Input for HRC46 Report: Report on Anti-Muslim Hatred and Discrimination

Part 1: About Medact & this submission

1. Medact is a public health charity focused on addressing the social, economic and political conditions which are root causes of health inequalities.

2. This submission focuses on the so-called "Prevent duty" in the UK National Health Service (NHS), drawing on the July 2020 Medact report *False Positives: the Prevent counter-extremism policy in healthcare*.[1]

3. As such, it pertains to specific elements of the call for input from the Special Rapporteur on freedom of religion or belief, namely section 2B, discriminatory laws and practices in the area of (ii) economic, social and cultural rights, wherein it focuses on healthcare; and 2C, counter-terrorism measures, preventing violent extremism legislations, de-radicalisation programmes.

Part 2: Background to Prevent

Legal provisions

4. The "Prevent" policy, one strand of the UK government's CONTEST counter-terrorism strategy, was implemented in 2006 following the London 7/7 bombings.

5. Since the Counterterrorism and Security Act 2015, specified public authorities are legally obliged to "have due regard to the need to prevent people from being drawn into terrorism".

Evidence base

6. There is no solid evidence base that Prevent reduces terrorism risk and the programe has never been independently evaluated. In addition, there has been very limited transparency about and scrutiny of the empirical work underpinning the policy.

7. Prevent training materials prime people to spot so-called "signs of radicalisation" based on criteria called the Extremism Risk Guidance 22+ (ERG22+), also known as Channel Vulnerability Assessment Framework. These were originally based on a single psychological study which identified at least 22 factors deemed to potentially indicate radicalisation risk. The ERG22+ paper was initially classified, and was not published in a peer-reviewed journal until 2015. Despite this, the framework has been embedded in Prevent since 2011.

[1] https://www.medact.org/wp-content/uploads/2020/07/MEDACT-False-Positives-WEB.pdf

8. In February 2020, the UN's Special Rapporteur on the promotion and protection of human rights and fundamental freedoms while countering terrorism noted that psychometric systems like the ERG22+ "mix structured forensic analysis models, traditionally focused on mental illness and deviance, with other models of intelligence analysis containing strong ideological and political connotations" and "consistently use ambiguous factors in their application". Their predictive value is highly questionable.

9. Evidence for government claims that people with mental health conditions or learning disabilities are more likely to be drawn into terrorism is not robust enough to base policy upon. In addition, use of mental health as a generalised, disaggregated category by government and by the ERG22+ is too ambiguous to be meaningful.

Prevent in the NHS

10. The UK is the only country in the world where healthcare bodies are legally obliged to be vigilant for potential "radicalisation". The UK government has long seen the health sector as a "critical partner" for Prevent. The NHS, with its 1.3 million workforce and 315,000 daily contacts with patients in England alone, is thought to be well placed "to identify individuals who may be groomed into terrorist activities".

11. Specific targets are set with regard to the online "e-learning" Basic Prevent Awareness (BPA) training and the Workshop to Raise Awareness of Prevent (WRAP), usually delivered in-person. NHS bodies are expected to train 85% of staff in at least the fundamentals of Prevent. Over 830,000 NHS staff have received Basic Prevent Awareness training and over 470,000 have attended advanced training.

12. The proportion of Prevent referrals coming from the health sector has consistently risen since the policy was placed on a statutory footing in 2015. However, the implementation and impacts of counter-terrorism measures in the NHS are markedly under-researched.

Part 3: Impacts of Prevent in the NHS on Muslims

Disproportionality and discrimination

13. Officially recommended Prevent training and risk assessment materials for identifying, operationalising and assessing radicalisation potential contain racial biases and, in urging workers to "trust your instincts" appear to elicit and empower widespread latent biases.

14. Accordingly, qualitative evidence suