goes on further to explain in the following excerpt how the programme structure in place at his mental health department at the IRC enables them to store and access the routinely collected information of their patients:

> The Care Programme Approach, which is effectively the structure through which mental health is delivered. In the electronic system that we use, there's a, you can click on a certain, like a page, you can click on a page and fill that form in and that then means that you are able to record and search for The Care Programme Approach form so you can then figure out who's on a Care Programme Approach for mental health in an IRC and that care programme approach form should have a lot of information on it relating to details of things like, what their diagnosis is and all their other information about their care plan and that kind of thing (lead consultant doctor).

The auditing process is also affected through the unreliable documenting of responses from detainee patients by doctors in some circumstances. It is perceived that doctors are the beacon of integrity with regards to their professional role. However, any of two factors may be at work here which may have compromised their professional role; either due to the lack of utilising interpreters, causing a miscommunication between the doctor and the patient or that the question of loyalty has come into play. It is possible that either one of these two factors may be the cause at any given time based on the accounts of the NGO doctor. This has a bearing on the professional practice of the doctor causing over-site of health conditions that are exacerbated by detention which poses a risk to the health of the detainee. This concern is re-iterated by the immigration lawyer in the following interview statement:

> …the Secretary of State has not complied with that rule (34) as there are clients who do not have that initial health screening as mental and physical health problems are left untreated, also making it difficult for the Home office to ascertain whether or not someone is a victim of torture as they could suffer further detriments (immigration lawyer).

The Rule 34 and 35 processes are often not adhered to as the majority of IRCs do not have a system in place to ensure that there is adequate screening for vulnerable patients and victims of torture.

4.3.2 Lack of training of staff

There is a lack of training of doctors and nurses in specialist areas in identifying vulnerable patients and victims of human rights abuses. Hence, weak implementation of policies is further evidenced in this instance, particularly with regards to procedures and protocols involving healthcare services in IRCs. The training and monitoring of healthcare staff to be compliant with the healthcare procedures of policies that govern IRCs is lacking, thus causing the HO to dismiss the medical reports of IRC doctors as they have not received training from the HO on how to comply. The HO policies are a double-edged sword as they are being created and revised with no training provided for the healthcare staff who are required to follow these specific procedures. This places the HO in a position of power to disregard the medical reports and exercise its discretionary power – referred to by Schmitt (2004) on refusing to accept a medical report that

identifies a patient as a victim of human rights abuses and hence, being harmed by detention. Audit reports produced by the HO and its commissioning partners typically focus on failings with procedures rather than informing on performance and outcome of specific healthcare services in IRCs reported on by Stephan Shaw's Review (2016) into the Welfare in Detention of Vulnerable Persons, HMIP (2017, 2018) and others.

In general, there is a huge demand for healthcare services within IRCs but due to the limited resources, the effectiveness in implementing standardised systems is hampered due to the reasons mentioned above. It is essential that these systems are given the opportunity to function in such an environment that is heavily reliant on order and would benefit from the collection and researching of data from the migrant population concerning their healthcare requirements.

In the interview I had with the lead consultant doctor, he emphasised on the need to have a system in place that allows for the auditing and researching into the prevalence of diseases within IRCs pertaining to both physical and mental health conditions. The HO permitting this to take place may potentially ensure the establishing of standardised systems within IRCs which may improve the provision of services. This would be made possible due to the collection of information that relates to what the needs are of the type of population which pertains to the type of health conditions that are presented by those detained in IRCs. The lead consultant doctor went further to impress on how effective this would be in informing on the model of care and the type of resources needed which would be an integral contribution to the improving of healthcare services in IRCs. The lead consultant doctor expresses further that it would be useful to have external reviews and research, not only from the prison ombudsman, but also independent ones that focus on the NHS and healthcare in IRCs and that it ought to be an ongoing process. This is based on the fact that institutions, be it a hospital, prison or an IRC tend to become insular and develop their own ideas and ways of running their affairs. Thus encouraging certain cultures to be conceived and institutionalised within organisations that govern the various actors involved.

The lead consultant doctor emphasises that having someone who can view the system from an external perspective would be invaluable where the detention of people that are coming from vulnerable groups that are highly politicised are concerned. This may provide an improved understanding of how immigration detention links to the acquiring

and exacerbation of health conditions as well as encourage the setting up of a system based on reporting, monitoring and evaluating which are specific to IRCs, not prisons – as such systems are lacking in IRCs that provide and organise this type of information. This feedback from the interview with the lead consultant doctor evidences the need to improve and develop the techniques that govern the healthcare services of IRCs. However, due to the will of the government in asserting its sovereign power, it prefers to maintain a monolith stance where they remain un-phased by the present reviews and recommendations that have been made on IRCs which are based on the outcomes produced as a result of their governing techniques. Schmitt's (2004) liberal legality is expressed once again in its entirety here as the will of the government in its persistence to encourage the thriving of market-mechanisms observed by Rose's (1999) neoliberal governance techniques exists where more power is being assigned to the private companies to manage and deliver healthcare services through contracts and sub-contracting. This has produced adverse effects in the delivery of healthcare services in IRCs causing a scarcity in; resources, staff training, specialist staff, interpreters and standardised systems specific to IRCs. The existence of this scarcity hampers the improvement of healthcare services, thus impacting detrimentally on the health and wellbeing of the migrant detainee.

Although detainees of both prisons and immigration detention have the right to primary health care services, IRCs experience various systematic problems that cause particular challenges that inhibit the effective and accurate identification and meeting of the health and wellbeing needs of migrant detainees (PHE, 2014). The systematic issues in healthcare services that were reported in 2013 by the commissioners of healthcare services in IRCs generally involved; the lack of a national template to be used for initial health screening and assessments, dependence on manual data systems causing difficulties and unnecessary consumption of time in the compiling of health needs and services (PHE, 2014). Inconsistencies were also problematic in the use of health needs recording systems where IRCs lacking long-term condition registers attributed to the often neglected recording of diagnostic classifications such as READ codes that represented specific health conditions (PHE, 2014). The variation in providers and historical commissioning arrangements attributed to the numerous differences in the types of service configuration in IRCs including the indefinite stay of detainees leaving

and being transferred between IRCs at unpredictable times thus hampering the continuity of care (PHE, 2014).

Rose's (1999) governance technique is further evidenced in the structures set up within the IRC system in the UK in the provision of their healthcare services. Since the inception of IRCs where the majority of these physical structures were transformed from prison buildings, IRCs have been placed in the same category as that of prisons with regards to the establishing of systems and protocols, particularly pertaining to that of healthcare services. Although attempts have been made to distinguish IRCs from prisons, particularly due to the legality issues and the rights of migrant detainees, governance mechanisms do little to distinguish IRC healthcare service procedures and systems from that of prisons. This reinforces the notion of the camp paradigm (Agamben, 1998) where migrant detainees are subjected to a lifestyle and treatment that reflects that of a prison, or worse still – a camp in the use of prison techniques to govern the healthcare delivery in IRCs, despite the contrast in legality and rights pertaining to that of a migrant detainee and that of a prisoner. A number of systems and procedures used in prisons are transposed into IRC systems making room for over-sight to occur in the identifying of specialist needs of the IRC population. In the following excerpt, Participant D provides this example:

> We call ourselves detainees, but they call us prisoner because every form we fill a medical line, they put in "prisoner" they don't put in "detainees" (Participant D).

A couple of procedures derived from the prison setting and used in the IRC setting which have experienced these over-sights are evidenced in the procedure used in identifying potential ACDT patients, initial health assessments and the health assessment forms. One of the main reasons for this may be due to the fact that IRCs are categorised as belonging to the same institution as prisons. Hence, little effort is taken to adjust procedures and systems that take into consideration the nature of IRCs. A selected few procedures in the IRCs are redesigned from the prison's template or designed specifically for assessing certain health conditions. The lead consultant doctor's healthcare team is one of very few teams that function in such a manner in IRCs where they work together in strategising and planning on a daily basis through routine patient review staff meetings. The main purpose of the patient review meetings

mainly resides in the identification of referrals coming in from primary care or the Rule 34 process (Rule 34 is an appointment with the IRC GP) and often includes having a detainee patient present. This is a rare feature in IRCs and seems to be implemented so far only in the IRCs in Heathrow for this particular healthcare department run by the lead consultant doctor. This may be due to the fact that prior to the time that the lead consultant doctor was placed in this role at the IRC, this IRC had been noted for exceptionally gross misconducts and negligence that gravely impacted on public health and infringed on the rights of the detainees. The implementation of procedures devised by the lead consultant doctor in his department affirms that doctors have the autonomy to assert their will based on their professional experience and authority to benefit the migrant detainee by improving on healthcare services. Hence, rendering the doctors as the professional advocates of migrant detainees who form part of the factors that determine whether the migrant detainee is able to make a tangible decision about their health or not in relation to Roses' (1999) healthism and Bachrach and Baratz (1962) decision-making concepts.

4.3.3 Initial health assessment

This is made evident at their first experience of healthcare services during their initial health assessment which should take place within two hours upon arrival at the IRC with a nurse (Detention Centre Rules, 2001). This does not appear to be the case based on the account of one of the male detainees I interviewed (Participant D) when I asked him about his experience of his first health assessment at the IRC:

> They don't do any health assessment, it's only a few questions, that's the only questions they ask…they won't come for any medical or, it might take 2 or 3 days before they could come and they send a screen called 'GP appointment' so that is it. Not on arrival you see someone receiving medical, no it's not possible.

The role of the initial health check according to Rule 34 of the Detention Centre Rules (2001), which is a medical examination to assess the detainee within two hours upon arrival at the IRC by a nurse to establish what health conditions they have and to refer them for an appointment to see the GP if required. According to Rule 34 of the Detention Centre Rules (2001), a detainee is required to be seen by a doctor within twenty-four hours upon arrival after the initial health assessment with the nurse at the

IRC. The Rule 34 process is a HO policy designed for IRCs, however this is not being complied with as IRCs have changed the rules where it has become common practice for detainee patients to be referred to see the doctor two or three days after their arrival rather than twenty-four hours later. The initial health assessment is required to be carried out by a nurse however, based on the accounts of the ex-detainees it may also be an IRC administration staff who asks a few basic questions that are health related with the aim it seems to be able to tick off boxes provided in the online assessment form. Revealed in the migrant detainee's initial encounter of healthcare services at the IRC affirms to them their non-rights and non-power in the process of accessing healthcare services and the decision-making process concerning health. The ex-detainee (Participant D) re-iterates this concept of power in recounting his experience of attempting to access healthcare at the IRC:

> Like somebody who is feeling dizzy and they are giving him paracetamol and ibuprofen, hmmm, I believe that is wrong. Paracetamol and ibuprofen, …that is the drugs they give out most in detention... And after then, they'll ask you "do you have a private doctor? They can come and visit you" (Participant D).

This exemplifies how healthcare is being denied the subjects of IRCs where basic pain-relief drugs are offered to every detainee that raises a concern about their health. This evidences that the will of the government overrides the healthcare policies set out by the commissioners of the NHS for IRCs as a result of the governance technique of Rose (1999) being applied in the assigning of private contractors to provide healthcare services. This has manifested in the restriction of the appropriate medication and adequate access to healthcare services where private contractors managing the IRC implement their own procedures and rules with little transparency and accountability being required.

Implementation of policies is weak enabling IRC contractors to devise their own rules which override the national policy set to govern healthcare services. The first line of contact in attempting to access healthcare are the security guards, who are not medically trained to decide the level of urgency or importance of each health issue that is presented to them by a detainee. This proves disadvantageous as they seem to follow a protocol with every detainee in offering pain-relief drugs despite the conditions or symptoms the detainee approaches them with. The matter of booking an appointment to

see a doctor is only noted and actioned once a formal complaint is made (this has been the general feedback from the participants I interviewed) which has to go through a process before an appointment is eventually made to see the doctor. The offer is also made to the detainee to arrange for a private doctor to come and treat them in compensation of being dissatisfied with the services of the IRC (as mentioned by Participant D I interviewed in the above excerpt). This is a bold declaration of the contrast in power relations of the migrant detainee and the IRC managers where the IRC staff and HO are able to present an option to the migrant detainee to access private healthcare in the knowledge that this is undoubtedly not a feasible option as they are unable to afford private healthcare. This option is presented in the guise of fairness and the false assignment of power to the migrant detainee by creating the perception of inclusion in the decision-making process in gaining access to healthcare services. This conceives a perception to the migrant detainee of disregard by the HO and IRC staff for their healthcare and wellbeing with the perpetual positioning within the space of abjection.

The referring of the detainee in immigration detention as “prisoner” explicitly declares their non-right or non-power in the decision-making process of accessing healthcare. The term prisoner is stated on the assessment form referring to the migrant detainee on their arrival at the IRC (as mentioned by Participant D in his experience - earlier in this chapter). Other forms provided for the detainee within immigration detention also use the term prisoner (HMIP, 2017, 2018). This technique of governance in the normalisation of the state of exception (Agamben, 1998), although the migrant detainee has not committed any criminal offenses re-affirms the sovereign power the HO wishes to assert over the migrant individual, rendering the subjects of immigration detention powerless and feeling disenfranchised despite having not committed a crime. This implies that the so-called crime that the migrant has committed is the mere fact of not attaining citizenship or documentation that permits legal residency thus justifying their alienation and exclusion from society, branding them as second-class citizens and undeserving of human rights and healthcare services. The recommendations made by HMIP (2017, 2018) regarding their inspection at Brook House IRC and Harmondsworth IRC included the desisting of the reference of migrant detainees to the term prisoner in forms and other documentation. This would be a step towards achieving a more equitable level of access in healthcare for the migrant detainee as compared to that of

the community. This would also be a strategic technique in boosting detainee confidence and morale which may enable an environment of mutual respect and compliance to be conceived. The contrast in power relations would be reduced enabling the migrant detainee to become more involved in the decision-making processes, particularly of matters pertaining to their health.

4.4 The attempt in recruiting healthcare professionals as border guards

Continuation of care is lacking for migrant detainees when they are released from detention back into the community as they often experience difficulties in registering with a GP. The lead consultant doctor reaffirms this issue by mentioning how his team work with NHS England to encourage GPs to register detainees who have been released into the community. These measures are integral to reducing the risk of the health of the migrant detainee deteriorating further after release from the IRC. The lead consultant doctor in the interview stresses on how vital it is for IRC doctors to be able to liaise with the migrant detainee's GP post-detention, particularly for those with mental health conditions. He mentions about further challenges presented in this instance where he believes that the initial health assessment process in the IRC is not functioning effectively and that it is a combination of staff not following the procedure properly and the detainees sometime not admitting to having a GP when they are registered with one. This has detrimental implications on the accessing of pathways for those requiring a mental health referral during their time of release from detention or referral to the hospital as it is a complicated matter that requires the involvement of the Mental Health Act (Care Quality Commission, (2018). The power relations formed in the process of the initial health assessment in IRCs presents a space of fear and apprehension for the migrant detainee as it is their first experience of healthcare in an environment that is alien to them where they are holding preconceived ideas of immigration detention. This places the staff member performing the health screening in a dominating position of power, particularly if the language spoken by the two parties are not the same. There is the need here for clearer standardisation of this process and stronger implementation of policies in the utilising of interpreters and the following of procedures involved in the healthcare services in IRCs. It is often the case that the experiences and memories of detention inevitably takes its toll physically and mentally on the health of the migrant

detainee during and post-detention for even those who may have begun their detention in a reasonably healthy state but then deteriorate.

IRC doctors may be discouraged from liaising with the community GPs in the continuation of care post-release of the migrant detainee from detention as it is typically the case that GPs are reluctant to register undocumented migrants (Mahase, 2018). Securing the continuation of care with the GP is further hampered due to the fact that migrant detainees remain fearful post-release from detention as the majority are unable to acquire their legal status at this stage and remain in danger of being arrested once again by the HO and repeatedly face either detention or deportation. Thus undocumented migrants released from detention tend not to seek healthcare services when released back into the community, causing continuation of care to become non-existent. IRC doctors also face the challenge of not being involved with the immigration aspect of the detainee. This causes the lived experiences of the camp paradigm to extend beyond the IRC post release from detention for the undocumented migrant as he or she continues to live under the mercy of state security and the watchful eye of the HO who have infiltrated the systems of public services, thus deterring them from attempting to access healthcare services in the community. The released migrant detainee continues to remain in the space of abjection with continued feelings of disenfranchisement where integration into the community becomes difficult as the fear of being detained once again becomes a prominent feature of their lifestyle. This shapes their decision-making process where they re-live the position of powerlessness in making a tangible decision concerning their health.

Although boundaries are constructed to some extent between immigration matters and the healthcare provision of the detainee by doctors who aim to assert their autonomy to ensure confidentiality and due care to their patient regardless of HO interests, IRC doctors are challenged to the effect that they are often not aware of the release date of the detainee – which may occur abruptly. This then brings the care plan for the migrant detainee to an abrupt end rendering the doctor powerless and unable to complete and establish the continuation of care for the undocumented migrant upon their release from detention. The HO has the tendency to override the decisions of the healthcare professionals by possessing the power to withhold information on the application status and release date of the migrant detainee. This presents the element of surprise for the doctors who are instantly rendered powerless to continue providing input in the

decision-making process of the migrant detainee's access to and the provision of healthcare services. This situation reflects liberal legality where the will of the HO often presiding over that of healthcare professionals is justified by their aim to securitise the nation against the undocumented migrant who is perceived as a threat due to their lack of legal status. The undocumented migrant is thus dispersed back into the community and positioned within the space of disenfranchisement with the IRC doctors powerless to intervene or follow-up on the migrants' healthcare.

This space of disenfranchisement where undocumented migrants are placed in is created by the government where migrants are perceived as a threat to the economy of the UK through the so-called practising of health tourism (Milne, 2014). The government has been impressing upon the citizens of UK since the rise of the Brexit, (the process of the UK withdrawing from membership of the EU (Kenton, 2019)) the need to reclaim funds for the NHS due to the construction of a perceived crisis in the provision of healthcare services due to a lack of funds for the NHS (Milne, 2014). Focus has been directed at the migrant population as the cause of the deficit in NHS funds branding migrants as health tourists (Milne, 2014). The utilising of the migrant population as a "scapegoat" has generated a hostile environment within the space of healthcare where their human security pertaining to healthcare is being threatened as they are perceived as a threat to the welfare of society (Robert, 2012). Some scholarly papers argue that human security is defined by the following indicators; life, well-being, safety, human dignity, needs, vital cores, capabilities, freedoms and rights, among others (Alkire, 2002; Bajpai, 2003; United Nations Development Programme (UNDP) 1995). Due to the act of securing the nation's welfare, within the space of immigration detention, migrant detainees are treated as though they are undeserving of even the basic amenities that pertain to human rights and healthcare (the implications on human rights in accessing healthcare in IRCs will be discussed further in the following chapters). Due to the Equality Act 2010, Health and Social Care Act 2012, Human Rights Act 1998, article 3 a migrant detainee should have the right to access healthcare services in the UK (Gov.uk, 2015; 2012; Equality and Human Rights Commission, 2016; Legislation.gov.uk, 2018; Curtis, 2018). There has been a breach of this policy as immigration laws override healthcare and human rights laws in the exercising of discretionary power referred to by Schmitt (2004) through the normalising of the state of exception (Agamben, 2005) in the government's work towards achieving state security.

The HO have been turning a blind eye to Stephan Shaw's (2016) report which made various recommendations to the HO concerning the need for improvement of the conditions and systems in the IRCs of UK. Included in the list of recommendations in the Shaw report (2016) were victims of rape and sexual violence, that they should not be added to the list of those who are to be detained by the HO, that there should be better healthcare screening when detainees are well rested and should be done in private and also that there needs to be more training for IRC staff to enable them to identify victims of trafficking. Numerous recommendations were made in the Shaw report (2016), but I mention only the above from the list due to its relevance to this chapter of the research project. The senior NGO doctor I interviewed re-asserts Mr Shaw's querying of the various NGO's to confirm whether any of his recommendations from his report of 2016 concerning the detaining of vulnerable people in IRCs have been implemented. Doctors in the UK have been raising concerns about the detrimental impact of tracking down and arresting immigrants through the releasing of patients' personal information via their NHS records (Wollaston, 2018). Yet to no avail, the doctors' plea to put an end to this breaching of confidentiality by the HO in the name of border enforcement, in its normalisation of the state of exception manifested in the accessing of patients' personal information via NHS Digital which have gone unheeded. The HO argue that this strategy has proved to be a solution as it is successfully deterring migrants from accessing healthcare services (Wilkinson, 2018). The notion on the state of exception is re-iterated in the regimes of the IRCs where detainees are being deterred from accessing healthcare services and being denied of adequate healthcare treatments. This places migrant detainees instantly in a space of abjection where they believe that they are being punished and treated as criminals for failing to possess a legal status and thus do not deserve to access healthcare services.

4.5 Summary of chapter

Conclusion

Lack of compliance to IRC policies are evidenced in several instances including the routine overruling of clinical judgment by the HO due to disbelieving the doctors and compromising their autonomy. There is a lack of compliance to IRC protocols which results from a lack of training, lack of interpreters, limited time to assess detainee patients whilst attempting to follow protocols that are not understood by every practitioner. The various factors mentioned provides the HO the basis for continuing the detention of a detainee who may be otherwise deemed clinically unfit to remain in detention where such a judgment is made possible by the HO's persistent changing of IRC rules and policies. These factors generate auditing issues which has led to inadequate documentation of medical records causing a lack of continuity of care for the detainee patient and a weak case to support their legal applications for residency. Accountability and transparency of the system and its workers in IRCs is undeniably lacking in IRCs and encourages a culture of diminished responsibility to thrive. The inadequate training of staff in specialist areas to meet the needs of the various nationalities and other issues pertaining to human diversity causes low staff morale in managing and treating the detainee population which attributes significantly to the inequities in the accessing of healthcare services in IRCs (Clarke, 2017, 2018). The inconsistences in the following of protocols which causes the lack of compliance to HO policies has brought to light the need and importance of standardising systems in IRCs to assist in improving the delivery of healthcare to the subjects of immigration detention. This has the potential of helping to define more clearly the power that the healthcare professionals possess pertaining to their clinical practice and judgement where their authority would no longer be questioned by the HO due to improved compliance to procedures. The governing technique of the HO is made evident in this instance where they neglect to provide the healthcare staff with training that would enable them to comply to their rules. Thus weak implementation of policy has placed the HO in a position of power over the healthcare professionals to the extent that they dismiss the medical reports of a migrant detainee based on the lack of compliance of the doctor to HO policy in producing the medical report.

Overall, the evidence produced reflects the government's agenda for border control and reiterates the non-rights that migrants of undocumented status are presented with in the UK which renders them powerless and unable to make tangible decisions on issues relating to health and life itself. It is clear that this tool of discretionary power is being exploited by the government over the lives of the migrant detainee population and has proven detrimental to the public health of migrants in the UK due to the limiting of their basic human rights. Systems ought to be put in place to combat such cultures of discrimination and dis-empowerment from thriving within the space of immigration detention who are assigned with the responsibility of ensuring that the dignity, health and rights of the detainee population are upheld (Detention Centre Rules, 2001). The UK and its public institutions are obliged to comply with Human Rights legislations as a state that is a member of the EU Council (The Council of the EU, 2008) where Human Rights is enshrined in a society governed by democracy.

Chapter 5

Immigration detention: A new penal system and the crisis of liberal legality

There seems to be a perception constructed by the government that the establishing of policies and regulations would help to govern and bring to order the systems (procedures, protocols and structures) and subjects (staff and detainees) within the space of immigration detention. This does not seem to be the case as what has been conceived within the institutional space of immigration detention through the experiences and accounts of ex-detainees and professional workers of IRCs suggest otherwise. My analysis in this research is constructed through the accounts and experiences of migrant detainees in their attempts in accessing healthcare services in IRCs including workers who assist or provide a service relating to healthcare in IRCs. The institutional structures which are conceived within the space of immigration detention involving both the government, that is the HO department where the Secretary of State devices immigration policies to be implemented in immigration detention and the private companies employed by the government to manage IRCs form the basis of discussion in this chapter.

The first half of this chapter is based on an analysis of the interview data produced from the professional workers I interviewed to enable an understanding of the perceived and conceived space of IRCs in their attempt to implement policies effecting healthcare delivery. I explore into what extent the workers' professional practice is hampered through the contentions between loyalty and a duty of care to their patients which reveals elements pertaining to the techniques of the democratic society through which migrants are being governed. Schmitt's (2004) concept on liberal legality best describes one of the governing techniques used by the government through the use of discretionary state power in making decisions and putting measures in place that over-ride the laws of the nation for the sake of securitising the nation against a perceived threat.

The crisis of liberal legality impacting on the subjects it governs leads this chapter to the second section which introduces an analysis of some of the data from the ex-detainees

to enable an understanding of the impact the governance and culture instituted in IRCs has on their health and wellbeing. In the second section of this chapter, I introduce the ideas pertaining to the migrant detainees that will be extended in the following chapter to help bring about an understanding of the impact of governance and culture, yet more specifically IRC systems – discussed in this chapter has on the health and wellbeing of the migrant detainee population. Also included are how models of care might reflect the existence of a standardised system and its impact on the health of the detainee patient. In utilising Rose's (1999) biopolitical concept in assessing the political structures that have been constructed within immigration detention, it enables a focus to be made on the power relations conceived within this space between migrant detainees and the actors of IRCs. The whole detention experience of the migrant detainee is reinforced by the notion of the camp paradigm of Agamben (1998) as a result of the state of exception (Agamben, 2005) where the focus is on us and them or the deserving and the undeserving in the bid to securitise the nation against the perceived social and economic threat posed by the undocumented migrant. I believe the two concepts; the camp and security paradigms work well together in helping to assess the issues pertaining to governance and the biopolitical agenda of border enactment within IRCs that impact on the healthcare access of migrant detainees. The governance approach of Rose's (1999) relates to the issues pertaining to the nature in which the IRC systems have been set up. The entire chapter is based on examining the governance issues of immigration detention and its contentions with the culture and structures of IRCs that impact both the detainees and the professional workers.

5.1 The impact of IRC governance and culture on health professionals' ability to perform their duties

The type of culture conceived within immigration detention has placed a tension on the practices of healthcare professionals. This is attributed to the undermining and challenging of the HO on the health professionals' autonomy and professional judgments by the impositions of their will through the constant changing of rules on the vast number of cases relating to migrant detainees. This behaviour draws on Schmitt's concept of discretionary state power which is a form of governing that is a prominent technique of the democratic state which began in the nineteenth century and was often used (Schmitt, 2004, p.4). There is a crisis in liberal legality that pertains to immigration

detention where contentions are being formed between border enactment and public health through the normalisation of the state of exception. This form of power through the governing technique mentioned by Schmitt (2004) goes in hand with Agamben's reference to the State of Exception where constitutional rights are diminished, superseded and rejected through the assigning of power and voice to the government who is deemed as possessing authority over the lives of undocumented migrants and migrant detainees. The stressing of Schmitt's (2004) on the crisis in liberal legality as a result of the normalisation of the state of exception extends further to the impact on the immigration system through the recruiting of healthcare professionals as an extension of the judicial system. Liberal legality is also evident where implementation of policies become weak due to the imposition of the will of the HO's primary purpose; to deport, detain and disperse (Bloch and Schuster, 2005) regardless of public health concerns where border enactment and the right to healthcare converge.

There seems to be a deep-rooted culture that effects the provision of healthcare services in IRCs, which implicitly suggests (through the predominant provision of privately contracted healthcare) that migrant detainees do not have a right to access healthcare in the UK. This suggestion is expressed in various forms embedded within the system of immigration detention beginning with the strategy deployed by the government to contract out the managing of IRCs to the private companies who in turn sub-contract their services to other private companies. This technique of governing in the contracting out of services to the local people termed by Rose (1999) as new public management or good governance has been adopted by the government where they become responsible only for establishing policies whilst assigning the managing of services to the local people and the private sector. This technique is clearly evident in how immigration detention is being managed in contemporary times. I examine not how well this new technique of governing is being practiced, but how the governing practices impact on the healthcare access and provision of the subjects of immigration detention. Whether or not this practice is good governance or not is debatable. I call upon Rose's notion of good governance or new public management to examine the institution of immigration detention to draw my analysis from based on the data produced from the interviews taken with some of the subjects of IRCs in addition to secondary data (NGO reports and grey literature). I asked the senior NGO medical doctor in the interview how healthcare is provided in IRCs. This is what he said:

> Now commissioning is done nationally by NHS England. The contracts for provision vary between centres. So that, for example, at Harmondsworth, where the prime contractor to run the centre for the Home office is a company called Mitie. They have sub-contracted care to Central North-West London NHS Trust, at Brook House the prime contractor is G4S and they sub-contract to their own medical service, so there are all kinds of arrangements. At Harmondsworth, Serco are the prime contractors and they sub-contract to G4S (senior NGO doctor).

The contracting and sub-contracting out of services, including healthcare in IRCs allows the government to share the responsibility of healthcare provision in IRCs by commissioning healthcare through NHS England, Public Health England and the Home Office (PHE, 2014; Home Office Enforcement, NHS England and Public Health England, 2015) and assigning the provision of healthcare services through the NHS and private sector. The private sector provides healthcare services in the majority of the detention estate with four out of the ten IRCs in the UK contracting out healthcare services to the NHS, whilst 60 percent of IRCs contract out healthcare services to the private sector (Shaw, 2016). In light of this, various issues may arise where policy implementation may prove quite challenging with regards to the improving and maintaining of the quality in healthcare services in IRCs. Although NHS England and PHE have taken over the Department of Health and formed a partnership with the HO to deliver services, oversee and implement policies (Home Office Enforcement, NHS England and Public Health England, 2015) in the government's bid to increase local engagement and accountability (NHS England, 2015, p.8), this does not seem to have prevented the lack of compliance to the policies relating to the provision of healthcare services in the institution of immigration detention. The private sector is often reluctant to conduct routine training, appraisals and assessments of their staff due to the following reasons; it is not within their interest to spend money on additional training of the nurses and doctors they employ who are state registered and general practitioners respectively to be qualified in more specialist areas of healthcare when only the bare minimum qualification of these specialist areas is required in order to comply with the HO's rules. The senior NGO doctor expresses his concerns on the lack of training of the healthcare staff in IRCs:

> A lot of the nurses and doctors are agency and irrespective of their quality, they are not around long enough for them to know what they ought to be doing, it's also questionable what sort of training they get before they start even in substantive posts (senior NGO doctor).

This concern stated by the senior NGO doctor affirms the effect the private sector has on the delivery of healthcare services within the space of immigration detention. Healthcare staff are provided on a temporary basis thus causing a higher turnover of staff to take place which is more cost effective for the IRC than to employ permanent staff. The characteristics of the market mechanisms described by Rose (1999) pertaining to the neoliberal governance techniques is clearly at work in the provision of healthcare staff by private contractors in IRCs. As a result, migrant detainees are impacted upon in various ways that limits the quality and timeliness of healthcare and lack in the provision of specialist care. The DSOS and the health commissioners state that the provision of healthcare in IRCs and prisons should reflect the level of healthcare provided in the community (Pollette, 2002; PHE, 2014). However, as asserted by Schmitt (2004), there is a crisis in liberal legality where the HO uses its discretionary power to limit the standard of healthcare services that are delivered in IRCs through the heavy dependence on contracted healthcare staff. The reliance on contracted staff reinforces the idea of the camp paradigm in its contemporary form – that is IRCs in a democratic society where the perception is created that equity, regarding the devising of healthcare policies in IRCs reflect that of the community.

A consensus of a group of doctors employed to work in IRCs reveals their concerns as they complain about lack of training by the HO (Medact Conference, 2015). Secondly, keeping track of the doctors and nurses who provide healthcare services in IRCs on a temporary basis would be a great task for the companies in assessing and training their healthcare staff in specialist areas involving health conditions typically found in the majority of the migrant detainee population. On this basis, the best way to ensure that good governance takes place would be that the HO and its commissioning partners take the responsibility to ensure implementation of policies are adhered to by training, assessing and appraising all healthcare staff that work in the IRCs. This would otherwise result in diminished responsibility where the medical staff and HO end up pointing the finger at each other when failings occur. The senior NGO doctor re-iterates this point in the interview:

> …it is usually the case that the Home office are hiding behind the doctors and the doctors are hiding behind the Home office, so it's kind of like a shell game (senior NGO doctor).

This diffusion of responsibility has a knock-on effect conceiving additional factors pertaining to the culture existing in immigration detention which hampers the provision of healthcare services. The lead consultant doctor of an IRC in the UK I interviewed explained that there is a difference in care provided at the IRCs depending on whether the healthcare staff are recruited directly from the NHS or from private contractors. The lead consultant doctor is on the same view point as the senior NGO doctor in his statements above and emphasises that those employed from private companies require significant amount of training to enable them to cope with the diverse and particular health needs of the migrant population who tend to come from vulnerable backgrounds. Unlike the healthcare staff with NHS experience, those employed through private companies do not have the opportunity that stability within a job would present such as, undergoing regular and mandatory training, supervision, shadowing and appraisals, including specialising in a specific area to build on experience. It seems that each IRC has a system or style of operating that may be slightly unique to their centre where healthcare is concerned. This may be due to the mix in staff and where they are being recruited from – as mentioned above with regards to private versus NHS healthcare staff.

The lead consultant doctor and his team are employed from the NHS and empresses on the matter of documentation – regardless of private or NHS background being an issue where healthcare staff tend to have their own way of clinically recording their notes. This presents a case for the need of IRCs to standardise systems to enable healthcare staff, regardless of what route of employment they are coming from to adhere to the procedures and policies that govern healthcare services in IRCs to ensure an effective delivery of services. The lack of standardising healthcare systems within IRCs places the detainee patient in a position of non-power where they are subjected to the varying provisions of care. The lead consultant doctor emphasises on the need to standardise certain aspects of the clinical assessment process in all the IRCs which they have worked to set up within their own IRC. The consultant doctor conveys his concerns in the following excerpt which has been re-iterated by the senior NGO doctor in the previous statements:

> My sense is that people don't always use it properly, but it seems to be improving and again, this is generally a training issue rather than anything else, it's about people being familiar with systems, staff moving around to different places, staff not being permanent necessarily or not having the correct access or you know these are sort of governance issues as to how well people use the system… (lead consultant doctor).

The concerns mentioned in the above excerpt is explained further by the lead consultant doctor based on the fact that the patient rarely sees the same doctor twice in combination with protocol and systems not being followed properly add to the inconsistencies in the documenting of patient medical records. The lead consultant doctor mentions of how they have set up a system in their department for ease of access in the assessing and recording of the initial and risk assessment forms for a detainee patient. This system provides a template of an initial assessment which is structured in a way that can populate and guide the initial assessment by providing prompts on things that may be asked relating to a certain field. A single location is then provided through the field with all the information relating to that specific field concerning the patient rather than having to scroll through the whole detainee record. Although time constraint was not a factor that the lead consultant doctor believed to be an issue in his department of mental health, the NGO doctor strongly emphasises time as one of the major factors that restrict IRC doctors in making adequate assessments of their patients during the Rule 35 process in examining and documenting victims of human rights abuses.

In light of the operating styles of the healthcare departments within IRCs in view of the feedback from the interviews, it seems it is heavily reliant on the route of employment that is, the NHS or private company. Very few IRCs recruit staff directly from the NHS thus revealing a notable contrast in the operating style of the healthcare departments within IRCs. The lead consultant doctor and his team (recruited from the NHS) have put certain processes and systems in place that encourages accountability and defines the line between what is a HO matter and what is a healthcare matter to ensure the safeguarding and wellbeing of the detainee patient. He emphasises on the fact that the NHS, in contrast to private companies over the decades has provided quality services and safeguards for both the patient and the staff due to well-formed structures that allows transparency and accountability to take place.

Governance thus plays a major role in the operating styles and characteristics of NHS and private healthcare delivery within IRCs which essentially reveals the contrast in the general model of healthcare provision depending on which sector the healthcare services are being retrieved from. In re-iteration of the lead consultant doctor, IRCs and prisons both commission services from the NHS but IRCs also predominantly sub-contract their healthcare services through private companies. An evidential uniqueness in the organisational structure and conflict of interests are constructed within the space of healthcare delivery based on the two types of healthcare provision mentioned. The type of structure established thus defines the lines of accountability which may be easily blurred in the space of immigration detention causing the implementation of policies to become weak. Accountability thus loses its substance and effect within the space of immigration detention allowing acts of abuse, discrimination, violence and gross negligence to feed the culture of punishment conceived in immigration detention as border enactment and the right to healthcare converge (Merrick, 2018; Miller, 2015). The lack of accountability prevents lessons from being learned when gross negligence occurs. This has given rise to a culture of blame and the paying out of huge sums of money in compensations to people who were wrongfully detained in immigration detention.

> …the Home office admits to paying out £5 million a year in compensation and related murders, when somebody is wrongfully detained… (senior NGO doctor).

The above statement made by the NGO doctor I interviewed has been re-iterated by a group of experts-by-experience who are ex-detainees known as the FreedVoices who work with the NGO named Detention Action report on the answer received from the former Tory minister Andrew Mitchell of the HO to a written question concerning the cost of unlawful detention. The HO admits to paying out 21 million GBP over the last five years in compensation for unlawful detention with figures revealing that the cost of claims was 3.3 million GBP in 2016 to 2017, 4.1 million GBP in 2015 to 2016, 4 million GBP in 2014 to 2015, 4.8 million GBP in 2013 to 2014 and 5 million GBP in 2012 to 2013 (Ben, 2018). The paying out of compensations affirms the HO's unwillingness to learn from mistakes and reluctance to strengthen the implementation of policies which govern immigration detention.

The HMIP and IRCs expressed to me that the purpose of their job is to bring transparency to what is taking place in IRCs and to ensure that the government is placed in a position of scrutiny by the public, thus making the HO and IRC contractors accountable in order to reduce the likelihood of abuse. However, although this is the intended purpose of the HMIP and IRCs, they cannot force the HO and the IRC managers to comply with their recommendations as it falls outside of the remit of HMIP and IRCs' powers. This is a matter of governance to the effect that the HMIP and IRCs conduct independent inspections and recommendations of IRCs and have the authority to enter and investigate every area pertaining to IRCs without restriction. HMIP may be perceived as possessing the power to apply penalties and enforcements however, this is not the case as the lead of HMIP and IRCs made it clear to me that it would turn them into managers – which is not their intention and it would compromise their independence.

5.2 Assessment of the factors contributing to the lack of compliance to HO's policies

The weak implementation of policies exists due to the rise in liberal legality referred to by Schmitt (2004) which is conceived as a result of the imposition of the will of the HO's primary purpose; to deport, detain and disperse (Bloch and Schuster, 2005) regardless of public health concerns. Doctors express their concerns about the HO constantly changing the rules despite their efforts to do their best. The senior NGO doctor gives his account on this issue in the following excerpt:

> …you'll see the consensus statement in which the doctors employed in immigration detention centres say, "… when they do their absolute best, the Home office very often disbelieves them or changes the rules" (senior NGO doctor).

This is made explicitly evident in the data as the HO apportions blame on the inadequacies of medical notes not achieving the standard of compliance with regards to protocols and procedures that are to be followed, therefore using this as grounds of refusal for the release of numerous migrant detainees. The doctor, on the other hand may not have received adequate training in following certain procedures and protocols or may have provided limited information concerning the patient detainee's assessment proving the adverse effects that immigration detention has on their health. Doctors raise

their concerns on the time allocated in following protocols devised by the HO in order to comply with procedures such as the Rule 35 in immigration detention (Medact Conference, 2015). The time allocated for doctors is insufficient to enable them to make adequate assessments that comply with the internationally authorised Istanbul Protocol Compliant Medical Legal Report in identifying a victim of torture, trafficking, modern slavery and other human rights abuses (Medact Conference, 2015). This is expressed by the senior NGO doctor in the following excerpt:

> …most of the doctors we've spoken to have said that they get given 20-30 minutes maximum. For context, a doctor doing medical-legal report will spend several hours reading the documents before-hand, several hours with the patient and many hours writing up. So this cannot be equivalent to an Istanbul protocol compliant report (senior NGO doctor).

Research studies report that there is lack of training of NHS professionals in identifying victims of human trafficking and other human rights abuses, with health professionals lacking the confidence to respond appropriately to the needs and safe referral of the victim (Ross *et al*., 2015). Regardless of whether or not there is adequate information provided in the medical notes, when the doctors do their absolute best to adhere to procedures and protocols, the HO often chooses to disregard the medical report and not comply with their own rules and regulations that they have devised to govern immigration detention. The immigration lawyer from Duncan Lewis also expresses his concerns in the following excerpt about the kind of culture conceived within immigration detention that persistently makes the decision to detain people who are vulnerable through the discretion of the HO as they disregard the medical reports of that of the doctors:

> The Home office doctors very rarely if never, reach out to the local GPs and so forth, cos quite frankly, they don't care what the medical records say, they'll do their own brief assessment and say, "whatever the condition, it can be satisfactorily managed within detention", and I've had that being the case for individuals with 237 scars on their back, there's individuals in detention with a pace-maker and it was specifically stated that he shouldn't be within 5 miles of an airport, but he was detained at Gatwick…(Immigration lawyer).

According to the Adults at Risk (AAR) policy which is a HO policy devised in 2017 after the concerns raised by Shaw (2016) in his report on Review into the Welfare in Detention of Vulnerable Persons: A Repot to the Home Office, the HO have revised their policy on identifying people who are classified as vulnerable and at risk of being harmed by detention. The HO have devised three levels to assess a person who is perceived as vulnerable and likely to be harmed by detention; Level 1 – self-declaration, Level 2 - professional evidence that the person is at risk, Level 3 - professional evidence that a period of detention would be likely to cause harm (Medical Justice, 2018). The perceived risk to the person in question is then weighed up against three levels of immigration factors; length of time in detention, public protection issues and compliance issues (Medical Justice, 2018). The AAR policy causes issues in effectively identifying undocumented migrants who are potential vulnerable victims in preventing them from being detained. The following issue begins at Level 1 of the AAR policy where victims of human rights abuses, such as those of trafficking tend to disclose their experiences late, which is a symptom known to the HO and is often displayed by trafficked victims due to the effects of trauma, the inability to express themselves clearly, fear of their traffickers, and mistrusting those in authority (Mohdin, 2018). This thus renders such a victim unable to meet the requirements of the self-declaration in Level 1 of the HO's AAR policy. Also, the Level 2 and 3 stages of the AAR policy presents issues in effectiveness based on the statement made above in the previous excerpt by the immigration lawyer I interviewed concerning the HO's dismissal of medical reports produced by the IRC doctors of their detainee patients' physical evidences of abuse such as scars, pace-makers and medical advice following a medical examination. This reveals that people who are potentially vulnerable are not being identified under the AAR policy as being harmed by detention and are persistently being detained or have their detention prolonged by the HO.

A perception is being conceived and promoted by the government that policies are being created which are fair and mindful of vulnerable people who are at risk of being detained in immigration detention (Medical Justice, 2018). The lived experiences of migrant detainees and the professional workers I interviewed for this research study does not appear to support this perception as the policies governing immigration detention and the transitioning of undocumented migrants into IRCs have rather enabled the HO to detain people in vast numbers. This has been achieved through the exercising

of the government's discretionary power over the lives of those who have been rendered powerless to contest the decision made by the HO over their lives due to their non-legal status. The lead of HMIP and IRCs I spoke to observed that there has been a change in the level of people being detained over the years with increases and fluctuations in the numbers of those detained and released. He expresses concern over the HO's persistence to detain those that are identified as vulnerable under its own policy. Based on this fact, immigration detention may be perceived as a contemporary camp as it strongly depicts that of the camp life and follows the concept of the World War I and II era including Agamben's (1998) camp paradigm. This is due to the restriction of human rights and the disregarding of health conditions that may be adversely affected by detention. Jesuit Refugee Service UK (JRS) (2018) and Detention Action (2017) in their reports in assessing the HO's AAR policy hold the view that people are being assessed against a high evidential bar that is difficult to attain thus enabling the AAR policy to act as a barrier to the safeguarding of potential victims from being harmed by detention. This goes against the UK government's commitment to identifying and preventing of harm from falling on such victims in accordance with its obligations to regional and international law.

There seems to be a conflict of interest on the part of the HO in terms of the duty the HO has in identifying victims of trafficking, modern slavery, torture and other human rights abuses against its role to deport, detain and disperse undocumented migrants. The HO's primary concern is the issue of absconding by the migrants in question which is the driving force of their persistence to detain thus causing any compelling or credible evidences to be dismissed. This may form the basis of the HO to disbelieve claims made on behalf of the detainee patient in being a victim of torture or other human rights abuses. This concern is evidenced in various incidences on numerous occasions that have been reported on from NGOs as they raise their concerns about the persistent arresting and detaining of vulnerable people with undocumented status. Immigration detention may thus be perceived as a tool and space of punishment for migrants with undocumented status where their health and human rights are overridden by immigration laws through the assertion of sovereign authority. This affirms the association between non-status and non-rights of undocumented migrants who are at risk of being detained in immigration detention as they are stripped to bare life – that is non-rights expressed in Agamben's (1998) concept of the camp paradigm through the

normalising of the state of exception (Agamben, 2005) in the measures taken by the government to ensure state security. Kris Harris, the director for the NGO group Medical Justice gave evidence in the pubic session to the Home Affairs Committee (2018) and stated that:

> The evidence has been mounting for decades now that (immigration detention) is a harmful system that places vulnerable people at great risk of harm (Home Affairs Committee, 2018).

The NGO group Bail for Immigration Detention (BID) tweeted about the HO continuing the detention of vulnerable asylum seekers in IRCs even after they have accepted that they have been tortured. BID tweeted this extract from Merrick (2018) (Deputy Political Editor for Independence) based on a statement made by Mr Hindpal S. Bhui, the team leader for the inspectors from Her Majesty's Inspectorate of Prisons (HMIP) and IRCs to the Home Affairs Committee:

> The sample for the Rule 35 cases – people known to be vulnerable – had been carried out at Harmondsworth Immigration Removal Centre, finding torture in 9 of the 10 people examined… Every one of those people had detention maintained despite the evidence of torture being accepted (Merrick, 2018).

This reveals that a significant group of people from the public who come from a background of practitioners in health, law and inspectors of prisons and immigration detention are deeply concerned about the conditions of immigration detention in the UK due to the arbitrary treatment of people who are going through the process to determining their legal status yet, are subjected to the exploitation of authority over their human and equal rights.

5.3 A fragmented doctor-patient relationship

The culture of disbelief and mistrust are other elements of culture conceived within the space of immigration detention that may prove detrimental to the health of the detainee patient. The HO's governing technique in recruiting doctors and having some level of influence on their decision-making concerning detainee patients has conceived a space in IRCs where mistrust exists and impacts on the doctor-patient relationship adversely

causing the relationship to become fragmented. Irrespective of whether the doctors are NHS commissioned recruited by the HO or doctors employed by the private company managing the IRC, the doctors are generally perceived as agents of the HO by the detainee. This generates feelings of apprehension and mistrust between the patient and the doctor expressed by the immigration lawyer in the following excerpt:

> …if I'm, not mistaken, there are NHS commission doctors who actually see the patients, but those doctors are instructed by the Home office so their independence is sometimes questionable (Immigration lawyer).

The above statement by the immigration lawyer emphasises on the reason why detainee patients are reluctant to confide in or voluntarily give out information concerning their health and medical conditions. As a result of this, migrant detainees are pushed into a space of non-power where they making the decision to not seek or pursue further healthcare services – as referred to by Bachrach and Baratz's (1962) concept concerning the non-ability in the decision-making process of the migrant detainees about their health, thus creating a barrier in their healthcare access. This causes migrant detainees to adopt a culture of mistrust as they exist within the space and institutional culture of hostility against migrants attempting to access healthcare services. Migrant detainee patients tend to mistrust the doctors assuming that the doctors' loyalty lies with the HO first before considering the detainee patient (known as dual-loyalty). This mistrust is based on the fear of an extension being placed on the length of their time spent in the IRC or that they may be fast-tracked and face expulsion with immediate effect. This point is also observed by the senior NGO doctor:

> …in many cases between the detainee and the doctor who may be perceived rightly or wrongly as taking the side of the detainee authority against their patient… (senior NGO doctor).

The institutional culture of hostility in the healthcare access of migrants conceived within the space of immigration detention has placed healthcare professionals in a situation where they are forced to choose a position of loyalty to the HO which often causes a neglecting of the duty of care to the patient. The conception of a hostile environment within healthcare services is a concept initially created by the then Home Secretary Theresa May in 2012 and was renamed as a compliant environment in 2018 by the new Home Secretary Sajid Javid. Despite the re-branding of the term to

compliant environment, the present Shadow Home Secretary Dianna Abbott emphasises that no one is being deceived by the new term, that they both mean the same thing as the purpose behind the new term has not changed (Mahase, 2018). This has conceived a kind of tension impressed on healthcare staff as to what the primary purpose of their practice is; to provide healthcare or to provide the HO with information about the identity and residential status of their patients. This sets a basis of mistrust within the doctor-patient relationship where the detainee patient is placed in a space where they lack the confidence and trust in disclosing their experiences and health conditions. Roses' (1999) healthism idea is affirmed in this instance and within the context of this research study refers to the healthy lifestyle choices of the migrant detainee being influenced by the involvement of the HO through the institutional culture of hostility which deters migrant detainees from seeking the necessary healthcare services.

The lead consultant doctor of the IRC impressed on me that clear boundaries have to be set between the clinical team and the HO team in terms of data-sharing of detainee patient health information – thus being mindful of breaching confidentiality of their patients. He went on further to state that there needs to be transparency concerning what the clinical team's objectives are as they are not the same as that of the HO. Although the clinical team are mindful of the partnership role of the HO, the lead consultant doctor emphasises that the HO ought to be careful of the information they decide to share with the clinical team as certain information pertaining to a detainee patient that comes to light which has the potential of posing a risk to the detainee's health will not be ignored by their clinical team. There is evidently a contrast in the commitments of loyalty to the HO based on the route of recruitment the healthcare staff are coming from – NHS or private. The lead consultant doctor who is employed by the NHS affirms that the commissioning technique used by IRCs of healthcare staff and services being provided directly from the organisation managing the IRC mirrors that of prisons from twenty years ago. He states that the prisons' healthcare services have developed to commissioning mainly via NHS which he believes has improved the level of care and safeguarding for both the prisons' patients and staff as compared to that of the IRCs. The senior NGO doctor had a migrant detainee patient who attended a consultation committee meeting at his IRC where he had been nominated to become a member of the committee. One of the questions he raised to the senior administrator of the NHS at the meeting was:

"to whom do you feel responsible, the NHS or the Home office?" (migrant detainee),

the senior administrator's response was:

"the Home office".

The enactment of the border in IRCs is perceived by the government as a technique of bringing to order the management of migration in the UK (Agamben, 2005, p.14; Bigo, 2009; Butler, 2004), thus disregarding boundaries and infiltrating systems within the various institutions of the UK, particularly those pertaining to social care and the health sector. NHS Digital previously known as the Health and Social Care have deployed strategies in the UK where personal patient information regarding their identity and residential status has to be provided and passed onto the HO before a patient may be able to access healthcare (Department of Health, Social Care and Home Office, 2017). A new space has been conceived within healthcare where it is no longer free to all at the point of delivery. Rather the enactment of the border in obtaining people's identity and residential status has become the focal point within the space of healthcare rather than the delivery of services. This institutionalised culture of hostility – in the sharing of patients' personal information with the HO is evident in immigration detention which has given rise to a type of tension impressed upon doctors as to where their loyalties lie; to the patient or to the HO. Their ethical practice which is based on the Hippocratic Oath is a principle of confidentiality taken by health professionals which has established a relationship of trust between the health professional and the patient (North, 2012). This has taught them to have a duty of care to the patient first in safeguarding their health and personal details, however the HO has created a tension with the imposition on doctors requiring them to act as border guards first before providing healthcare (BMA, 2017, p.5). Thus, conceiving a new arm of the law that is extended through health professionals by recruiting them as border guards where they are expected to turn-in or serve deportation notices to patients on request of the HO.

The crisis in liberal legality is affirmed in this instance where the government uses its discretionary power to deploy tactics that override the laws of the nation to enable them to gain access to patients' personal information, which would not have been ordinarily permitted due to breaches in confidentiality. This is evidence of the state of exception at work where the government normalises actions or governance techniques in the name of

securitising the nation against a perceived threat. Such incidences are becoming common-place where a GP in Liverpool was asked to hand over a patient to the HO at his or her next appointment by serving a deportation letter as the patient had a mental condition (Bostock, 2018). The HO deemed it appropriate that a GP's expertise would be best suited in dealing with any un-for-seen circumstances that may potentially arise from handing out such an order. This doctor refused to be involved in the border enactment process or for his profession to be used as an extension of the law in handing over patients to the HO (Bostock, 2018). This behaviour of staff who are not health professionals challenging the clinical independence of doctors due to disciplinary and security issues emphasises on the crisis of liberal legality where immigration laws supersede healthcare and human rights laws, a culture that is amplified in IRCs.

This technique of governance mentioned by Rose (1999) in delegating power to the local people by turning them into border guards is un-ethical to the extent that the professional autonomy of doctors and their duty of care to the patient is being compromised. Doctors are the figures of society who often advocate for marginalised groups of people and for those who are vulnerable thus ensuring that the dignity, comfort and safety of the patient is not at risk.

5.4 Summary of chapter

Conclusion

In conclusion, the evidence of "good governance" being attributed to the practicing of the "new public management" of assigning managerial responsibilities to the local people and the private sector argued by Rose (1999) is clearly functional and has proved successful in producing the desired result expected from engaging in market mechanisms which involve aspects such as; competition, profit making, supply and demand. In the context of this research topic, supply refers to the migrants being detained in IRCs and demand refers to the IRCs reliance on the detaining of migrants to drive up profits. However, the perception constructed by the government that the establishing of policies would bring to order the systems and subjects of immigration detention is arguable. The enabling of good governance suggested by Rose (1999) to

thrive in the context of immigration detention has grave implications on the migrant detainees' health and wellbeing causing inequities in the accessing of healthcare services.

The first-hand experiences and accounts of detainees and professional workers suggest that the technique deployed in governing immigration detention has not been effective in achieving equity and ease of access to healthcare services. This has become the case due to what has evidently been conceived within the space of immigration detention regarding healthcare service provision and access. Healthcare professionals in immigration detention are impacted on in a way that hampers their ability to carry out their duties effectively along with the fear instilled in detainees which deters them from accessing healthcare services. This has caused the relationship between the doctor and the patient to become fragmented due to the construction of dual loyalty as a result of the recruitment of healthcare staff by the HO and the perception from detainees of doctors as border guards.

The normalisation of the state of exception by the government in deploying techniques to securitise the nation against a perceived threat – being that of migrants to the welfare and security of the UK society suggests that the government has a hidden agenda and are rather concerned with state security and protecting their borders than the welfare of its citizens. This concern has been presented in the guise of a threat posed by the migrant population by constructing the idea that they are responsible for the ills of the UK society. It has become the norm to apportion blame to those whose voices seem muted in society due to their non-rights where the short-comings of governing the nation is attributed to migrant infiltration as the cause of limited resources and the rise of levels in crime.

Hence, the notion is conceived that migrants are deserving of punishment which presents itself in the hostile environment constructed by the UK government, through the stripping away of the basic human and health rights which is evidenced in its entirety within the space of immigration detention. This has conceived barriers to healthcare access for migrant detainees and has brought about challenges in the delivery of healthcare services where healthcare professionals' ability to do their duty is hampered under the governance of the HO and the IRC managers. The functioning of liberal legality in the HO's use of discretionary power has led to further infringements

on the rights of migrant detainees where they are impacted upon adversely through the inadequacies in the healthcare provision as a result of the lack of accountability of IRC and healthcare staff. The government's deploying of governing techniques has been produced in the form of weak implementation of policies evidenced in the lack of training, lack of supervision, lack of transparency and the lack of establishing systems that effectively report, monitor and evaluate cases of illnesses and disease in IRCs. This has conceived and institutionalised elements of mistrust between the doctor and the patient – as a result of dual-loyalty of the healthcare professionals in their tendencies to feel responsible to the HO. The element of disbelief by the HO is also conceived regarding the evidences produced in the medical records of detainee cases presented to them causing dismissal of cases which they justify is due to the lack of compliance of doctors to procedures and policies.

Chapter 6

The Mechanisms of Disempowerment: Migrant Detainee Health and the Inequities in Accessing Healthcare in IRCs

In this chapter, I implement the conceptual analytical framework influenced by the biopolitical notions of Agamben's (1998; 2005) camp paradigm and state of exception respectively. In addition, Rose's (1999) healthism concept is applied along with Lefebvre's (1980) trialectics of space; lived, conceived and perceived spaces. This is supported by Bachrach and Baratz (1962) concept on the ability or non-ability in the decision-making process of migrant detainees about their health in Immigration Removal Centres (IRCs) support the main concepts of Agamben in this chapter. The application of these theories bring to light the cultural sociological aspects of the lived and conceived spaces of hostility and abjection within IRCs in the accessing of healthcare services of migrant detainees where they are reduced to "bare life" and stripped of their legal and human rights. The perceived space of "them" and "us" is created by the government through the normalisation of detention, deportation and dispersal of migrants with irregular status in their attempt to securitise the state (as their focus to protect their borders supersedes the securing of the welfare of its citizens or us) against the perceived threat - migrants or them. The lived space of IRCs for migrant detainees is viewed under the public health pathways to help in identifying inequities of healthcare access.

6.1 The variations of power and space in context

There are three variations of power that are explored in this research study that focus on the embeddedness of power and space at an individual, institutional and societal level thus revealing the social production of space expressed by Lefebvre (1980). This begins with the normalisation of strategies deployed by the government thus creating a perceived space of the assurance of state security exerted by Agamben's (2005, 1998) biopolitical concepts. This variation of power is evidenced in the lived space of migrant detainees who are stripped of their legal and human rights and are affected through the

utilising of discretionary power by the HO conceived within the space of liberal legality – relating to Schmitt's (2004) concept where there is weak implementation of policies in IRCs as the interests of the HO prevails. The second variation of power is represented in the government's lived space in the forming of governance strategies where they assert their authority by enacting border controls. This is achieved through the deployment of tactics that conceive a space of hostility within the healthcare service against migrants and migrant detainees that enables the infiltration into systems and the coercing of the public into becoming border guards. This is evidenced in the lived space of the healthcare professional's ability to do their job within the conditions of an IRC, where their autonomy is challenged by the HO who attempt to recruit them as an extension of the judicial system. The governance strategies of the decentralisation of state power explained by Rose's (1999) concept in the transferring of authority of the government to the people is evidenced in the government becoming less involved in the provision of healthcare services in IRCs. The final variation of power is based on Bachrach and Baratz's (1962) concept which focuses on migrant detainee's non-ability in the decision-making process where they are unable to make tangible decisions about their health. This is as a result of the migrant detainee being pushed into the conceived space of disempowerment through the instilling of fear of being detained, deported and dispersed by the HO. These three variations of power operate within the trialetics and social production of space which form the basis of analysis for this research study.

In utilising the above mentioned theories in creating an analytical framework, the presupposition is power and space where the tools of control and punishment are formed by the instilling of fear and the undermining of legal and human rights within IRCs. This is evidenced in the data produced in this chapter through various factors where detainees are thus prevented from making a tangible decision about their healthcare as they are pushed in the direction of non-ability in the decision-making process whilst being held in the conceived space of abjection. This has a bearing on migrant detainees' socio-economic and political position as they experience exploitation of labour due to the need to purchase amenities within the IRC such as; their medical records, food, clothing and the paying of rent for the cell they are detained in. Monetary allowances are provided for detainees by the government along with donations from charities however, detainees are told by the IRC staff that they have to purchase the donations. Migrant detainees are impacted upon through their irregular status where

they are perceived as criminals and used as scapegoats for the ills of society. This is made evident through the normalisation of them and us referred to by Agamben's (2005) state of exception with the aim of securitising the nation against a perceived threat where HO policies are contradictory and weak in implementation. IRC procedures and systems generally reflect that of prisons and are mostly superimposed into the IRC system thus re-affirming the culturally social and institutionalised attitude towards migrant detainees as criminals or undeserving. Various issues mentioned in this chapter inform on the political factors concerning migrant detainees which are evidenced through various instances revealing their position of power.

6.2 The socioeconomic and political context of the CSDH

The socioeconomic and political context of the CSDH model (Solar and Irwin, 2007) are the structural determinants that reveal what the SDH of health inequities are. To enable a discussion to be formed within the socioeconomic and political context of the CSDH model, a breakdown of the intermediary factors that is, the behaviour, biological and psychosocial factors and material circumstances forms the basis of the investigation of this research study. This is in order to be able to explore how the governance and power relations of IRCs affect the intermediary factors of migrant detainees and how this determines the level of equity in their healthcare access, health and wellbeing.

6.2.1 The behaviours, biological and psychosocial factors of migrant detainees and IRC systems that impact on the inequities in healthcare access

In identifying the behaviours, biological and psychosocial intermediary factors of the SDH for migrant detainees based on the public health's CSDH model (Solar and Irwin, 2007, please refer to Appendix E), the understanding is that detainees are entering IRCs with illnesses that become exacerbated by the conditions of the IRC. The intermediary factors exist as a result of the structural factors of the SDH which are placed within a socioeconomic and political context conceived in IRCs and is examined through the bridging of the gap between power and the production of space.

The lived space of migrant detainees within IRCs expressed in this research study – particularly this chapter reveals that the conditions of the IRC cause illnesses to be acquired or exacerbated. The following section provides insight into the lived, perceived

and conceived spaces of migrant detainees pertaining to the various routes that they experienced which lead to their detention in an IRC and how the variations of power at work has a bearing on their behaviours, biological and psychological position concerning their health upon arrival and during their detention in an IRC.

The type of population I have been interviewing are predominantly male ex-detainees with the exception of one who was a detainee at the present time, ranging from the ages of 30 to 60 years. The participants are coming from various backgrounds and experiences which have lead them to enter the UK and overstay their visas causing them to eventually be detained in an IRC. All the participants I interviewed have been detained for at least one to five months at a given time which – in most cases occurred multiple times ranging from a one to three-year period. A majority of the ex-detainees I interviewed for this research stated that they have been detained in more than one detention centre. Participant F, for example, revealed in the interview that he was detained in four different detention centres. Another male participant – Participant I, despite being detained on multiple occasions was also detained in a prison for a period of time even though he had not been convicted of a crime. Two of the three female participants expressed that they were fleeing domestic violence which was their intentions of coming into the UK. One of the female participants – Participant N stated that she came to this country due to an issue with her husband regarding domestic violence. Two of the other female participants – Participant P and Q (separate cases) were fleeing from their step-father who had abused them resulting in pregnancy thus causing them to come to the UK.

The male participants entered the UK for either with the intention to visit or seek asylum due to fleeing war, or to join the army in the UK. The participants overstayed their visas mainly due to applying for asylum or indefinite leave to remain which has either failed or is in the application process, whilst one participant had embarked on a course to join the army but was taken ill in the process being diagnosed with diabetes and brain tumor. A couple of the male participants were first detained either in a police cell or a STHF for some days or weeks before being sent to an IRC. Others were picked up by the police or immigration officers at their home, workplace or police station – after being picked up on the street by the police. The majority of participants explained how they were driven for long distances after they were picked up by the immigration

officers and arriving in the very early hours of the morning ranging between 2am to 8.30am at their designated IRCs.

The participants I interviewed shared accounts of the various types of illnesses they acquired during their detention in an IRC. This reveals how detention exacerbates illnesses. The detainees I spoke to some acquired tooth-ache, stomach ulcer, stomach aches, eye problems, mental conditions, disabilities among others during their detention in an IRC. The following excerpt expressed by Participant I reveals the type of challenges that detainees are faced with in accessing the healthcare they require:

> I was not deserved to be in detention in the Block, I was deserved to be in the hospital because they're not qualified to look after me, they've not been trained to look after me, that was the issue.. (Participant, I).

The lack of compliance – which is a term used by the IRC staff of a detainee in not adhering to the rules of the IRC subjects them to being punished whereby the HO and IRC staff deem it necessary to place a detainee in solitary confinement (termed "the Block") with their privileges taken away which includes the lack of access to healthcare services. Healthcare is a basic human right and not a privilege which is expressed in the DSOS (Pollette, 2002) and PHE (2014) that the provision of healthcare services within IRCs are to match what is provided in the community. Participant I was unable to comply as he was experiencing mental health illness as a result of depression due to issues with his legal case which affected him gaining access to his daughter and the fact that he was being locked up in a country where he sought refuge in fleeing for his life from his country of origin. Participant I experienced barriers to receiving the specialist care that he needed due to HO policies where he was suffering from mental health illness which he explains was due to depression and anxiety causing him to self-harm and behave erratically, which he expresses in the following excerpt:

> I was there for 3 months, I was told until I try to behave normal yer, I'm not going to get back to the wing, so now I'm crazy, they're not referring me to a mental health hospital and they're asking me to behave normal and how can I behave normal when I'm crazy? … And I'm not getting my medication and now they've blocked all the nurse to come and see me because they just see me as "oh why do you bang your head on the wall? You're doing this purposely" this

> time I'm not doing this purposely, you know this time I'm crazy, I'm traumatized, I'm mad… (Participant I).

As explained in the above excerpt, the HO policy to detain Participant I in solitary confinement for three months at two IRC sites in Heathrow's IRCs (Harmondsworth and Colnbrook) prevented him from receiving the specialist care that he needed. In the paper by Athwal (2015) he reports on the victimisation of male detainees particularly those from the black minority ethnic Asian (BMEA) community who are stigmatised as bad people by the IRC staff and the HO rather than considering the possibility of a mental illness. The behaviour of Participant I – if this had taken place in the community would require a psychiatric or some form of mental healthcare. NHS England who is responsible for commissioning healthcare in IRCs as well as the community in England has a duty to ensure that the same level of healthcare is accessible to detainees – both migrant and non-migrant, adult and children as compared to the citizens of England (NHS Commissioning, Direct Commissioning Change Projects Team, 2016). This form of specialist healthcare or any form of health assessment by a doctor or specialist clinician was denied Participant I and was rather being told by the IRC staff and HO that he must behave himself and comply before he can be released from solitary confinement and have his privileges returned to him. Despite being told this, he was unable to comply and was eventually taken to a nearby prison to be detained there. Similar incidences have taken place in IRCs where migrant detainees are threatened with being transferred to prison or with immediate deportation because they are seen as "trouble-makers" as a result of being outspoken or taking a stand against the kind of treatment detainees were subjected to thus, were catagorised as not compliant with IRC rules. Examples are found in the following excerpts by the two female ex-detainee participants, Q and P:

> …these people sometimes they take advantage because their English is so poor, they can't really say anything… and one of my friends, …because we had always been active in Yarl's Wood anyway, I remember me and her, we were warned by Serco that they were going to put us in Kingfisher, Kingfisher is like a jail under Yarl's Wood so because we used to report incidence outside to Movement for Justice (Participant Q).

> …so they gave us letters saying, "if you continue to resist food and drinks, we're going to accelerate your case, we're gonna deport you" and stuff like that and I remember the doctor calling me in and saying, "if you continue to be on hunger-strike, you need to find a letter that we're not liable for any health hazards that would happen to you", like resuscitating, in case I faint or anything, that I should sign a letter and I refused…(Participant P).

Movement for Justice is one of the NGOs that have a regular presence in Yarl's Wood IRC – due to their volunteer detainee befrienders who visit detainees and offer some level of support and connection to the world outside the IRC. Participant Q and P took their stand against the unjust treatment they and their fellow inmates at the Yarl's Wood IRC were receiving which caused them to be threatened by the HO on various occasions with imprisonment at the local prison as punishment for speaking out. Few other detainees also took a similar stand in fighting for their rights as expressed by Participant P in the excerpt above. The lead of Her Majesty's Inspectorate of Prisons (HMIP) and IRCs I spoke to regarding this issue expressed that if a detainee is posing a danger to himself or others, he is then placed in confinement based on health and safety. He further emphasises that the purpose of an IRC is not to place detainees in confinement with the intention of punishing them whatever the reason may be. However, based on the findings of this research project, it seems that there is an intentional denial of specialist care which is being used as a tool to subdue detainees into compliance in a number of cases, as expressed in the previous excerpt. The following excerpt by Participant D is another example of the denial of specialist healthcare to a detainee suffering from a toothache:

> … I was having a tooth ache and it gave me a lot of problems, you understand, so they told me that I have to speak to one of the officers directly that if this thing is getting worse and me too I ring, made a serious complaint, they gave me nothing, where eventually I was able to meet the nurse on duty in the clinic … So after all this and that, they even told me that "…I have to be in detention for one year, they can look into my proper case…". So with that, I just have to bear it and the only thing they did listen to me are the pain relief drugs… (Participant D).

The above excerpt reveals that Participant D was threatened with an extension on his detention in the IRC for up to one year if he continued to pursue treatment for his toothache. He made the decision to no longer seek dental care and to bear with the pain and request for paracetamol or ibuprofen – which were the pain-relief drugs he mentioned were supplied in the IRC. The decision to no longer pursue healthcare after initial attempts and then being threatened with deportation was re-iterated by all of the ex-detainee participants. An example is expressed in the following excerpts by Participant Q:

> …most women are vulnerable, even when they're feeling pain, they're not gonna go and report because they're not gonna trust the person they're reporting to and they know the fear of, if I say something that's gonna effect my case (Participant Q).

The role of fear works as a barrier to migrant detainees accessing healthcare services which seems to be used as a tool in which to deter detainees. There are HO policies concerning the delivery of healthcare services in IRCs that are not being complied with due to the techniques being used rather to instill fear in the detainees by the IRC staff in order to deter them from seeking healthcare services. All the ex-detainee participants expressed how they approached the IRC officers when they were ill as their initial attempt in accessing healthcare during their detention in the IRC. The majority of cases recount being offered paracetamol or ibuprofen in response to their illnesses where the following excerpt reveals the policy devised in the Yarl's Wood IRC's healthcare department where Participant P (a female ex-detainee) approached a nurse to book an appointment to see a doctor, but was told to follow this procedure:

> …sometimes they would actually ask if you end up with any pain, they'll tell you to take paracetamol four days, like, "oh you'll have to take paracetamol at least four days, then we'll make you see a doctor, then we'll put you on our appointment list for a doctor" (Participant P).

Few and specific cases occurred relating to the participants I interviewed whereby a referral to see the doctor in an IRC would follow the procedure laid out in the DSOS (Pollette, 2002) and NHS England's (Public Health England, 2015) national guidelines, even then it would be based on the discretion of the IRC staff and the HO at the time. This may be a combination of policy implementation and a lack of resources in not

being able to supply detainees with the appropriate medication according to their specific illnesses. Participant E in the following excerpt also re-iterates this frequent administering of paracetamol in IRCs by the staff in response to detainees' health conditions:

> … if you have a blurry vision they give you paracetamol, if you have a broken leg, they give you a paracetamol, if you have cold, they give you paracetamol, anything is basically paracetamol over there… So I don't think they really care about anybody, they're just doing their protocol, following protocol. (Participant E).

The non-prescription drugs – paracetamol and ibuprofen seem to be the two main drugs given to detainees on a frequent basis in response to their illnesses as mentioned by the participants. Kalms – which is also a non-prescription but over-the-counter drug seems to be dispensed frequently in response to those who suffer from depression. Participant Q expresses her experience in the following excerpt:

> I developed really bad depression when I was in there… they take me one time to have some bloods done outside Yarl's Wood…they said, "oh everything is ok", but I still felt that I wasn't well and the only thing they could give me in the end was just Kalms, these pills that help you sleep, but that's not what I wanted and I kept saying, "I don't want to sleep, I want to feel ok, but I'm not ok", it's just not the attention you'd get from the hospital (Participant Q).

In the case of Participant F, he had his anti-depressant medication taken from him and locked away by the healthcare staff and not given to him during his time in detention. Participant F was advised countless times by the nurses and IRC staff to earn a living in the IRC to help treat his depression and insomnia despite being placed under the Rule 35 category (this means that he was examined by the IRC doctors and documented as a victim of human rights abuses which has been acknowledged by the HO) when he entered the IRC. This is expressed by Participant F in the following excerpt:

> but I wasn't sleeping when I was in detention... my medication was self-administered …when I was outside, but inside they had it locked up, like they don't believe me, I was taking anti-depressants and at the point I was taking it… I couldn't sleep, they asked me that I should go and work, it will help my mental health, it would help me to sleep (Participant F).

Participant F was classified as a victim of torture and human rights abuses by the HO as he had been examined by the IRCs doctors under the Rule 35 – which is a HO policy. However, his anti-depressant medication was taken off him and not replaced, he was rather being advised to work for less than the minimum wage in the IRC as an answer to his health problems. This reasserts the notion of Agamben's (1998) camp, where migrant detainees are reduced to bare life with their rights taken away from them, as the border control techniques that are deployed reaffirm that migrant detainees are undeserving of human and healthcare rights. The denial of medication for migrant detainees is presented in another case involving Participant P in her request for a non-prescription drug to treat her sinus condition but was refused by the healthcare team who told her that this medication is not a prescription drug so the IRC cannot order it for her. This is expressed in the following excerpt:

> I had to literally run around asking for it and they were telling me "we can't get it in" and I told them can I get someone from outside to get me the Olbas oil, cos when I turn to health and they were saying "no its not on our prescription list" so it was such a hassle to get it, so like it got to a point where I had to write a letter and ask for it officially and when I get there the nurse that I actually spoke to tells me "oh, I forgot about it".. (Participant P).

The letter that Participant P spoke of in the above excerpt had to be written in order to request for the Olbas oil as it was not on the healthcare's list of medication that they provide for the detainees. This would cause the request for non-prescription medication to take a great deal of time to obtain after the request is made, if they are successful in being provided the medication by the healthcare team. Participant P explained how she persisted in trying to obtain this medication – which was her regular medication pre-detention to the extent where she broke down and cried causing the Christian patron to offer and find a way of getting it for her. The denial of this particular non-prescription drug to a detainee seems to contradict the basis upon which the IRC stand on in doing so. The assumption may be that the IRC have limited the access to other non-prescription drugs where they make available specifically the two analgesic drugs, that is the paracetamol and the ibuprofen due to the simple reason of wanting to keep the costs to themselves - as private contractors to a minimum. Liberal legality is at work here where the discretionary power of the HO permits the IRC staff to make their own rules pertaining to the supplying of non-prescription drugs to detainees thus causing the

IRC managers to assert their will over the lives of the detainees by providing them with bare minimum of resources, including limiting the supply of medication.

In view of the feedback from all the participants – with the example presented by Participant D, E, Q and P in the excerpts above, detainees generally felt that the IRC staff did not care about their health and the illnesses they were suffering from due to the response of the staff in administering detainees with paracetamol regardless of the type of illness they were complaining of. The majority of ex-detainee participants expressed how they were not assigned a date for an appointment to see a specialist or a doctor for their specific health conditions until the day after their release from the IRC. This is re-iterated in the following excerpt:

> …the day they were about to transfer me, that was the day they gave me a date and I still haven't got anything. Imagine, does it take 5 months for somebody to get attend to? No. and they don't follow the medical history when you're outside (Participant E).

Significant delays in receiving an appointment to see a doctor at the IRC was expressed by all the participant ex-detainees I interviewed, with delays also expressed by the participants pertaining to the acquiring of medication that have been placed on request by the IRC doctors on behalf of the migrant detainees. This caused frustrations and exacerbation of illnesses expressed in the following excerpt:

> …cos I wasn't feeling well at all, at this point and because I'm asthmatic, every stress I got, I really got bad, so I felt like they were not really doing much that's why I had to reach out to Medical Justice… I was in Yarl's Wood, when I went to the GP outside they didn't give me anything, I think it was maybe 2 weeks after, I think the results came in they gave me, these are the pills, I don't even remember their names but they just said I had an infection or something like that (Participant Q)

When illnesses have become exacerbated to the extent of requiring a trip to the hospital, detainees are fearful of being placed in handcuffs as is the HO procedure for escorting detainees to the hospital where they feel the shame of the public perceiving them as criminals as is the connotation of wearing handcuffs. This adds to the trauma and anxiety of the migrant detainee, as expressed by the experiences of the female

(Participant Q) and male (Participant F) ex-detainee participants in the following excerpt:

> When I got to the doctor, the doctor was normal, they were even kind and very, I don't know whether its because they knew that this person is coming from Yarl's Wood cos it was obvious, I was in handcuffs when I went to the doctor. And you know the feeling that everybody is actually looking at you, it's not like they're hiding it and I remember there had to be a female officer in the room with us, …so I wasn't expecting that the officers were gonna stand outside, … its degrading, I remember that feeling, I kept saying to myself, "oh my God", and then in that moment you just say to yourself, "why did I say I'm not feeling well?, I should've just endured it"… (Participant Q).

> I was tested right in detention for emergency purposes, they called the ambulance to airlift me from The Verne to the A&E, I was held in chains. 2 immigration officers were there with me, despite that fact that I was handcuffed, chained to the bed like a dog, so, I was sobbing cos I didn't even know what was wrong with me… (Participant F).

The fear of being placed in handcuffs is a barrier to the healthcare access of migrant detainees as they become apprehensive of approaching the healthcare services in the IRC for their health conditions. The detainees also express the reluctance of the IRC staff to make a referral of the detainee to the hospital as in doing so, may potentially strengthen their case for a swift release from detention. This may be also noted in the case of the woman who collapsed during the time she was lining-up with her fellow detainees to receive her medication. The ambulance was called by her fellow detainees, but when it arrived, it was sent away by the healthcare staff who later were left with no choice than to call the ambulance back again to take the woman to the hospital. After being treated at the hospital, the woman returned to the IRC wheelchair-bound due to the extent of the damage that was inflicted on her as a result of the delay in the timely healthcare she required at the IRC that may have potentially prevented her health condition from becoming exacerbated. This was re-counted by Participant Q in the following excerpt:

> I remember asking her like, "do you really want her to die here?" and now this is freaking everybody because we were like 10, 15 of us that are going to get

> medication, so now one of us is on the floor and then they're chasing us, but they haven't called an ambulance, yer maybe they did first aid but they're not merciful doctors at that situation, we called the ambulance outside, when it came, they sent it back… but the time the ambulance came and I think they took her but when she came back she was in a wheelchair and that's how she stayed (Participant Q).

The above cases further asserts the notion of the camp and the border control style of governing migrant detainees by reducing them to death through the stripping away of their rights in order to secure the nation as they are perceived as a threat. In support of the case presented in the excerpt above, another barrier in accessing specialist healthcare is frequently the situation that detainees find themselves in – if the detainee is fortunate to be registered with a GP prior to detention. The majority of ex-detainee participants I spoke to were not registered with a GP prior to being detained in an IRC. A few of the people who did not have a GP later acquired one that was an NGO GP whilst being detained or upon release. Participant F and N express the lack of communication in the following excerpts between a detainee's existing GP, the detainee and the HO:

> I now gave the HO my GP details to contact him, since its my GP that has been talking to me mouth-to-mouth before, but the moment I gave the HO his contact details, he stopped talking to me completely… (Participant F).

> I was living as an illegal immigrant, so by the time I got to detention, the GP I was using, I couldn't use it any longer… (Participant N).

Participant F expresses how he lost contact with the GP he was registered with after giving his GP details to the HO when he was detained. He has a history of depression and had been prescribed medication of anti-depressants prior to detention. Participant F explains how he had been in constant communication with his GP during detention at the IRC however, the communication he had with his GP ended abruptly after he gave the HO his GP's contact number. It seems to be the case where some GPs are reluctant to maintain patients who have been detained by the HO which is re-iterated by Participant N (in the above excerpt) for those who are fortunate enough - although rare to be registered with a GP despite their irregular status. This may explain why detainees often do not have access to their medical history or records upon entering an IRC. Thus

the IRC doctors tend to rely solely either on or in combination with the accounts from the detainee, the information given during the detainee's initial health assessment at the IRC (depending on whether or not this health assessment was done) or what has been communicated to them by the HO caseworker upon their arrest aside from their own assessment.

Another barrier to a detainee receiving specialist healthcare in an IRC pertains to the Rule 35 (Medact Conference, 2015) which is a procedure that a detainee who has experienced human rights abuses, such as, trafficking and modern slavery, torture, gender-based and domestic violence, female genital mutilation (FGM) and other human rights abuses is referred to see the doctor at the IRC for a medical examination in order to create a report which is kept in the detainee's medical records.

> Even the doctor who did the Rule 35 and everything they said there's inconsistency and it is not an independent medical evidence, so it cannot be accepted (Participant H).

The above statement by Participant H reveals that IRC doctors' reports are denied by the HO despite it being based on a medical examination of a detainee who has undergone the process of a Rule 35 (Medact Conference, 2015; Shaw, 2016). The doctors' report from their assessment of a detainee under the Rule 35 procedure would usually be grounds for the release of the detainee but is often rejected by the HO (Shaw, 2016). The grounds for dismissing a Rule 35 report by the HO is often mainly based on two arguments. The first argument is that the report has been influenced by the detainee's account - which the HO deems to be inconsistent and that the doctor has not used their clinical judgement. The second argument by the HO is that the doctor has not followed the protocol for the Rule 35 procedure correctly (Medact Conference, 2015). These two arguments are often what the HO base upon to render a medical report from a doctor in the IRC as invalid and not an independent assessment thus deeming it necessary to continue the detention of detainees who are victims of human rights abuses. The detention of such victims in IRCs goes against the HO's policy of detaining people coming from vulnerable situations and acts as a barrier to the detainee receiving the necessary and specialist medical care that is required in treating such patients that may not be readily accessible in IRCs. Participant H and F have been detained on several occasions and recalled how after being transferred to one of the IRCs that on

their first day of arriving at the IRC the nurse approached them with a file of their health conditions. The information in the file enabled them to be booked to see a doctor under the Rule 35 procedure for a medical examination and documentation to be carried out to establish that the two participants fall under the category of vulnerable person that is, victims of human rights abuses.

The two examples above are evidence that continuation of care is possible and can only work if there is an adequate level of record-keeping pertaining to the medical records of migrant detainees that meet the guidelines set out by NHS England, PHE and the HO – who are joint commissioners for the provision and monitoring of healthcare services in IRCs (PHE, 2014). Participant J was detained for six to seven months in four different IRCs in the UK and experienced episodes of seizures whilst being detained because he suffers from epilepsy. He was also diagnosed with a brain tumor before being detained with the HO aware of his health conditions prior to detention, but this information either does not appear to have been communicated between the various IRCs he was transferred to or was disregarded due to the HO's primary concern that the detainee is likely to abscond. Communication between the IRCs in the UK in the sharing and transferring of detainee medical records is key to maintaining the continuation of care for migrant detainees, which is rarely practiced. Lack of communication between the IRCs concerning the sharing or transferring of a detainee's medical records causes barriers in a detainee requiring specialist care from receiving the necessary healthcare needed to treat their health conditions efficiently and effectively. The issues pertaining to confidentiality in the sharing of detainee medical records do not have to be of concern as IRCs use a system called the "SystemOne" to hold detainee medical records. The SystemOne is a system used in the communities' health services including prisons in England and may have the potential to be made centralised for IRCs to enable the sharing of information specific to IRCs alone. I believe this may be the case but that the system is not being utilised as effectively as it possibly could.

The impact of power relations and governance on the vulnerability of migrant detainees:

Two of the female participants I spoke to (Participant P and Participant Q) mentioned how they witnessed a tremendous level of neglect of care towards their fellow female detainees to the extent that they became less aware of their healthcare needs and more concerned about that of the other female detainees and decided to become part of a

group of detainees who protested in the IRC and spoke out by informing NGOs who came to visit the IRC about the various incidences that would occur there. An example of the gross neglect Participant Q mentioned in the following excerpt of a pregnant woman that was detained and was extremely mal-nourished that she was constantly falling unconscious on the floor in the Yarl's Wood IRC:

> …you've never seen a skinnier pregnant person than this woman, she couldn't eat, she couldn't sleep and all they could bother about is, "we want to know the father of the baby". They'll ask her so many personal questions… you know them tiny bottle of milk, that's what they'll give her at lunch because she wasn't eating, who does that? so to a point where she started passing out, so imagine a pregnant woman keeps on passing out, waking up, passing out, waking up, passing out, what about the baby? (Participant Q).

The excerpt above reveals the case that pregnant women are being denied of the necessary medical attention and adequate healthcare services in IRCs. The disregard for her health conditions being exacerbated as a result of being harmed by detention is disregarded by the HO and IRC staff reducing her to bare life and being de-humanised by the governing techniques of border control. Another case revealing the denial of adequate healthcare for women being detained in IRCs is recounted by Participant Q of another female detainee who fell over at the IRC due to her health condition. Her injuries were severe to the extent that she was unable to walk after the incident occurred and became bound to using a wheelchair for the duration of her detention which lasted over a year and continued even after Participant Q was released from the IRC.

> Yes, that lady I told you about, she got paralyzed in Yarl's Wood because of negligence, we were meant to go and get medication at 9 o'clock and while we were waiting, she started complaining … and then she collapsed… the ambulance outside, when it came, they sent it back… it was so bad, but the time the ambulance came and I think they took her but when she came back she was in a wheelchair ... I remember she would poo on herself, there were people coming from where I lived, where I was sleeping going up to complain, "help her please", her own room-mates would leave her to say, "she stinks" (Participant Q).

The detainee woman who was rendered disabled after passing out in the IRC and then not receiving the necessary and timely healthcare that she needed became a life-changing experience for her concerning her health after the incident which affected her detrimentally by no longer having control over her bowels and bodily functions. The aftermath experience would undoubtedly have placed her in a traumatised state which also affected her cell-mates. IRCs are under-resourced in terms of the provision of skills and specialist staff to cater for disabled people thus causing the woman experiencing this unfortunate incident in the excerpt above to become – in a way a burden to her fellow detainees. Through the accounts of the participants, particularly from the example just mentioned and including the following excerpt, the experiences that detainees face affect their fellow cell-mates. Participant Q recalls the time when she was extremely depressed that she did not want to eat at the IRC. This is expressed in the following excerpt:

> I didn't want to eat and I remember how, you know when you don't eat at Yarl's Wood they'll start bringing a guard to sit by your door and that alone takes your privacy because you can't close the door, so even the person in your room, you're taking away their privacy (Participant Q).

The case presented in the excerpt above reveals the additional trauma placed on the detainee through their lack of appetite or a decision to go on a hunger-strike – which is a cry for help and is an action that the IRC responds to by placing a guard at the detainee's cell to watch the individual twenty-four hours a day. This intrusion affects not only the individual, but also the cell-mate causing contentions between them. Although the placing of the guard at the door may be intended for the securing of the safety of the detainee, this action also suggests that the IRC and the HO are protecting their own interests by deploying this technique of governing to ensure themselves against an incident occurring that may cause them to become liable for the life of the detainee. This form of governing reveals the lack in provision of the necessary healthcare for migrant detainees. The lack of provision in IRCs for people suffering from health conditions that require specialist care adds to the frustration of detainees and exacerbation of illnesses as presented in the following excerpts:

> but they don't check that because the tumor and the epilepsy is all down to stress, they don't consider all of that that the more you're there and the more you stress yourself, the worse your problem becomes (Participant J).
>
> …a few weeks later, there was a man that died, a family man it was him and his wife and he died in Yarl's Wood but I don't think they ever reported it (Participant Q)..

The above cases from the ex-detainee migrants I interviewed reveal that there are various types of people who are vulnerable and or are being made vulnerable by the regimes of immigration detention and are thus being denied of adequate healthcare services. Pregnant women, people with learning and physical disabilities, elderly people, children, people with mental disorders, people suffering from PTSD, victims of sexual and gender-based violence, victims of homophobia and other human rights abuses are examples of vulnerable people who are detained in immigration detention and are being harmed by detention in the UK (Shaw, 2016). Mr. S. Shaw in his 2016 report of, Review into the Welfare in Detention of Vulnerable Persons: A Report to the Home Office and Medical Justice in their 2018 brief recommend that a more extensive classification is devised by the HO of those being identified as vulnerable people in their Adults at Risk (AAR) policy to prevent the neglecting of those mentioned in the list above and any other persons who may be harmed from detention from being detained (Shaw, 2016; Medical Justice, 2018). The HO ought to protect these vulnerable people from being harmed or detained but despite their policy changes have failed to do so as they continue to justify the detention of these vulnerable people. In 2017, 100 Rule 35 reports of cases referred to Medical Justice were analysed and revealed that 97 percent of those cases were accepted by the HO as AAR (Medical Justice, 2018). However, 95 percent of those cases received a decision to continue detention indefinitely by the HO (Medical Justice, 2018).

In the first instance, before a decision is made by the HO to detain someone an initial assessment is carried out by the caseworker to ascertain whether or not the person in question falls into the AAR category and that detention may cause harm to him or her (Medical Justice, 2018). There have been consistent failings by the HO to adequately assess and identify such people to prevent them from being detained. These vulnerable people are disregarded and pushed through the system also as a result of policy change

by the HO on the identifying of vulnerable people where a person is categorised by the evidence rather than the level of vulnerability (Medical Justice, 2018). Even when they eventually end up in an IRC and obtain a Rule 35 report through a medical examination by the doctors a majority of these detainees are being denied the necessary healthcare and also the right to be released from detention. This is re-iterated in their briefing on, Putting Adults at Risk: a guide to understanding the Home Officer's AAR policy and its history' by Medical Justice (2018) which explains the HO's policy on AAR (which was the HO's response to the Shaw Review, 2016 on his concerns of the HO's persistent detention of vulnerable people and of victims of human rights abuses which contradicts their own policy). The HO's AAR policy was devised with the purpose of protecting vulnerable people at risk of harm in detention to reduce the numbers of such people from being detained but has failed to do so (Medical Justice, 2018). Detention - especially prolonged detention generally exacerbates diseases, increases levels of trauma and harms mental health particularly for vulnerable people.

This system failure evidences the will of the government presiding over the rights of the migrant detainee in the prevention of a tangible decision-making to take place on the part of the migrant detainee concerning their health care needs. The denying of access to adequate and specialist healthcare services encourages inequities in healthcare access for migrant detainees thus rendering them powerless and at risk of acquiring illnesses and diseases.

6.2.2 The material circumstances of migrant detainees and its impact on their health and healthcare access in IRCs

In identifying the socioeconomic factors pertaining to the material circumstances of migrant detainees in relation to the public health's CSDH model (Solar and Irwin, 2007), detainees are placed in the lived space of deprivation within IRCs where they are unable to afford decent food, clothing, private healthcare or a private solicitor. Although these are all separate elements that detainees experience in IRCs that pertain to the socioeconomic factors of a detainee's position, they all impact on the health and wellbeing of the detainee and identifying them ensures a more holistic view of health. This holistic view of health is fundamental to public health where health is defined as:

> …a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2014).

Due to the economic position of migrant detainees and being held in the lived space of deprivation in being unable to afford food, very few options are presented to them concerning the choice and provision of food. Bachrach and Baratz's (1962) concept on the second face of power in an individual's non-ability to make a decision for themselves is evidenced in the migrant detainee being unable to make a decision about their health.

The impact of food supply on the health of the detainee:

Migrant detainees do not possess the power to make a choice on what type of food they will eat to enable a balanced diet to maintain a healthy body. Their economic position whilst being detained in an IRC does not allow them to afford to purchase and select food. This has a bearing on their diet and health thus restricting their decision-making powers. All participants expressed their dissatisfaction not with the quantity, but with the standard of food provided in the IRCs pertaining to variety and palatability. The following excerpts are examples of feedback from some of the participants I spoke to concerning the food provided in the IRCs:

> The food is bad.. there are Bulgarians, there are Romanians, there are Egyptians, there are Togolese, Nigerians, Ghanaians, like a whole lot of people... we're all eating the same …food, curry curry curry curry curry curry curry!… Monday to Sunday, no other food ... (Participant E).
>
> You don't have a choice, it's the same food that you eat all the time, just the basic food... (Participant F).
>
> ..even the food that we eat they will give you rice and bread with salad on the side, no tomato sauce, nothing. So the balanced diet, the food was very very bad. (Participant J).
>
> In the morning you get a good breakfast, when you can...microwave, a slice of bread, you struggle with the eggs they provide… gigantic cooking, it's tearful (Participant K).

> The food there, you know they just give you, it's not really healthy because you keep on eating the same routine, the same thing every day... (Participant N).

Due to the lack of a balanced or varied diet provided in the communal canteen for the detainees in the IRCs detainees did not enjoy the food and had no choice but to eat what was provided, unless they could afford to buy food elsewhere, which was quite rare or else go hungry. The rule in the IRCs as stated by the female participant (N) was that whether you had an appetite for the food provided or not, a detainee had to be present at the canteen and could not remain in their cell during meal times, else the officers will be promptly positioned "twenty-four seven" at the detainee's cell door to keep a constant watch on them as the IRC staff automatically suspect either a hunger-strike or a suicide attempt. Participant E expressed how he developed a terrible stomach problem directly after he was released from the IRC which he associated with the food (rice and curry) that he and his fellow detainees were being provided with on a constant basis with no other meal option for the duration of his five-month period spent in detention. The following excerpt from Participant P gives an example of this case:

> …one of them I remember was allergic to something we did not find out in the food, every time she would eat, she would throw up every time she would eat and they would say, "oh, I think they're pretending they just want to be out of this place" (Participant P).

The lack of variety in the food that was provided at the IRC canteen in combination with the fear of the detainee to refuse food caused her to vomit each time she consumed the food that was provided at the IRC. Despite this taking place, the IRC staff chose to disbelieve that she was suffering from a condition or potentially an allergic reaction to a type of food or an ingredient that was being persistently served to the detainees. The disregard for the detainee's health in this instance is as a result of the IRC staff perceiving the migrant detainee of not being genuine about her health condition, despite her constant inability to retain the food she was consuming and deciding not to carry out tests on her at the healthcare to establish whether or not she was suffering from an allergy or some type of condition. The element of disbelief comes to play in this instance where the use of discretionary power that Schmitt's (2004) liberal legality refers to takes place with the IRC staff perceiving that the migrant detainee is acting up by having a condition that is caused by being harmed by detention in an IRC that may

essentially speed up her case for release from detention. This caused the IRC staff to maintain the decision to disbelieve her and to not provide her with the healthcare she required as no referral by the healthcare team was made to establish whether or not the detainee was suffering from a condition caused by the food she was being provided with at the IRC. Hence, the notion of the camp is fuelled in such instances and continues to thrive as a result of the HO working to ensure state security through the infringement of the basic human and health rights of the migrant detainee.

The disempowering techniques in the denial of entitlements and privileges and its impact on the health of the detainee:

Migrant detainees are presented with limited options in earning an income during their time spent in IRCs. One of the options presented to them is through government allowances. Some of the ex-detainee participants shared with me how the government provides allowances ranging from 71 pence to 1 GBP per day to migrant detainees. One of the female participants (Participant N) I spoke to expresses this in the following excerpt:

> I think you're entitled to, I think it's 71 pence daily, so maybe you could use that one to buy your toiletries there because, per day maybe you could save it, you could use it, you could save your own maybe for the week and you can do what you want to do at the end and if you don't use it maybe by the time they release you, you can collect your money. (Participant N).

> …they were giving everybody one pound every day that you can use so that money if you can put it together every week you can get 7 pounds and that 7 pounds, you can use it to get top-up or if you want to buy food, you can go to the shop inside there to buy food that you need. (Participant J).

The above excerpts expressed by some of the participants reveals the government's initiative in providing some form of income for migrants whilst being detained in an IRC, although this is barely adequate to provide for the basic amenities within an IRC. IRCs in the UK are predominantly run by private contractors with very few being run by the government directly (this is discussed further in the Introduction chapter). This brings to light the contrasts in the management techniques of the IRCs, particularly where privileges for detainees are concerned. Based on the accounts of the participants

and in view of the IRCs they have been detained in, Participant H in the following excerpt recounts the contrasts between two of the different IRCs he has been detained in. The Morton Hall IRC which is managed by The Prison Service on behalf of the UK Border Agency (Gov.Uk, 2017) provides a government allowance to the detainees without charge whilst the Harmondsworth IRC which is managed by a private contractor - Mitie, Care and Custody (Inside Time, 2015) also provides a government allowance to the detainees but charges detainees to rent the cell they are being detained in. This is explained by Participant H in the following excerpt:

> So the government will pay your pounds into your account … while you will be assigned an account in the detention, so you will be paid 5 pound a week, so this was in Morton Hall, but in Harmondsworth it is a private sector they charge you I think it's 21 pence or 19 pence per day for rent per detainee. (Participant H).

Based on who is managing an IRC - the government or a private contractor will reflect in the type of rules and regulations an IRC will implement in managing their centre. This reveals issues pertaining to governance in its affirmation of Rose's (1999) concept on the governing techniques of the neoliberal era where the decentralisation of state power is practiced and the market mechanisms are encouraged. In this instance, the government has assigned a significant part of its responsibilities over to the private sector in the managing of IRCs. The private sector is renowned for its thirst for making profit with interests centred mainly on the quickest way to generate income regardless of the effect on others. Reports reveal a 20 to 40 percent profit is made by the private contractors for running IRCs in the UK where eight-year contracts enable earnings ranging from 42 million pounds per 282 beds per year in Campsfield IRC to 240 million GBP per 1,065 beds per year in Heathrow and Colnbrook IRC (CorporateWatch2, 2018a). Often is the behaviour of private companies who are given the mandate to devise and implement their own rules, as permitted by the HO such as in Harmondsworth IRC seek opportunities to generate a profit in any given situation without considering the ethical implications and its impact on the health of the detainee. I did not come across the requirement of a detainee in the paying of rent for their cell within the HO's DSOS (2002) and can only assume that this may be a policy devised by the individual private contractors who manage the IRCs. I am also unable to establish whether the requesting of rent payments of detainees at an IRC is a policy that is universally implemented by all privately run IRCs within the UK or if it is an individual

case, but am certain of the typical opportunistic behaviour of private contractors in seeking ways and means to make a profit. One IRC whose contractor seems to have not behaved as typically as other privately managed IRCs do is evidenced by the account of Participant N in the following excerpt:

> ..if you don't have, the moment you get into detention, they give you clothes, maybe like 2 or 3, they give you jumper, they give you a night dress, they give you socks then they give you cup… (Participant N).

The above excerpt is recounted by the female ex-detainee participant of her time in Yarl's Wood IRC. This privately managed IRC by Serco (Serco, 2018) permits and provides the donation of clothing on a routine basis to every detainee upon arrival at the IRC free of charge. This may be due to the fact that the detainee population in this IRC are predominantly female and with families also being detained there. The majority of the women detainees in this IRC are coming from vulnerable and abusive experiences prior to detention (Bowers, 2014). An NGO named the Yarl's Wood Befrienders (YWB) are also a regular feature in the IRC where the second female ex-detainee I spoke to recalls that the YWB volunteer workers are in Yarl's Wood every weekly to fortnightly providing some form of support and donations to the detainees. I am unable to establish whether the donation of clothing and other items from NGOs to detainees in IRCs is a regular feature in other IRCs (with the exception of Yarl's Wood IRC – as mentioned previously) in the UK as the other participants aside from Participant J (male participant in the following excerpt) did not mention it. The statement below by Participant J re-iterates the behaviour of private contractors in their management of IRCs by making a profit out of clothing donated by charities to detainees which they take the initiative to sell to the detainees instead of providing it free of charge as intended by the NGO:

> Even sometimes, they have some week, some period that the charity, the stuff that people donate to give to detainees, they have to sell it for money, if you don't have money to buy them, you cannot get some because they said the money they're looking for, they're gonna give it to charity.. (Participant J).

The lived space of deprivation concerning the economic position of the migrant detainee is further evidenced here as they are subjected to the conditions of the IRC which provides minimal access to amenities. The depriving of detainees of the basic essentials

of life such as decent clothing, food and other amenities in the IRCs impacts detrimentally to their health and exacerbates their health conditions with the potential of new illnesses being contracted as a result of poor diet, poor sanitation of cells and communal areas (the sanitation issues will be discussed further down in this section) and poor levels of healthcare provision along with stress, anxiety and depression. The governance technique mentioned by Rose (1999) which permits private contractors to manage IRCs has impacted on the economic position of migrant detainees, not only with regards to deprivation but also by assigning the managers of the IRC with the power to exploit, control and punish detainees by denying or limiting access to essential items. This re-affirms Agamben's (1998) camp paradigm in the 'stripping of bare life' where the government asserts its power through the managers of the IRC to undermine the migrant detainee's human and health rights. This is further evidenced in the following section.

A majority of the ex-detainee participants I spoke to mentioned that they were offered the option to work in the IRC to earn an income and to help reduce anxiety. The majority of participants I spoke to mentioned about opportunities presented to them by the IRC staff to work for some income whilst in detention. Below are excerpts from some of the ex-detainee participants expressing this issue:

> I didn't have money, so I have to apply for a job which pays 4 pounds a day… in detention I'm talking about. I had to wash people's clothes to have that money. (Participant E).
>
> ...because when we work in detention, depending on the job, some skilled job in detention like painting, construction work and stuff like that, even laundry we're paid something different like £5 a week… (Participant F).
>
> If you're able you can work, it's 1 pound an hour, you'll be doing like 5 hours a day maximum. (Participant H).
>
> ..and if you want to work, you're allowed to do some little work at least to get some money for yourself… I wasn't working because I was not interested, all I was interested in was to get out of that place because it's not a good place to stay. (Participant N).

Due to the economic situation of detainees during their time in the IRCs the option of work for some was considered in order to earn an income, despite earnings being extortionately below the minimum wage and the fact that undocumented migrants are not permitted to work in the UK, but are being employed in IRCs. One of the detainees – participant E viewed it as a way to enable him and his fellow detainees to purchase essential items such as, food clothing and phone credit top-up. Others refused to work in the IRC despite their desperate circumstances. In general, the detainees felt that they were being exploited by being asked to work in the IRCs. The HO however, viewed the employment of detainees to work within IRCs as a privilege for the detainees as it would provide them with something to occupy their time, a solution to boredom and a means to provide for the essential amenities during detention (Pollette, 2002). The HMIP and IRCs I spoke to re-iterates how beneficial he views the provision of employment to detainees whilst being detained in IRCs for those who are able to work. However, the visitor detainee support worker (Participanr C) I spoke to is not in agreement with this view as she recalls a detainee repeating to her what an IRC officer said to him concerning him working in an IRC for one pound an hour in the following excerpt:

> "how does it feel to be a slave?" (Participant C).

The above comment was made by the security guard towards a Nigerian detainee (Participant D) for the reason that he had been employed to work at the IRC for one pound an hour. This comment reveals an abusive culture of racism which is not a rare case in IRCs including the exploitation of labour where undocumented migrants do not have the right to work in the community. The perceived space of discrimination against undocumented migrants – particularly the BME group is affirmed in this instance where the power to exploit is made possible through creating the concept of working in an IRC as beneficial to occupying time, preventing illnesses and generating an income. The HO permits detainees to work in IRCs, which should not be the case as this exemplifies the will of the HO presiding over the laws of the nation. This reveals liberal legality at work where the government uses its discretionary power to override the laws of the nation where undocumented migrants are not permitted to work in the community, yet are given the option to do so in IRCs for much less than the minimum wage. In the report by the inspection conducted by HMIP in October 2018, the HO admit to recruiting

detainees to work in IRCs for up to thirty hours a week for one pound an hour (Clarke, 2018).

Recruiting detainees to work in IRCs is a double-edged sword as it helps to keep detainees occupied and is a source of income to purchase food and other amenities in IRCs which are not adequately provided. It is also being used as a tool of punishment and control on detainees who are deemed as not complying with the HO (Clarke, 2018). Detainees are assigned to duties in domestic, catering and peer-support roles in order to earn grossly below the national minimum wage of 7.83 GBP for adults over twenty-five years (Minimum Wage, 2017). This creates a space of exploitation (as re-iterated by an immigration lawyer in his article; Hossain, 2017) in assigning the subjects of immigration detention onto duties that is presumed to be assigned to staff employed externally who are qualified to embark on such roles and have gone through the due processes involved in recruiting and ensuring workplace safety and employee rights are adhered to. The strategy to introduce employment is a tool the HO may utilise to control detainees as it becomes established that earning a wage in detention is a way of accessing amenities including one's own medical records, credit to make phone calls and the purchasing of decent food and clothing. Section 3.18 of HMIP'S report of 2018 in their inspection of Harmondsworth IRC (Clarke, 2018, p.47) states the following in re-iteration of the HO denying detainees who are able to work from accessing jobs in the IRC:

> Home Office continued to prevent detainees from accessing paid work if they were considered to be non-compliant with Home Office. In the previous five months, 96 detainees had been refused a paid job for this reason.

The above statement suggests that the HO often use their discretion at will to deny employment to detainees. To access their medical records a detainee has to pay a ten pound fee each time they request it which they usually find difficult to pay and resort to getting assistance from friends, family members, NGOs or saving up their allowances earned within the IRC to make this payment. This causes delays in their legal application in court which requires detainees to produce their medical records to support their legal cases. The immigration lawyer I interviewed states how he has to follow IRC procedure in accessing a client's medical records from the IRC by writing to the IRC and paying the fee of ten pounds. The statement made by the immigration lawyer below

also evidences the denying of medical records to detainees and their legal representatives according to their discretional power:

> …the IRC said "we're not providing them to you", so I had to get on the phone with the detention centre and say, "look, we've paid the fee, you've got it there, give our medical expert the medical records because you're wasting public funds. (Immigration Lawyer).

The immigration lawyer's statement above emphasises the lack of compliance of the HO to their own rules which impacted adversely on the migrant detainee as delays were caused in their cases at court, thus denying the immigration lawyer access to the health information that may have supported the case of the detainees to be released from detention. Several migrant detainees have attempted to take their own lives and have been successful as a result of being detained indefinitely or not being released when granted bail (Bazalgette, 2018). One of many examples may be found in an incident that occurred in 2017 concerning a male detainee who died two weeks after he had been granted bail (The Guardian, 2019a). The migrant detainee had attempted suicide two weeks after his bail was granted and was placed on a life support machine which the HO instructed to be switched off causing him to die shortly after (The Guardian, 2019a). This incident came about due to the HO refusing the release of the migrant detainee from immigration detention despite being granted bail and had also been suffering from physical and mental illnesses during his detention (The Guardian, 2019a). This reveals the authority the HO exercises in overriding its own rules by using its discretionary power in several cases concerning migrant detainees which causes implementation of policies to become weak hence, positioning them in a space of sovereign authority due to their disregarding of other professional authorities. The expression of the state of exception in defining "them" and "us" is affirmed in such incidences where the migrant detainee is implicitly told – but explicitly treated as undeserving of the right to live amongst society therefore, deserving to be locked up despite suffering from medical conditions and adhering to the laws of the nation that has allowed him to be granted bail.

There is a service provided within the IRC at the Welfare department which is an office located at one of the wing areas in the IRC that Participant E was detained in which provides additional support to the detainee population. Access to the services at the

Welfare department is one of the routes in seeking support pertaining to legal issues and does not require any pre-booked appointment but can only be accessed during the opening hours – as stated in the following excerpt:

> Appointments are not being booked to go to the welfare...we have sessions of solicitors' legal aid, like Duncan Lewis, Fadiga, I think there are about 3 or 4?... Then we have Medical Justice there, we have Detention Action, their contact number, then we have BID… (Participant E).

As described by Participant E in the above excerpt there are a number of organisations that provide services of a legal nature whose details are provided at the Welfare department. Legal aid firms providing immigration lawyers which are government funded are the main source of additional support or legal access that a detainee may receive at an IRC. There are procedures in place, as mentioned above if the detainee wishes to contact the lawyers, NGOs and caseworkers, this is done through the Welfare office. Detainees typically seek legal representation for court hearings from the contacts provided at the Welfare department concerning matters pertaining to applications or appeals for residency or refugee status. Detainees rarely approach this department for health concerns, however their health issues eventually become an integral element of the majority of cases brought before the courts in applying for residency or refugee status, thus providing a strong case for the release of the detainee from detention. This is due to the fact that the majority of the migrant detainee population are coming from a background of vulnerable positions, though not all people arrive at the IRC with a health condition. However, due to the conditions of the IRC, the migrant detainee is placed in a position of risk as illnesses may easily be acquired as a result of the stress and anxiety of indefinite detention which also causes the health conditions to become exacerbated through prolonged detention. The ex-detainees express how obtaining the contact details for a solicitor at the Welfare department is like playing the lottery as there is no picking-and-choosing, the detainee has to take the solicitor details that have been provided for that week. The procedure in this department in the provision of solicitors' details is to display on a weekly basis a different contact for detainees to access.

It may be presumed that the services of the Welfare department, although limited in the provision of contacts of NGOs and organisations that provide legal aid provides some

kind of hope for the migrant detainee as an alternative or compensation to the lack of healthcare provision in the IRC. However, this is seldom the case as the experiences of each detainee differs according to the level of expertise each legal organisation has acquired in dealing with immigration cases and the categories the HO sets which determines whether or not a migrant detainee has a strong case for legal representation to continue. There is a lack of formal training of lawyers in immigration cases causing them to learn by experience. Lawyers have to deal with the complexities of immigration laws, which are difficult to follow and are constantly being revised in combination with dealing with the HO and administrative staff of IRCs who often are not cooperative. Lawyers are also presented with the task of accessing detainee medical records and the detainee themselves as many miles of travelling will need to be covered to arrive at an IRC in the UK. This reality is only revealed and experienced through the process of the immigration lawyers' duties in the event of building a case to represent the detainee. The immigration lawyer expresses this point in the interview:

> …it's a constant battle with the Home office and with healthcare to try and get a just outcome for any particular client. And that's no exaggeration, you can ask anyone in this field and they'll tell you the same. (Immigration Lawyer).

The limitations of legal representation for migrant detainees has a bearing on the disempowering process where lawyers who are experienced in their profession are presented with the task of dealing with the institutional laws of immigration which hampers their efforts in performing a quality service to their clients. This impacts adversely on the migrant detainee as the legal representatives provide a voice for them in the event of presenting their case in court. In light of the data, detainees were generally limited in their choice of options in obtaining legal representation. Those who had not been working on their legal case with a solicitor prior to entering the IRC did not have any legal representation and had to result to accessing legal aid from within the IRC. It is the duty of the HO according to their DSOS for IRCs in their policy on Access to Legal Services to provide all detainees that enter the IRC within twenty-four hours with a solicitor (Pollett, 2002, p.1). Legal aid solicitors are thus employed by the HO. Based on this fact, detainees did not have much confidence in the solicitors as they believed that the legal aid solicitors' loyalty resided first and foremost with the HO. However, those who were unable to afford or receive help in obtaining a private

solicitor or one from an NGO had no choice but to approach the legal aid for representation, as expressed by the following participants:

> I did not have private solicitors, I didn't have money, so I had to get the legal aid... (Participant J).

> No, I really don't want to talk about the solicitors some of them are bad… they just take your money for that month and they just do nothing... I did my case myself, my solicitor took the money and never took a pen, never filled a form, nothing. I went to court 4 times, I got myself the bail, no barrister, no assurity, nothing. They're just rubbish, the government needs to stop paying them. (Participant E).

> when I was in detention …. I had a solicitor who was rubbish and he didn't even know what he was doing and in detention you'll be given legal advice where you can get a legal aid solicitor… you had to wait for like a month or two sometimes to get an advice from them. (Participant H).

Participant J in the above excerpt affirms the problem that the majority of migrant detainees face whereby they do not have the money to access a private solicitor, hence have no choice but to seek legal aid at the IRC. Participant E in the above excerpt is referring to the legal aid solicitors which he as well as many other detainees had no choice but to access to represent his case. He expresses his experience in the legal aid solicitor working on his case, which turned out to be a disappointing experience for him as the solicitor did not commit to working on his case. This is re-iterated by Participant H in the above excerpt concerning the ineffective handling of his legal case – which was expressed by all the participants I interviewed who sought legal aid. Some detainees are able to come across information about NGOs who then help them to get legal representation, which often results in a successful outcome concerning their case. Participant F mentions in the following excerpt how he came about this information:

> Freedom from Torture referred me to Medical Justice, I was going through therapy in London that is Helen Bamber Foundation, so they referred me to Freedom from Torture…(Participant F).

Participant F in the above excerpt was able to access an NGO solicitor – Medical Justice for legal representation through Freedom from Torture to help with his case through

initially contacting the of the NGO after his release from the IRC the first time he was detained. Participant F stated that the multiple occasions that he was detained in an IRC, he had never come across any information provided within the IRCs he was detained in concerning legal aid or other legal representative organisations. This is evident that particular services may not necessarily be provided universally in all the IRCs in the UK, such as this Welfare department – provided in one of the IRCs mentioned by two of the participants who were detained in the same IRC which provides information concerning legal aid. On the other hand, it may be the case that such a department exists in all the IRCs but may not be readily accessible in some IRCs. Having said this, it is HO policy as part of the DSOS for IRCs on Access to Legal Services that information of a list of solicitors must be provided by the IRC for detainees to access (Pollette, 2002).

Participants F and H during their detention were documented under the Rule 35 and with Participant H being also diagnosed by the IRC doctors with post-traumatic stress disorder (PTSD) which are strong grounds for their release under HO policy regarding the identifying of vulnerable persons (which is based on the evidence of vulnerability rather than the level of vulnerability in the AAR policy (Medical Justice, 2018)). If this did not take place, then their legal aid solicitors ought to have worked tirelessly and effectively on their cases to get them released. This was not the case for Participant F and H, which is a common situation that is experienced by detainees that are identified by the HO as vulnerable persons that further detention would pose as a serious risk to their health.

This gross failing of policy implementation is re-iterated by the NGO doctor I spoke to who expressed how frightened he was on the monstrous failings of the system and that he believes that these failings pose a threat to not only the detainees' health but also to public health. Participant E expressed in the excerpt above how he had to resort to representing himself in court as the legal aid solicitors were not effective in dealing with his legal case. Few others were fortunate to have either their partner intervene for them whilst they were detained in obtaining legal representation from a private solicitor and granted bail (an example of this case was expressed by Participant K) or were able to stay in contact with the solicitor they had obtained prior to being detained who was already working on their legal case to enable them to get bail (an example of this case was expressed by Participant N). Detainees such as Participant I who were unfortunate

to be subjected to the procedures of isolation in an IRC as a result of his lack of compliance – a term used by the staff in the IRC due to his escalating mental health condition. The IRC deems it necessary to remove certain privileges away from detainees as a form of punishment which they resort to included being forbidden to receive visitors, such as their solicitors.

Detainees were also advised by the IRC staff to seek private healthcare outside of the IRC if they were dissatisfied with the healthcare they were receiving in the IRC – this is not a reasonable option as detainees are not able to afford paying for a doctor to visit and treat them. Geographically, IRCs tend to be located long distances away from most communities which may have been the obvious factor to causing reluctance or delays in referring a detainee patient to a hospital for treatments which cannot be provided within the IRC. It is also costly to transport the detainee patient to the hospital including the provision of security officers to escort them. Detainees expressed the issue of being coerced or threatened with expulsion or prolonged detention by the IRC staff in their attempts in seeking specialist healthcare and legal aid, as expressed in the previous excerpts by the ex-detainee participants.

The feedback from the participants in the section above who had no choice but to seek legal aid express a great deal of stress and frustration in receiving help with their legal case which impacted greatly on their health by exacerbating existing health conditions or developing new illnesses. Participant N expressed how she developed a stomach ulcer during the one-month period in detention due to lack of appetite as a result of depression, stress and anxiety. Participant K also stated how he used to stammer but had been able to suppress or keep it under control for many years prior to being detained in an IRC. He states how the experiences of detention had caused him to stammer as before also due to depression, stress and anxiety. Participant Q expressed how she was suffering from depression and asthma prior to detention, which then became more severe during her time in detention. Participant F also suffered from depression prior to detention which became exacerbated by his experience in detention causing it to affect his blood pressure resulting in immediate referral and transportation via ambulance to the nearby hospital. Participant J suffered from a brain tumor before being detained in an IRC where his health conditions were known to the HO who maintained the decision to detain him, despite it going against their policy which caused Participant J to experience even more regular episodes of seizures within the IRC.

Participant I who also suffered from depression prior to detention eventually lost his sanity during his time in detention, which led to the HO detaining him in solitary confinement in the IRC for some months and depriving him of healthcare services before transferring him to a prison because they found it difficult to control him. Participants F, H and O were diagnosed as victims of torture and human rights abuses after undergoing the Rule 35 process within the IRC however, the HO maintained the right to continue their detention. Participants E, N and P developed severe stomach problems and stomach ulcers either due to being subjected to eating the limited options of food that was provided for Participant E or as a result of refusing to eat at the IRCs in the case of Participants N and P. Participant D experienced a tooth problem which left him in severe pain for the duration of months that he was being detained in the IRC as he was unable to get treatment for it, despite his attempts in seeking healthcare. Participant E suffered from eye problems and also attempted to seek healthcare for an appointment and did not get one until he was released from the IRC. All the participants I interviewed also experienced various levels of depression, stress and anxiety along with their health conditions during their detention at the IRCs.

Every detainee shared their cell with another detainee, either with two to a cell or up to seven in a communal cell where the toilet and the wash basins were provided within the cell. All participants expressed that the sanitation standards of the IRC, particularly the cells were very poor. The male wings of IRCs shared a communal shower room whilst the female wings had a shower room in their cell. This is expressed in the following excerpt by Participant K and N:

> ..because the wash facilities it was like a gym shower room... in the cell you had your toilet, wash-basin, just demeaningful,.. (Participant K).

> ..each room has a bathroom and a toilet, yer, so the shower-room is there inside your room, the toilet is there. It's just 2 people, one bed here, one bed here and by the side of the door the shower-room and the toilet as well. You do everything in your room before you go out. (Participant N).

Participant N, a female ex-detainee stated how all the women's cells also included a shower unit in the IRC. However, the men's IRC shared a communal shower room. The female participant expressed how there was a disregard for their privacy where officers would frequently and freely enter their cells at any given time without warning. The

disregard for the detainee women's privacy in their cells is based on fulfilling the IRC policy of routine searches of cells which take place regularly by the security officers at the IRC who may be male officers and unannounced, particularly when a detainee decides to go on hunger-strike. This is re-iterated by Participant Q in the following excerpt:

> …at the end of the day, it's not like Yarl's Wood had privacy, the officers, even the male ones, they came in as they please, they opened our drawers where we had knickers, where people had their medications where everybody has to know what they're suffering from, and they'll call it routine search or check or something like that and I've never felt so degraded and everyone felt like that, but it's like they've got that power, there's nothing we can do, they're instructed to do so (Participant Q).

The above excerpt expresses how the detainees, particularly the women felt that the policy of the IRC concerning routine searching of their cells was very inappropriate, distressing and demeaning causing the women to be caught off-guard whilst not being fully clothed or in the process of taking a shower or using the toilet which are facilities that are all provided within the female cells. The female participants also mentioned that most of the officers in the IRCs were male. When I asked the question on why they thought that the HO deemed it necessary to employ a proportionately higher number of male officers as compared to the female officers, Participant N answered that it may be that the HO believes that the male officers would be better equipped to restrain the female detainees, if the need arises.

The instilling of fear through the removal of the detainees' rights by disregarding issues pertaining to their dignity works as a barrier to migrant detainees accessing healthcare services. This behavior practiced by the IRC staff is being used as a tool in which to deter migrant detainees. There are HO policies that would have secured the dignity of migrant detainees in the delivery of services in IRCs but are not being complied with. An example is presented in the case where one of the female ex-detainee participants witnessed a male health officer (which suggests he may possibly be a male nurse) being left alone with a female detainee patient whilst a female health officer (probably was a female nurse) was nearby in another office. This is recounted by Participant Q in the following excerpt:

> …there was a lady officer she was just sitting eating her apple and there was a man, the man officer said "go outside so I can check her" and the rule said 'no man with the woman', there has to be another woman but the lady, the officer wasn't interested, she just sat there...(Participant Q).

I believe this to be a matter of concern which is re-iterated in the report by (Bowers, 2014; Lousley and Cope, 2017; Women Against Rape (2019) on Yarl's Wood IRCs which holds a great number of female detainees and has half of its officers who are male. Yarl's Wood IRC has a history of rape and abuse of the female detainees by the male officers and yet no policies have been implemented to-date that safeguard female detainees who have previously been subjected to human rights abuses against being violated by the IRC officers. It seemed that the women ex-detainees felt a sense of disregard and disrespect by the IRC staff and the HO for their privacy where their dignity was being tarnished. The lack of regard for the privacy and dignity of detainees, particularly female detainees which also has a bearing on the infringement of their rights is found in the following example pertaining to a female detainee who was a lesbian, gay, bisexual or transgender (LGBT) recalled by Participant Q in the following excerpt:

> …a few weeks I left Yarl's Wood, one of my friends was still in there, as she was about to be deported, and then they had to bring her back... and they were telling her to go and buy female underwear because she can't wear boxers, normally they know that "oh this girl is actually gay, but because we still want to deport her but we can't because of how she looks". And I remember she refused… (Participant Q).

The above example reveals not only the disregard for the rights of the female detainee whom they were attempting to deport, but also the will of the HO superseding that of the national law as a result of their determination in enforcing border control at the detriment of the life of the detainee whose life would be in danger if successfully deported back to her country of origin where LGBTs are not accepted. Hence, the notion of the security and governance paradigms (Agamben, 2005; Rose, 1999) respectively continue to be reinforced, particularly in this instance where discretionary power overrides the laws of the nation in the attempt to secure the nation's borders against a perceived threat whose rights are stripped away to subject them to death in

order to protect the nation's borders. The disregard for the human rights of a detainee is further evidenced in the counselling session Participant Q had with an IRC doctor who counselled her regarding the situation concerning her stepfather who abused her as a child resulting in the conception of her daughter. This instance is mentioned in the following excerpt by Participant Q:

> …there was an elderly man who used to counsel women in Yarl's Wood, I think they were counsellors but I think on the day I went to register, that man was on call and I remember telling him some of my story and he just said, because part of it was because I was molested back home when I was 13 and I got pregnant by my dad, so the daughter I was talking about is my father's child, so he was just like "oh that's just your stepfather, you can easily marry him so I thought that's what you do in Africa" and I felt very very depressed… (Participant Q).

Participant Q, in the above instance felt a sense of worthlessness and disregard for her human rights and dignity due to the counsellor's response to her troubling experience with her stepfather. The response by the counsellor was of great shock to her and compounded her existing state of depression which led to her approaching a woman from an LGBT organisation in London who placed a complaint to the HO about the man who counselled het at the IRC. However, after the complaint was submitted to the HO nothing was done about it which Participant Q believed was attributed to the fact that the counsellor was employed by the HO that is why the matter was brushed under the carpet, nothing was ever said about it again. She further explained that many of the other female detainees who were even released at the time experienced the same problem with the counsellor but they did not take the matter further. The role of fear comes into play in such circumstances where the female detainees accept that this is the standard of care that is provided in IRCs due to their non-legal status. The female detainees reside to the fact that they are not deserving of a good standard of healthcare as provided in the community to the citizens. This causes them to be highly reluctant to approach the HO to complain about the standard of healthcare they are receiving and the disregard for their human rights as they believe that making a complaint would result in the speeding up of their case for deportation, hence the decision is made to remain silent. Regardless of this, there were a few detainee women who believed in standing up for their own and their fellow inmates' rights in the IRC who were outspoken.

Participant Q who was one of the outspoken woman detainees explains her experience in the following excerpt:

> …I can't sit down and be ok with what is happening over here, because one day, it could be me and I'll need somebody to stand and run around for me like that, you know and if they're not gonna do it somebody has to do it, of course so many women would want to do it in Yarl's Wood but because of the fear, I told you, that they'll think "if I be forefront, these people are gonna mess up with my case", but because some of us knew, we were dealing with Movement for Justice that "no no no, your case is different, you're not doing anything illegal, you're only looking out for someone, so that's ok". It's bad, it's bad (Participant Q).

Participant Q explains in the above excerpt how linking with the NGO boosted her confidence and empowered her to maintain her ground concerning the standing up for her rights during her detention in the IRC. Being armed with information proves the notion that 'information is power', thus providing Participant Q and any other detainee who is able to come into contact with an NGO with the tools to become confident and less fearful of being deported whilst standing up for their rights. In light of this, the contrast in healthcare concerning counselling in IRCs compared to that of prisons is greatly evidenced and re-iterated by Participant I who experienced both IRC and prison care for those suffering from mental health conditions. This is expressed by Participant I in the following excerpt:

> …cos I seen the psychiatric many times yer, then I got better, but they was prepared to send me to hospital, but in detention, when you behave like that… they don't wanna listen to you… they think we should not go crazy because we are foreigners, we should be able to cope with everything cos we black, cos we African yer, we don't get crazy, we don't get depressed and we don't get mad, you know that's how I see it, cos in prison, it's all English boy, people get treated fairly so in detention we don't get treated fairly, why because people think we don't feel that emotion, that's my understanding (Participant I).

Participant I echoes the perception that all the detainees expressed which is backed up by his experiences of the two types of detention, highlighting the contrast in care between the two which he perceived was based on the ethnicity of the people that were being detained. This renders the institution of detention unjust as the laws that govern

immigration detention are similar to that of prisons however, the practices of immigration detention are based on weak implementation of policies which suggests that a culture of discrimination against those from the ethnic minority thrives in the institution of detention.

Another aspect relates to dignity issues which was expressed by another male participant related to disregarding the diverse culture and religious beliefs of the varied population being detained in IRCs. Participant F explains how difficult it was for him to share a cell with a detainee who had to follow certain rituals on a routine basis due to his religion which he did not share along with certain beliefs. This caused issues between himself and the detainee he shared the cell with which added to his insomnia and depression and was not a pleasant experience for his cell-mate either. This is expressed by Participant F in the following excerpt:

> We have toilet in the room and some Muslims don't do that, but they don't have a choice. I was paired up with a Muslim, it disturbed me, I couldn't sleep, it was terrible. The place was dirty anyway, when I think about it, its not fit for human being to live in, definitely. (Participant F).

The above excerpt reveals that there was also issues with the hygiene element of sharing a cell as staff are employed to clean the IRCs routinely however, this does not appear to be done as regularly or as thoroughly as is required to meet the needs of the IRCs. All detainees expressed their concern on the poor hygiene levels of the IRCs they were detained in. The female participants (Participants N, P and Q) explained how they would take the initiative to clean the cells regularly themselves as the domestic cleaners contracted to clean the IRCs rarely appeared to carry out their duties. All the ex-detainee participants explained that detainees could be employed to carry out various domestic tasks in the IRC – of which Participant E undertook in the washing of other detainees' laundry. Another example of the lack of consideration for hygiene by the IRC was expressed by Participant E in the following excerpt:

> The sanitation is really bad, the officers are supposed to be cleaning the rooms when a detainee gets released, they don't clean it. A detainee is detained today and he has to come and clean the room, a room full of lice and mice and bed bugs… tomorrow you'll come and the other room tells you, there's bed bugs,

> they'll come and spray that room, the following day there's bed bugs here, just shut the whole detention down and spray the whole detention to prevent these bed bugs. I knew one Burkeenan guy who was bitten by bed bugs so bad that you couldn't even look at his skin. (Participant E).

The concern expressed in the excerpt above by Participant E reveals the lack of commitment to a thorough sanitation of the IRC cells on a routine basis, particularly in the event where detainees are released from the IRC and also in preparation for the new-comer to the cell. It is essential that the IRC staff ensure that regular and thorough cleaning is carried out on a regular basis to reduce the risk in infectious diseases being acquired and to help reduce the spread of the diseases. Due to the nature of IRCs in its relation to Agamben's (1998) camp which implies that migrant detainees do not have a right to certain privileges, detainees, particularly those who are classed as not compliant with HO rules are denied the privileges of having their cell cleaned. The denying of a detainee to have their cell cleaned is also used as a tool of punishment which is expressed by Participant I who suffered from a mental health condition whilst being detained in the IRC in the following excerpt:

> … I was mad, I used to stand there and I'll pee yer and they used to clean cos they saw it as "ok you peed yer, your gonna stay in your cell, you peed in there we're gonna keep you in the same cell" and the hygiene is nasty, bad bad hygiene. (Participant I).

Participant I was placed in isolation or solitary confinement as punishment for his 'lack of compliance' – a term used by the HO due to his depression which developed into a mental condition causing him to self-harm and behave erratically. During his time in solitary confinement, he had the tendency to relieve himself in his cell and on the landing area of his cell. He expresses how the urine was not cleaned up by the IRC workers, but was added to his punishment to the effect that he should live in the mess he made.

All detainees expressed how the IRC rules required detainees to be locked up within their cells at certain periods of time during the day and night time. This IRC rule which may be considered as a health and safety precaution impacts the detainees immensely as their movement becomes restricted in being confined to their cell for long periods of

time and are denied a greater range of movement and access to other areas of the IRC. Participant F expresses this in the following excerpt:

> We're always banged up. They open the door at 7.45 for breakfast then we go out, in the afternoon by 12 or 2, I can't remember now they'll lock us up again. Then it's either after lunch they'll lock up after lunch again, then in the evening they'll open up again for about 2 hours, then they'll finally later in the night after dinner they will lock up about 10 o clock, I can't remember. (Participant F).

The locking up of detainees for long periods of time in the IRC poses concern for the health of the detainee not only as a result of feeling restricted and rendered helpless along with physical and mental illnesses that thrive in particular institutions due to the confinement of people in spaces for prolonged periods of time (Basu, *et al.*, 2011), but particularly due to being unable to access healthcare services – medical staff and medication during the lock-up period. The locking-up of detainees in their cells poses another health and safety concern based on the design of the cells in the IRCs which firstly, have their windows unable to open and are sealed with iron bars. Secondly, participants mentioned that they did not see any fire exits in the whole IRC or were not made aware of the fire exits during the time in detention at the IRC. Thirdly, very few officers are assigned to watch each wing with the ratio being an average of three to four officers per 100 detainees per wing. Participant N expresses some of these concerns in the following excerpt:

> …the windows, there's no fire exit, all the windows were barred by strong iron bar and the one that didn't have an iron bar, you could not open the windows. There's no proper ventilation at all. (Participant F).

The above excerpt raises some of the health and safety issues pertaining to IRCs and the risk to the health of migrant detainees. As explained in the section above, the health and safety issues outlined is detrimental to the health of detainees as the lack of ventilation causes the risk of acquiring and the spreading of diseases (Basu, *et al*., 2011). Participants mention that an air-conditioner is used within the cells, however it is not used productively as detainees complain of the cold air being switched on during the cold seasons and the hot air being switched on during the warmer seasons (Participant E). In referring to the third health and safety concern outlined above, based on the fire safety issue if a fire was to break-out, the detainees' lives would be in grave danger as it

seems there are no sign-postings for fire exits (even if there are, detainees are not briefed on where to find them). Also the officer ratio per wing is grossly inadequate to be able to open all the cells during a fire situation which has the potential of causing a devastating number in the loss of lives. An example of this is evidenced in a fire incident that occurred at Campsfield House IRC in Oxfordshire in 2013 which caused two male detainees to be admitted to hospital and more than half of the detainees to be relocated to another site due to the extensive damage to the IRC building (The Guardian, 2019b). A similar incident of fire outbreak also occurred at the Morton Hall IRC in Lincolnshire in 2014 causing significant damage to the centre (ITV, 2019). Lessons do not appear to have been learnt by the HO and the IRC contractors as little change or action has been taken to improve the fire safety conditions of IRCs. This re-iterates the notion of Agamben's (1998) camp in the denial of rights and removal of privileges from the detainees within the space of immigration detention.

The Health and Wellbeing services, including the joint commissioners (Department of Health (DH), NHS England (NHSE), Clinical Commissioning Groups (CCGs) and the HO) have been assigned the responsibility of tackling health inequities and the wider determinants of health in IRCs to ensure that the health and wellbeing of migrant detainees are improved (Home Office Enforcement, NHS England and Public Health England, 2015). It is therefore their responsibility to prioritise the seeking of ways to reduce inequities that exist in the accessing to and the outcomes from healthcare (Allen, 2016). In identifying the socioeconomic factors relating to the public health's CSDH model (Solar and Irwin, 2007), it becomes evident that detainees are being placed in the lived space of deprivation within IRCs where they are unable to afford decent food, clothing, private healthcare or a private solicitor (as they are being denied the basic healthcare services and the majority of cases not being supported by legal aid). The institutional systems of healthcare and law in the UK are governed in such a way that allows the HO to impose its will and influence decisions and procedures that have been set up with the intention of not discriminating against migrants. The influence of power exerted by the HO inevitably introduces the space of disempowerment and non-decision making power of the undocumented migrant where inequities in the accessing of services, particularly healthcare services are formed.

6.3 Summary of chapter

Conclusion and implications

This chapter reveals how healthcare is an essential element in the life of a migrant detainee or indeed, any other human being and how their need for healthcare is being used as a tool of discipline to control them within the space of immigration detention. The migrant detainee is therefore unable to make any tangible decisions about their health due to the enacting of the border within the institution of immigration detention where immigration laws supersedes laws pertaining to human rights and healthcare (Butler, 2004).

The instilling of fear has become a tool used in deterring migrant detainees from seeking healthcare services as the feelings of mistrust and disbelief between the migrant detainee, the IRC staff and HO becomes established. The need of the migrant detainee to access healthcare services is being used as a tool through which to control the detainee and influence their decision-making process. Migrant detainees are often told that they will be subjected to immediate expulsion if they seek further medical care or that an extension will be placed on the length of their detention. Those responsible for governing IRCs have established a culture where migrant detainees are stripped of their right to make a tangible decision about their health through the instilling of fear and the denying of their healthcare and human rights. This places migrant detainees in a position of non-decision referred to by Bachrach and Baratz (1962).

The feelings of fear cause the detainee patient to mistrust the doctor as they may perceive either rightly or wrongly the IRC doctors as agents of the HO thus preventing them from opening up or revealing to the doctor their health issues or concerns about their care in the IRC. Hence, the fragmented doctor-patient relationship is formed within the space of healthcare in IRCs as a result of mistrust. The provision of legal aid solicitors who are employed by the HO in taking on particular cases in IRCs also influence the decision-making process of detainees as they are presented with limited options in gaining legal representation and are generally deterred as the majority of cases do not fit the criteria for legal aid. These issues contribute to the political factors that places migrant detainees in a position of abjection and disempowerment.

There is a lack of regard or respect for the dignity of detainees within IRCs for both genders by the IRC officers, particularly women where privacy in their cell is

concerned. This is mainly attributed to the policies that govern the IRC officers involving the monitoring of detainee movement and their cells including being the first line of contact in the communication of their needs and the accessing of items, services, facilities and staff within the IRC. The IRC officers who are predominantly prison officer trained tend to implement the prison style of treatment on the detainees in IRCs. These factors place the IRC staff in a position of power over the lives of the detainees who feel intimidated, disbelieved and feel a lack of concern for their welfare during their time in detention which tend to cause barriers in accessing adequate healthcare thus hampering their wellbeing and the exercising of their rights.

Migrants with irregular status and detainees are treated as criminals thus forming the distinct lines of power relations between the detainee, the HO and IRC staff. The detainees feel a sense of unworthiness – that people in the society of the UK believe that they do not deserve to be provided with the same level of care as that which is provided in the healthcare service for the community. The accounts from the detainees generate a perception that they are not being treated as human beings by the HO and believe that the public are not well-informed. They believe that the misinformation is attributed to the public's perception of them as criminals and undeserving as a result of the political agenda set by the government which has positioned them within the space of abjection and being subjected to hostility and non-rights. The political agenda set by the government to normalise the state of exception by deploying strategies to achieve state security is made possible through creating the perception of a threat and conceiving the idea of the need for security measures to be put in place. This has fuelled the government's persistence in detaining, deporting and dispersing undocumented migrants with disregard to their health, wellbeing and rights. This has caused a crisis in liberal legality where the HO use their discretionary power to override their own policies which determines that an individual is not fit to be detained but still maintain the decision to detain regardless of the evidences provided. The HO's concern for migrants with irregular status seems to rest solely in the anticipation of the migrant absconding and slipping through the net, thus providing the driving force behind their persistence in detaining migrants despite the health problems they present with.

The policies that govern IRCs are regarded by detainees as being implemented for the purposes of ensuring compliance is achieved by the detainees. Migrant detainees perceive the complying to rules within an IRC as being regarded by the HO of a greater

level of significance than concern for the health conditions the they are suffering from, as encountered by the participants I spoke to, particularly those persistently placed in solitary confinement and eventually prison despite the evidence of a mental health condition. The detaining of migrant detainees in prison is perceived as a form of punishment by the detainee and the UK society. This is due to the HO dismissing the evidences and the manifestations of the detainee who was suffering from a medical condition and justifying their case that he was refusing to comply with the rules of the IRC.

The detaining of migrants in prisons also suggests to society that they are deserving of such treatment and that the punishment is justified due to the migrant not securing a legal status in the UK – which is deemed as a result of their own actions, thus having themselves to blame for their demise. The participant I interviewed along with other migrant detainees are detained in prisons by the HO even though they have not committed a crime and are detained along with convicted criminals. They are not given the opportunity to be tried in court to defend their case prior to their detention, but are rather detained first and later present their case in court, if they are fortunate enough to acquire a solicitor who is determined to see their case through. This places the migrant detainee who is already in a position of vulnerability at greater level of vulnerability and trauma. Hence, the governing techniques used in the normalising of the state of exception through the detaining of undocumented migrants for the purposes of achieving state security places them in a position of fear and non-rights where the perception is created by the government that they are undeserving of the basic human rights.

The account of the migrant detainee who experienced both immigration detention and prison in the UK believes that healthcare services are more improved and much more accessible in prisons as compared to the IRCs. He believes that English people or those with a legal status are detained in prisons and are therefore more privileged and treated more fairly than those detained in IRCs. A distinct contrast is thus evident in the standard of care provided in prisons of a generally better quality than that of IRCs where the standard of healthcare provided is perceived to be associated with the legal or non-legal status of the detainees where an institutional culture pertaining to the undocumented migrant has been conceived that they are undeserving of healthcare and are to be disbelieved of suffering from illnesses, particularly those pertaining to mental

health conditions. Hence, placing a migrant detainee in prison for further detention, regardless of whatever the case justified by the HO is reinforces the notion of the tools of punishment and control being wielded as a strategy deployed by the government over a marginalised people who are being perceived as a threat to the nation of the UK.

The ex-detainees I spoke to expressed a strong feeling of disenfranchisement in residing in the UK, particularly through their experiences of entering an IRC. They express a disappointment in their expectations of the UK government and despair as their lived experiences in the UK has not measured up to their initial expectations of what they perceived the UK could offer them in terms of safety, legal status and opportunities towards improving their life and wellbeing. Instead, a conception has been conceived regarding a sense of the government working against them. This has caused the migrant ex-detainees to believe that there are barriers that are being purposefully set up to prevent them from contributing effectively towards the nation of the UK thus disabling them from attaining the empowerment needed to become positive role-models for their children and ethnic community. There is a strong sense of tension expressed by the migrant ex-detainees as they recount their experiences generally pertaining to the government utilising its discretionary power by constantly changing the rules governing migrants, which attributes to the crisis in liberal legality mentioned by Schmitt (2004). This makes it difficult for undocumented migrants to maintain a stable lifestyle thus disabling them from being able to provide for their families as they are rendered jobless and homeless.

The migrant ex-detainees expressed a sense of neglect as a commonwealth citizen as to why they are being deprived of the basic human and healthcare rights in the UK and why they are being denied of access to healthcare services, work, education, housing and others despite coming from a nation that has the UK monarchy as their sovereign, thus expecting to receive the same level of rights as the UK citizens. The migrant ex-detainees I interviewed all came from the commonwealth countries and expressed heavily the feelings of being demeaned in the UK and particularly in immigration detention as they are stripped to bare life as a result of the governing strategies in the normalising of the state of exception. There is a strong sense of *them* and *us* governing the lived spaces of migrants where this distinction impacts detrimentally on their health, rights, lifestyle choices and wellbeing, placing undocumented migrants in a position of anxiety, depression, mental and physical ill health and destitution. This renders them

powerless to make tangible decisions about life itself as they live in limbo as undeserving beings under the mercy of the government and its desire to detain, deport and disperse in the name of state security.

Chapter 7

Conclusion

This study shows that equity ceases to exist at the point where border enforcement and the right to healthcare converge. As my analysis points out, this is because, the two worlds of border enforcement and healthcare are unable to co-exist as they contradict each other and are linked together only through "power". This is causing high levels of stress among health care professionals who feel a great tension when performing their duty in IRCs. Hence, it can be argued that the governing techniques of the HO have led to significant risks to the health and wellbeing of the migrants in detention. In order to be able to understand better the concept of immigration detention, I deemed it necessary to begin this research study with the history of how IRCs were established in the UK. This allows an insight into the initial governing strategies and laws that were enacted pertaining to immigration detention in the UK during and after the first and second World Wars to this day.

7.1 Contribution to knowledge

This research study extends the conceptual debate of power and governance initiated by Agamben's (1998; 2005) camp and security paradigms and Rose's (1999) notions of good governance and healthism. It provides an insight into the type of barriers migrant detainees face when accessing healthcare services in IRCs.

The lack of research on IRCs and the public health implications on the life of migrant detainees has led this research study to examine immigration detention in order to bring to light the variations of power within the social production of space and how it affects the migrant detainee's decision-making process in the accessing of healthcare services. The theoretical framework of governance and biopolitics are applied to assist in analysing the representations of migrant detainees and workers of IRCs on immigration detention in the UK where the criminalisation of undocumented migrants and the

governing techniques of border control are denying migrant detainees of accessing adequate healthcare services.

The questions central to this research study asks: What impact does the governing strategies of immigration detention have on the healthcare delivery of detainees? How do these strategies influence and determine the lifestyle choices and health outcomes of migrant detainees? What role does human rights play in light of these strategies? What type of institutional system has been established which determines the power relations that exist between the actors of immigration detention?

In answering the first question central to this research study on what impact the governing strategies of immigration detention have had on the healthcare delivery for detainees is revealed in the overall findings which show the following: there is a failure in the provision of care where the doctor-patient relationship has become fragmented due to the lack of trust, disbelief by the HO and a lack of respect for privacy in the maintaining of an individual's dignity, limited options in the detainee gaining legal representation. There is also a lack of consistent recording, reporting and evaluating of patient data. The use of market mechanisms, that is, the using of private contractors to manage IRCs impacts greatly on the delivery of healthcare services which has caused its access to become hampered.

The overall findings obtained in answering the second question central to this research study concerning how the governing strategies of IRCs influence and determine the lifestyle choices and health outcomes of migrant detainees is revealed through the disempowerment and denial of healthcare services. This is achieved through the removal of the rights of the migrant detainee where they are blocked from making a tangible decision about their health as they are deterred from seeking healthcare through; the instilling of fear, institutionalised culture of discrimination and the lack of resources and specialist staff in the provision of healthcare services.

The overall findings support the answering of the final research question pertaining to what role human rights plays in light of these strategies which begins at the detaining of migrants who have not committed a crime and do not go through a judicial hearing before being sentenced to detention. The subjecting of people to arbitrary treatment of detention in an IRC, the conditions of an IRC in combination with the knowledge of indefinite stay causes vulnerable people including those who are not to become

vulnerable as a result of immigration detention where their illnesses are exacerbated. The HO over-ride their own policies in order to detain and prolong the detention of migrants, including those who have been classified as vulnerable by disregarding their health conditions.

The type of institutional system that has been established in immigration detention is based on a culture of discrimination which is encouraged to thrive as it determines the power relations that exist between the service providers (the HO, the private companies, healthcare commissioners and professionals) and the service users (migrant detainees) of healthcare in immigration detention.

This research study captures the power relationships between the service users and the service providers of IRCs through the social production of space at an individual, institutional and societal level which is achieved by using the three variations of political power based on concepts derived from the paradigms of governmentality, the camp and security. These paradigms help support the argument based on the government using its sovereign and discretionary power in the deploying of techniques to securitise the nation against a perceived threat. This technique is assisted by the strategies of governing through the delegating of power and responsibilities to the local people with the inclusion of market mechanisms where private security companies are used to manage and provide goods and services for IRCs causing a demand for the arresting and detaining of migrants in IRCs to drive up profits due to the supply of IRCs. The delegation of responsibilities by the government is evidenced in the deploying of strategies to coerce people by recruiting frontline workers such as, administrators, managers, practitioners, agencies and contractors in the various institutions of the UK, as border guards in the attempt to control migration. The use of electronic and biometric systems combined with the recruiting of people as border guards assists the virtual border control of migration on a great scale. The variations of power in governing, securitising and delegating, including the imposition of state will on its subjects in the context of immigration detention has led to failures of practice and weak implementation of policies which proves detrimental to the public health and rights of migrant detainees.

Healthcare in Europe and the UK is a basic human right which is recognised by all the Member States that regardless of status, ethnicity, age, gender and others, everyone has

the right to access and receive healthcare. Due to the absence of rights in accessing healthcare as a result of the migrant's legal status, they are used as a scapegoat for the ills of society and are seen to be a threat to the security and welfare of society where stigma is placed on migrants who attempt to access healthcare services. Hence, the perception is created by the government that migrants enter the country with the intention of taking advantage of the healthcare system and are thus deserving of border control enforcement even in its punitive form in order to deter and act as a warning to migrants who may wish to free-ride the NHS – termed as health tourists. However government reports reveal that health tourism costs 0.3 percent of the total NHS budget where the government seeks to recover funds in order to plug the hole in NHS funding (Full Fact, 2019; Chalabi, 2013). Despite this minute proportion of migrants, which includes ex-patriates taking advantage of the UK's health system, the government has decided to use this to their advantage and create a false perception to the UK public that migrants have contributed greatly to the NHS budgetary crisis (Full Fact, 2019; Chalabi, 2013).

Migrants being perceived and treated as criminals has led to the conception of a hostile environment within the space of healthcare. This has repercussions for public health on both citizens and non-citizens alike. Delays in detection and treatment of illnesses have the potential of increasing the prevalence of diseases and causing a financial strain on the NHS in the long-run. This is as a result of the majority of detained migrants who are being released back into the UK community and have not had the adequate healthcare they required whilst being detained where their illnesses may have reached the advanced stage, thus requiring treatment that may have been avoided or would have been of less cost to the NHS if the health condition had been attended to in its earlier stages. Deploying public health pathways enables the location and streamlining of structural determinants and factors that lead to barriers in healthcare access. This will allow for effective allocation of interventions that would result in early detection and treatment of diseases and provision of information on ways to navigate the system to increase confidence and access so as to reduce inequities in healthcare access.

The government must also regard the need to reduce health inequities for everyone who wishes to access healthcare services in England according to the Equality Act (2010) and Health and Social Care Act (2012). This means that migrant detainees have the right to receive healthcare that is equivalent to that which is available to the general

population within the community, which is also in line with the Detention Centre Rules (2001). Health and wellbeing services are responsible for dealing with health inequities and the wider determinants of health in IRCs by seeking to improve the health and wellbeing of migrant detainees (Home Office Enforcement, NHS England and Public Health England, 2015). The DH, NHS England and CCGs are also responsible for regarding the need to reduce inequities in access to and outcomes from healthcare as a priority (Allen, 2016). Exploring the three variations of power based on the governmentality, camp and security paradigms helps bring about an understanding of the impact the hostile environment has on the health and healthcare access of the migrant detainee. The techniques of governing within IRCs and the border control enforcement within the wider UK health system reveals the ways in which the migrant detainee becomes disempowered and deterred from accessing healthcare services. This affirms the need to examine immigration detention through a public health perspective in order to be able to understand what type of barriers are presented to the migrant detainee that lead to the inequities in their healthcare access.

7.2 Implications for the migrant detainee in the accessing of healthcare services

Healthcare is an essential element in the life of a migrant detainee or indeed, any other human however, the migrant detainee's need for healthcare is being used as a tool of discipline to control them within the space of immigration detention. The migrant detainee is therefore unable to make any tangible decisions about their health due to the enacting of the border within the institution of immigration detention where immigration laws supersedes laws pertaining to human rights and healthcare (Butler, 2004).

The instilling of fear has become a tool used in deterring migrant detainees from seeking healthcare services as the feelings of mistrust and disbelief between the migrant detainee, the IRC staff and HO becomes established. The need of the migrant detainee to access healthcare services is being used as a tool through which to control the detainee and influence their decision-making process. Migrant detainees are often told that they will be subjected to immediate expulsion if they seek further medical care or that an extension will be placed on the length of their detention. Those responsible for governing IRCs have established a culture where migrant detainees are stripped of their right to make a tangible decision about their health through the instilling of fear and the

denying of their healthcare and human rights. This places migrant detainees in a position of non-decision referred to by Bachrach and Baratz (1962). Using fear as a tool in which to instil fear within migrant detainees in order to deter them from accessing healthcare services is in breach of the legal obligations of the IRC where they have a duty to provide healthcare services to the detainees according to the level that is representative of that which is provided in the community of the UK as stated by the healthcare commissioners for prisons and immigration detention (PHE, 2014; Home Office Enforcement, NHS England and Public Health England, 2015).

The overall findings reveal that there is a failure in the provision of care where the doctor-patient relationship has become fragmented due to the lack of trust. The feelings of fear cause the detainee patient to mistrust the doctor as they may perceive either rightly or wrongly the IRC doctors as agents of the HO thus preventing them from opening up or revealing to the doctor their health issues or concerns about their care in the IRC. Hence, the fragmented doctor-patient relationship is formed within the space of healthcare in IRCs as a result of mistrust. The government's deploying of governing techniques is produced in the form of weak implementation of policies evidenced through the lack of training, lack of supervision, lack of transparency and the lack of establishing systems that effectively report, monitor and evaluate cases of illnesses and disease in IRCs. Mistrust in the doctor-patient relationship has been conceived and institutionalised in IRCs as a result of dual-loyalty of the healthcare professionals in their sense of responsibility to the HO (which pertains particularly to those who are employed by the HO through private companies). Disbelief by the HO is also conceived regarding the evidences produced in the medical records of detainee cases brought to them causing dismissal of cases (despite the compelling evidence presented of detention posing a harm to the health of the detainee) which they justify is due to the lack of compliance of doctors to HO procedures and policies. The lack of compliance to procedures by the doctors is mainly attributed to the lack of transparency by the HO in providing training to follow procedures correctly. This has given rise to the functioning of the hostile environment in the space of healthcare in IRCs where liberal legality allows the HO to use the lack of compliance to their policies as a tool in which to punish migrants in maintaining and prolonging their detention in IRCs.

The overall findings further reveal that although access to healthcare is a right and not a privilege, migrant detainees do not have access to the avenues in which to assert their

rights. The provision of legal aid solicitors who are employed by the HO in taking on particular cases in IRCs also influence the decision-making process of detainees as they are presented with limited options in gaining legal representation and are generally deterred as the majority of cases do not fit the criteria for legal aid. These issues contribute to the political factors that places migrant detainees in a position of abjection and disempowerment. This leads to another key finding concerning the respect for privacy in the maintaining of an individual's dignity which is a political factor that further reveals how barriers to healthcare enable the construction of the wider machinery of dehumanisation through the stripping away of rights of the migrant detainee. There is a lack of regard or respect for the dignity of detainees within IRCs for both genders by the IRC officers, particularly women where privacy in their cell is concerned. This is mainly attributed to the policies that govern the IRC officers involving the monitoring of detainee movement and their cells including being the first line of contact in the communication of their needs and the accessing of items, services, facilities and staff within the IRC. The IRC officers who are predominantly prison officer trained tend to implement the prison style of treatment on the detainees in IRCs. The practicing of sexual exploitation and harassment has become widespread in immigration detention and is used as a tool of intimidation by the IRC officers in order to instil fear within the female detainees. The tool of intimidation also works to silence those who are victimised including fellow workers who perceive and accept such acts of violence and inappropriate behaviour towards the detainees as an IRC culture. Such acts of sexual exploitation and harassment by IRC staff are dismissed even if reported where the victims are disbelieved and their case brushed under the carpet by the HO. These factors place the IRC staff in a position of power over the lives of the detainees who feel intimidated, disbelieved and feel a lack of concern for their welfare during their time in detention which often causes barriers in accessing adequate healthcare thus hampering their wellbeing and the exercising of their rights.

7.3 Power relations of the undocumented migrant and detainee on an individual, institutional and societal level

The migrant detainee is disempowered on multiple fronts pertaining to the individual, institutional and societal level. The institution of immigration detention has established a culture of discrimination where the migrant detainee is stripped of its rights and

becomes dehumanised. This culture of discrimination and the blocking of migrant rights has infiltrated the UK systems where laws and policies have been designed to deny migrants, particularly those with irregular status of the right to access adequate services. This has enabled the conception of the idea that a predominant proportion of the migrant population are made up of criminals and people who aim to take advantage of the UK systems. This has caused a misconception to be constructed within the UK society about migrants where they have become apprehensive in seeking public service due to fear of being arrested by the HO and detained.

Migrants with irregular status and detainees are treated as criminals thus forming the distinct lines of power relations between the detainee, the HO and IRC staff. The detainees feel a sense of unworthiness – that people in the society of the UK believe that they do not deserve to be provided with the same level of care as that which is provided in the healthcare service for the community. The accounts from the detainees generate a perception that they are not being treated as human beings by the HO and believe that the public are not well-informed. They believe that the misinformation is attributed to the public's perception of them as criminals and underserving as a result of the political agenda set by the government which has positioned them within the space of abjection and being subjected to hostility and non-rights. The political agenda set by the government to normalise the state of exception by deploying strategies to achieve state security is made possible through creating the perception of a threat and conceiving the idea of the need for security measures to be put in place. This has fuelled the government's persistence in detaining, deporting and dispersing undocumented migrants with disregard of their health, wellbeing and rights. This case is based on another key finding pertaining to the notion of Schmitt (2004) relating to the crisis in liberal legality where a decision is made to suspend the application of the law in order to deal with a crisis situation where border enactment and the right to healthcare converge, resulting in the government exercising its discretionary power by causing immigration laws to override health and social care and equality laws. In this case, the HO uses its discretionary power to override its own policies which determines that an individual is not fit to be detained but still maintains the decision to detain regardless of the evidences provided. The HO's concern for migrants with irregular status seems to rest solely in the anticipation of the migrant absconding and slipping through the net,

thus providing the driving force behind their persistence in detaining migrants despite the health problems they present with.

The rules and regulations that govern IRCs are regarded by detainees as being implemented for the purposes of ensuring compliance is achieved by the detainees. Immigration law is constructed in such a way as to deliberately undermine human and healthcare rights, thus subjecting the migrant detainee to surrender their will to the rules and regimes of the IRC which is designed to disempower and mute them to allow the HO and IRC workers to enforce their will over the lives of the detainees, thus hampering their access to the necessary healthcare. Migrant detainees perceive the complying to rules within an IRC as being regarded by the HO of a greater level of significance than concern for the health conditions they are suffering from, as encountered by the participants I spoke to, particularly those persistently placed in solitary confinement and eventually prison despite the evidence of a mental health condition. The detaining of migrant detainees in prison is perceived as a form of punishment by the detainee and the UK society. This is due to the HO dismissing the evidences and the manifestations of the detainee who was suffering from a medical condition and justifying their case based on the detainee's refusal to comply with the rules of the IRC. The detaining of migrants in prisons also suggests to society that they are deserving of such treatment and that the punishment is justified due to the migrant not securing a legal status in the UK – which is deemed as a result of their own actions, thus having themselves to blame for their demise. The participant I interviewed along with other migrant detainees are detained in prisons by the HO even though they have not committed a crime and are detained along with convicted criminals. They are not given the opportunity to be tried in court to defend their case prior to their detention, but are rather detained first and later present their case in court, if they are fortunate enough to acquire a solicitor who is determined to see their case through. This places the migrant detainee who is already in a position of vulnerability at a greater level of vulnerability and trauma.

Hence, the governing techniques used in the normalising of the state of exception through the detaining of undocumented migrants for the purposes of achieving state security places them in a position of fear and non-rights where the perception is created by the government that they are undeserving of the basic human rights. This pertains to Agamben's (2005) argument on the state of exception where in order for the

government to ensure state security, those classified as the illegitimate citizen must face death in order to protect the nation's citizens against the perceived threat – which is the migrant. The account of the migrant detainee who experienced both immigration detention and prison in the UK believes that healthcare services are more improved and much more accessible in prisons as compared to the IRCs. He believes that "English people" or those with a legal status are detained in prisons and are therefore more privileged and treated more fairly than those detained in IRCs. A distinct contrast is thus perceived in the standard of care provided in prisons of a generally better quality than that of IRCs where the conception is that the standard of healthcare provided is associated with the legal or non-legal status of a detainee. This suggests that an institutional culture pertaining to the undocumented migrant has been conceived that they are undeserving of healthcare and are to be disbelieved of suffering from illnesses, particularly those pertaining to mental health conditions which are exacerbated due to lack of medication and treatment and long periods of stay in an IRC. Hence, placing a migrant detainee in prison for further detention, regardless of whatever the case justified by the HO reinforces the notion of the tools of punishment and control being wielded as a strategy deployed by the government over a marginalised people who are being perceived as a threat to the nation of the UK.

The predominance of BMEA population that are detained in the UK IRCs in contrast to the predominance of *white* or European population in the UK prisons re-affirms the statement made by Participant I, whom I interviewed including the accounts by the participants from the report by Inegbenebor and Saga (2012) that people detained in UK prisons are treated much more fairly than those detained in IRCs. Thus there is a contrast in the treatment of people in prisons as compared to those in IRCs based on the institutional culture of discrimination towards the BMEA population. This conception of discrimination in the institution of detention is also supported by the evidence produced by the account of Participant D in his statement in the IRCs referring to the migrant detainees as prisoners, particularly in the healthcare forms they fill out (please refer to section 4.2) despite not being convicted of a crime or having completed serving their time in prison prior to detention in an IRC. This asserts the notion of hostility and disregarding of human and healthcare rights which disempowers the migrant detainee, preventing them from making a tangible decision about their healthcare and stigmatises them as criminals, thus not deserving of the basic human rights.

The ex-detainees I spoke to expressed a strong feeling of disenfranchisement in residing in the UK, particularly through their experiences of entering an IRC. They express a disappointment in their expectations of the UK government and despair as their lived experiences in the UK has not measured up to their initial expectations of what they perceived the UK could offer them in terms of safety, legal status and opportunities towards improving their life and wellbeing. Instead, a notion has been conceived of a sense of the government working against them. This has caused the migrant ex-detainees to believe that there are barriers that are being purposefully set up to prevent them from contributing effectively towards the nation of the UK thus disabling them from attaining the empowerment needed to become positive role-models for their children and ethnic community. There is a strong sense of tension expressed by the migrant ex-detainees as they recount their experiences generally pertaining to the government utilising its discretionary power by constantly changing the rules governing migrants, which attributes to the crisis in liberal legality mentioned by Schmitt (2004). This makes it difficult for undocumented migrants to maintain a stable lifestyle thus disabling them from being able to provide for their families as they are rendered jobless and homeless due to the laws devised by the HO that restricts and monitors their movement, housing, healthcare, work and other amenities of life. This makes integration back into society difficult post-detention as a result of living in fear of re-detention. Housing is provided by the private companies of IRCs for those who do not have family or friends to help, hence remaining under the watchful eye, power and control of the HO where some eventually become destitute as a result of the harsh and discriminating conditions that the migrant ex-detainee continues to be subjected to post-detention.

A migrant ex-detainee expressed a feeling of neglect by the UK government as a commonwealth citizen questioning why they are being deprived of the basic human and healthcare rights and asks why they are being denied of access to healthcare services, work, education, housing and others despite coming from a nation that has the UK monarchy as their sovereign, thus expecting to receive the same level of rights as the UK citizens. This assumption from the migrant detainee is also based on the law that was set after the second World War where the UK government opened its borders to migrants from the commonwealth nations to settle in Britain (Mustad *et al*., 2018) however, the necessary mechanisms that were to be put in place in order to safeguard

the commonwealth migrants against future issues with the law were not done thus subjecting them to the injustices of immigration law and the infringement on their rights. All of the migrant ex-detainees I interviewed expressed heavily the feelings of being demeaned in the UK and particularly in immigration detention as they are stripped to bare life as a result of the governing strategies in the normalising of the state of exception. There is a strong sense of them and us, that is, the legitimate citizen and the non-citizen or the deserving and the undeserving governing the lived spaces of migrants where this distinction impacts detrimentally on their health, rights, lifestyle choices and wellbeing, placing undocumented migrants in a position of anxiety, depression, mental and physical ill health and destitution. This renders them powerless to make tangible decisions about life itself as they live in limbo as undeserving beings under the mercy of the government and its desire to detain, deport and disperse in the name of state security.

The governance concept of Rose (1999) has been employed in order to be able to bring into context the discussion based on Agamben's (2005) state of exception to help bring about an understanding of how the governance techniques deployed in securing the state against a perceived threat does not enable good governance to thrive. The evidence of good governance being attributed to the practicing of the new public management of assigning managerial responsibilities to the local people and the private sector argued by Rose (1999) is clearly functional and has proved successful in producing the desired result expected from engaging in market mechanisms which involve aspects such as; competition, profit making, supply and demand. In the context of this research topic, supply pertains to the detaining of migrants in IRCs whilst demand is attributed to the IRCs reliance on the detaining of migrants to drive up profits. However, the perception constructed by the government that the establishing of policies would bring to order the systems and subjects of immigration detention is debatable.

The first-hand experiences and accounts of detainees and professional workers suggest that the technique deployed in governing immigration detention has not been effective. This has become the case due to what has evidently been conceived within the space of immigration detention regarding healthcare service provision and access. Healthcare professionals are impacted on in a way that hampers their ability to carry out their duties effectively along with the fear instilled in detainees which deters them from accessing

healthcare services. This has caused the relationship between the doctor and the patient to become fragmented due to the construction of dual loyalty as a result of the recruiting by the HO of healthcare staff, particularly through private companies and the perception from detainees of doctors as border guards. This has conceived another outcome of immigration detention which disrupts Rose's (1999) concept of good governance.

The normalisation of the state of exception by the government in deploying techniques to securitise the nation against a perceived threat – being that of migrants to the welfare and security of the UK society suggests that the government has an agenda and are rather concerned with state security and protecting their borders than the welfare of its citizens. This concern has been presented in the guise of a threat by the government by constructing the idea that the migrant population are responsible for the ills of the UK society. Hence, the exercising of sovereignty by the government extends to the protecting of its citizens which has involved the deploying of border control techniques, which also involves the prevention of access of non-citizens to healthcare services. It has become the norm to apportion blame to those whose voices are perceived as muted in society due to their non-rights where the short-comings of governing the nation is attributed to migrant infiltration as the cause of limited resources and the rise in levels of crime. Hence, the notion is conceived that migrants are deserving of punishment which presents itself in the hostile environment constructed by the UK government, through the stripping away of their basic human and health rights which is evidenced in its entirety within the space of immigration detention. This has conceived barriers to healthcare access for migrant detainees and has brought about challenges in the delivery of healthcare services where healthcare professionals' ability to do their duty is hampered under the governance of the HO and the IRC managers. The functioning of liberal legality in the HO's use of discretionary power has led to further infringements on the rights of migrant detainees where they are impacted upon adversely through the inadequacies in the healthcare provision as a result of the lack of accountability of IRC and healthcare staff.

7.4 The implications of the power relations between the HO and healthcare professionals

The lack of compliance to IRC policies are evidenced in several instances including the routine overruling of clinical judgment by the HO due to disbelieving the doctors and compromising their autonomy. The various factors mentioned provides the HO the basis for continuing the detention of a detainee who may be otherwise deemed clinically unfit to remain in detention where such a judgment is made possible by the HO's persistent changing of IRC rules and policies. These factors generate auditing issues which has led to inadequate documentation of medical records causing a lack of continuity of care for the detainee patient and a weak case to support their legal applications for residency. Accountability and transparency of the system and its workers in IRCs is undeniably lacking and encourages a culture of diminished responsibility to thrive. The inadequate training of staff in specialist areas to meet the needs of the various nationalities and other issues pertaining to human diversity causes low staff morale in managing and treating the detainee population which attributes significantly to the inequities in the accessing of healthcare services in IRCs (Clarke, 2017, 2018). The inconsistences in the following of protocols which causes the lack of compliance to HO policies has brought to light the need and importance of standardising systems in IRCs to assist in improving the delivery of healthcare to the subjects of immigration detention. This has the potential of helping to define more clearly the power that the healthcare professionals possess pertaining to their clinical practice and judgement where their authority would no longer be questioned by the HO due to improved compliance to procedures. The governing technique of the HO is made evident in this instance where they neglect to provide the healthcare staff with training that would enable them to comply to their rules. Thus weak implementation of policy has placed the HO in a position of power over the healthcare professionals to the extent that they dismiss the medical reports of a migrant detainee based on the lack of compliance of the doctor to HO policy in producing the medical report.

Weakness in policy implementation is also attributed to the failure to recognise IRCs as an institution that holds people that are not criminals and typically come from a background of vulnerability or are made vulnerable as a result of being subjected to the conditions of immigration detention. In order to secure the welfare of migrant detainees, it is fundamental that the issues pertaining to the legality and rights of this marginalised

population are addressed. Hence, the majority of IRC policies ought to reflect that of its own environment to meet the needs of its population rather than attempting to meet the standards set by prisons and IRC contractors.

In putting into context the impact and relevance of the State of Exception (Agamben, 2005) for this research project through the addressing of the public health implications for the migrant detainee population, Agamben's work has enabled this research project to extend the concept further to investigate what is happening as a result of the normalisation of the State of Exception, rather than focusing solely on why this is the case as noted by Colatrella (2011); Huysmans (2008, p.7) and Neal (2004, p.373, 2006, p.31-46). Addressing the SDH has helped to locate the various pathways associated with public health that identify potential barriers to the healthcare access for migrant detainees and the underlying factors.

7.5 Inequities in healthcare for migrants in IRCs

The following is an overview of the key findings of migrant detainees' experiences in IRCs for this research study revealing the SDH pathways that lead to the inequities in accessing healthcare.

Socio-economical effect:

1. Lack of finances to pay for access to medical records or other amenities, such as, food, clothing, medicines, phone credit, rent of cell and lawyer
2. NGO hand-outs, such as clothing are provided for free, but the items may have to be purchased in some IRCs
3. Some IRCs provide detainees with the option of working also provision of government allowance, however, not all detainees are able to work due to health conditions whilst others do not work as they believe that they are being exploited
4. Cannot afford a lawyer, most have to access legal-aid, however, legal-aid have their criteria of cases they take on hence the majority of cases are not followed through causing frustration and decline in their health conditions.

Biological and psychological effect:

1. Decisions are made to detain or prolong detention regardless of the migrant's health conditions
2. Migrants, especially undocumented are less likely to seek healthcare in the community, hence enter detention often with pre-existing illnesses
3. Language barrier prevents or delays the necessary treatment from being accessed
4. Being detained indefinitely causes and exacerbates diseases and illnesses.

Socio-political and institutional culture:

1. Racism – acts of violence and stigmatisation towards certain race, that is, disbelief of BMEA mental health and other conditions by HO
2. Homophobia – stigmatised and targeted by IRC officers, disbelief and mistrust between HO and IRC of detainee
3. Sexism – lack of regard for the detainee's privacy and dignity, especially females with acts of rape and indecent behaviour by IRC staff – disbelief and mistrust between detainees, HO and IRC staff
4. Criminalisation – migrants are perceived as more inclined to indulging in criminal activity hence undeserving, particularly those with undocumented status.

7.6 The effects of resistance and future work

The work of NGOs advocating for migrant rights is essential to bringing about awareness of the injustices that migrants face due to border enforcement and the hostile environment that has been instantiated in UK's public and healthcare systems. NGOs are integral to enabling the empowering process to take place for migrants as they act not only as the mouthpiece of migrants to provide a platform to speak out about their discourses but to also enable them to access the necessary care and support pertaining to health and their human rights. NGOs are generally comprised of professionals from a legal, medical or related background, including others who are experts through experience as an ex-detainee. The work of NGOs with migrants provides a solid ground

for discussion in the creation of awareness of the arbitrary treatment of migrant detainees and the existence of an institutionalised culture of punishment and control, not only evident in the immigration detention system, but also in the wider systems of the UK. This drives the work of resistance in the strife towards bringing about a change in the techniques used in managing immigration, to implement a more equitable and just alternative that does not infringe upon the healthcare and human rights of migrants. The strength and courage displayed by the participants who have contributed to this research project reveals that despite the intentions of immigration law and detention to punish and control migrants, they have a voice and cannot be silenced.

The privatisation of the healthcare rights of migrants – through the prevalent deployment of private contracting in healthcare has the potential to negatively impact on the wider UK society and healthcare system in the long-term. This will prove detrimental to the citizens of the UK as their healthcare rights may also become privatised resulting from the government's continual engagement with new public management through the extending of the role of private companies in providing goods and services.

Overall, the evidence produced from the findings in this research project reflects the government's agenda for border control and reiterates the non-rights that migrants of undocumented status are presented with in the UK which renders them powerless and unable to make tangible decisions on issues relating to their health and life itself. It is clear that the tool of discretionary power is being exploited by the government over the lives of the migrant detainee population and has proven detrimental to the public health of migrants in the UK due to the limiting of their basic human rights. Systems ought to be put in place to combat such cultures of discrimination and disempowerment from thriving within the space of immigration detention who are assigned with the responsibility of ensuring that the dignity, health and rights of the detainee population are upheld (Detention Centre Rules, 2001). The UK and its public institutions are obliged to comply with Human Rights legislations as a state that is a member of the EU Council (Council of the European Union, 2008) where Human Rights is enshrined in a society governed by democracy.

Future work following on from this research may focus more on gender issues concerning harassment and treatment of women in immigration detention. Other

possible areas for future research may be directed at investigating how access to healthcare is implemented in a hostile environment or how staff are recruited as border-guards.

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Appendix A

Interview questions' themes & codes for Health Professionals in IRCs

Theme 1 - Type of Health Service Provision
o General mix of population of patients assessed/treated o Contact/liaising of IRC doctor and the detainees' GP o The model of care for secondary or other specialist care, eg. the Rule 35, ACDT, mental health, communicable illnesses, etc. o Contact/liaising of IRC doctor and the HO concerning the health conditions of a detainee
Theme 2 - Health Policy Implementation
o Experiences and procedures that impact on the effectiveness of health record keeping o Aspects of working in an IRC that enhances or impedes the doctor's practice
Theme 3 - Training & Health Promotion
o Opportunities available to promote healthy lifestyle choices within the IRC o Evidence of forms of regular training and review of staff
Theme 4 - Monitoring, reporting and evaluation
o Strategies/systems in-place for data collection and monitoring for evaluation and improvement o Experiences in the non/consistent health record documentation and the impact on health service provision

This table provides a break-down of the interview schedule I produced for the health professional participants revealing the codes pertaining to the type of questions that were asked which are grouped into the 4 main themes.

Appendix B

My interview questions' themes and codes for the ex/detainee participants

Theme 1 – Health conditions of detainees and access to healthcare services in IRCs
o Individual routes to entering the IRC o Experience of initial health assessment (non/existent) o Unique/individual health conditions upon arrival & the care given o Health conditions acquired during detention & care given o Barriers/interruptions/delays in accessing healthcare specialists o Evidence of IRC health record-keeping for continuation of care
Theme 2 – Conditions of IRCs and its effect on detainee health
o Economic issues o Sanitation issues o Health & Safety issues o Perceptions & relationship between detainees & staff (HO + IRC)
Theme 3 – HO policies and its effect on detainee health & wellbeing
o HO rules & regulations in relation to the health & wellbeing of detainees o Detainee access to their medical records o Avenues of promoting health & aid/legal aid o Conditions/experiences of isolation/separation IRCs & its effect on detainee health o Prison involvement/experiences & its effect on detainee health o The effects of IRC on the detainee's ability to make a decision on their health & wellbeing o Detainee's perceptions of the government/HO

This table provides a break-down of the interview schedule I produced for the ex/detainee participants revealing the codes pertaining to the type of questions that were asked which are grouped into the 3 main themes.

Appendix C

Mechanisms of power within IRCs

Migrant Detainee	Professional Worker
Legality & Rights	*Provision of legal representation*
1.Undocumented migrants are detained/prolonged detention due to their non-legal status irrespective of health conditions. 2. Are limited in their human and legal rights. 3. Face difficulties in accessing a lawyer who can adequately deal with their case.	1.Lawyers are quite limited in the provision of legal representation to migrant detainees. 2. The legal system is a complex matter where numerous barriers arise in representing a migrant detainee.
Decision-making	*Autonomy*
Migrant detainees are unable to seek the necessary healthcare services or make informed decisions about their health through the instilling of fear.	IRC workers, esp. doctors make it a point to maintain their autonomy, ie. by drawing a line between a HO issue and a healthcare issue however, the assertion of autonomy is usually dependent on the route of employment of the doctor - via NHS or IRC contract.
Fear	*Coercion*
Migrant detainees fear seeking specialist healthcare as they are threatened with deportation or prolonged detention.	HO introduces and attempts to implement new systems into healthcare services which allows for data-sharing of patient information.

The above table presents issues that emerged from analysing the data I collected which are products of power as a result of the governance and biopolitical effect on migrant detainees and the professional workers of IRCs for this research study.

Appendix D

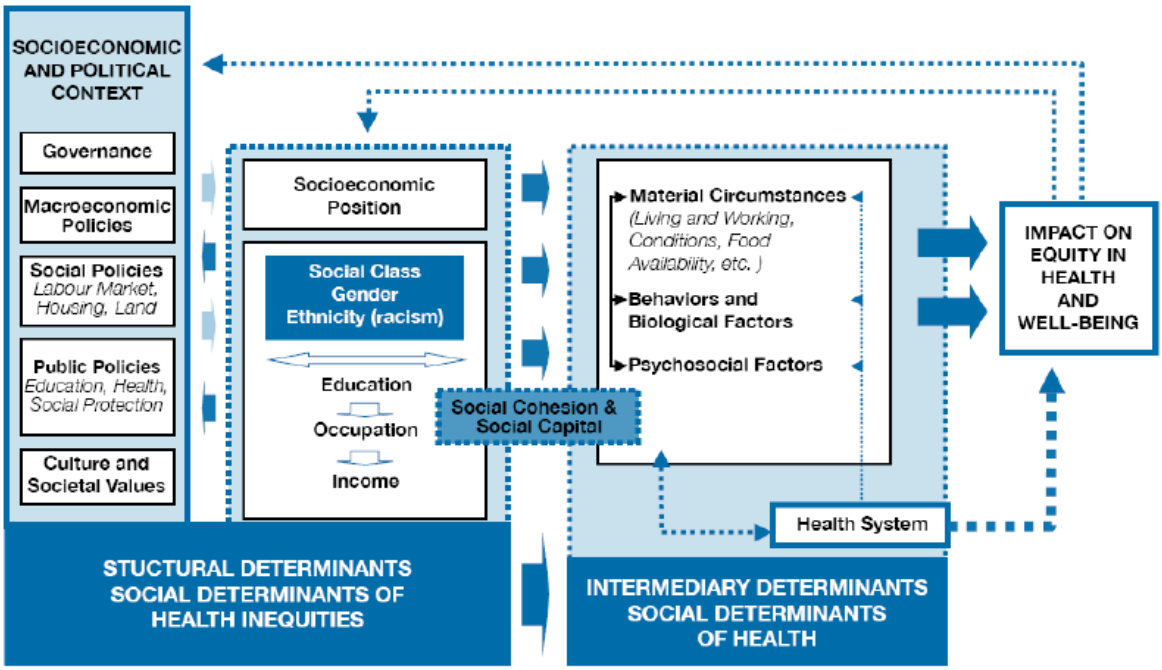
Inequities in Healthcare for migrants in IRCs

Socio-economical effect
5. Lack of finances to pay for access to medical records or other amenities, ie. food, clothing, rent of cell, etc. 6. NGO hand-outs are provided for free, but the items may have to be purchased in some IRCs. 7. Some IRCs provide detainees with the option of working also provision of government allowance. 8. Cannot afford a lawyer, most have to access legal-aid – causes frustration and decline in their health conditions.
Biological/Psychological effect
5. Decisions are made to detain or prolong detention regardless of the migrant's health conditions. 6. Migrants, esp. undocumented are less likely to seek healthcare in the community, hence enter detention often with pre-existing illnesses. 7. Language barriers prevents or delays the necessary treatment from being accessed. 8. Being detained indefinitely causes and exacerbates diseases and illnesses.
Socio-political/ Institutional culture
5. Racism – acts of violence and stigmatisation towards certain race, eg. disbelief of BME mental health and other conditions by HO. 6. Homophobia – stigmatised and targeted by IRC officers, disbelief and mistrust between HO and IRC of detainee. 7. Sexism – lack of regard for the detainee's privacy and dignity, esp. females with acts of rape and indecent behaviour by IRC staff – disbelief and mistrust between detainees and HO/IRC staff. 8. Criminalisation -perceived as criminals and undeserving, particularly those with undocumented status

The above table is based on information retrieved from the primary and secondary data collected on migrant detainees' experiences in IRCs for this research study revealing the SDH pathways that lead to the inequities in accessing healthcare.

Appendix E

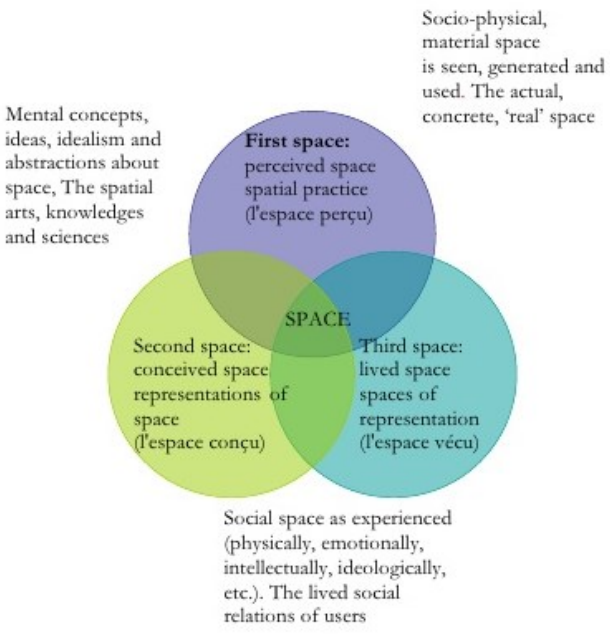
WHO Commission on Social Determinants of Health (CSDH) Model



Solar and Irwin (2007) 'A conceptual framework for action on the social determinants of health'.

Appendix F

Spatialised Trialectic



Pugalis, L. (2009) 'A conceptual and analytical framework for interpreting the spatiality of social life'.

Glossary

Refugee

Under the 1951 Convention Relating to the Status of Refugees, a refugee is someone who has a well-founded fear of persecution on one of five specific grounds.

Asylum seeker

People who have requested recognition in the UK as a refugee and are awaiting a decision are known as asylum seekers.

Undocumented migrant/migrant with irregular status

Undocumented migrants find themselves without the right documents for a variety of reasons, often beyond their control. These include:

- Refused asylum seekers
- People on spousal visas whose relationship breaks down
- People who don't claim asylum due to lack of legal advice
- People who came to UK to work without a visa
- People whose visa has expired (student/working/tourist)
- Survivors of trafficking
- People who came to the UK as children with undocumented parents
- People on spousal visas whose relationship breaks down
- Domestic workers on expired visas which their employer doesn't renew

Immigration Removal Centre (IRC)

These are holding centres for foreign nationals awaiting decisions on their asylum claims or awaiting deportation following a failed application.

Home Office (HO)

The Home Office is the lead government department for immigration and passports, drugs policy, crime, counter-terrorism and police (Bolt, 2015).

Immigration Rules

The Rules laid before Parliament by the Home Secretary about the practice to be followed in regulating the entry into and stay in the UK of people subject to immigration control (Bolt, 2015).

The Social Determinants of Health (SDH)

This is formed from the public health pathways and are based on the Commission on Social Determinants of Health (CSDH) model (Solar and Irwin, 2007) devised by the World Health Organisation (WHO).

University of East London

Dear Esther

Application ID: ETH1819-0211

Original application ID: u1035095

Project title: Migrant Detention: A Public Health Challenge

Lead researcher: Mrs Esther Afari-Mensah

Your application to Research, Research Degrees and Ethics Sub-Committee meeting was considered on the 24th of July 2019:

The decision is: Approved

The Committee's response is based on the protocol described in the application form and supporting documentation.

Your project has received ethical approval for 2 years from the approval date.

If you have any questions regarding this application please contact the Research, Research Degrees and Ethics Sub-Committee meeting.

Approval has been given for the submitted application only and the research must be conducted accordingly.

Should you wish to make any changes in connection with this research project you must complete 'An application for approval of an amendment to an existing application'.

Approval is given on the understanding that the UEL Code of Practice for Research and the Code of Practice for Research Ethics is adhered to.□□

Any adverse events or reactions that occur in connection with this research project should be reported using the University's form for Reporting an Adverse/Serious Adverse Event/Reaction.

The University will periodically audit a random sample of approved applications for ethical approval, to ensure that the research projects are conducted in compliance with the consent given by the Research Ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of the project

Yours sincerely

Fernanda Silva

Research, Research Degrees and Ethics Sub-Committee

10th August 2017

Dear Esther,

Project Title:	**Migrant detention as a public health challenge: A qualitative study**
Principal Investigator:	**Professor Gargi Bhattacharyya**
Researcher:	**Esther Afari-Mensah**
Reference Number:	**UREC 1617 71**

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered by UREC on **Wednesday 5 July 2017.**

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

The Committee would like to commend you on the presentation of this application for ethical approval.

Should you wish to make any changes in connection with your research project, this must be reported immediately to UREC. A Notification of Amendment form should be submitted for approval, accompanied by any additional or amended documents:
http://www.uel.ac.uk/wwwmedia/schools/graduate/documents/Notification-of-Amendment-to-Approved-Ethics-App-150115.doc

Any adverse events that occur in connection with this research project must be reported immediately to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
NGO building, public space, place close participants' homes, public space convenient to participants	Professor Gargi Bhattacharyya

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
UREC application form	2.0	31 July 2017
Participant Information sheet	1.0	20 June 2017
Consent form	1.0	20 June 2017
Interview schedule	1.0	20 June 2017
Distress protocol	1.0	20 June 2017
Medact permission letter Research and Advocacy Manager Feryal Awan	1.0	20 June 2017

Approval is given on the understanding that the UEL Code of Practice in Research is adhered to.

The University will periodically audit a random sample of applications for ethical approval, to ensure that the research study is conducted in compliance with the consent given by the ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Fernanda Silva

Fernanda Silva
Administrative Officer for Research Governance
University Research Ethics Committee (UREC)
Email: researchethics@uel.ac.uk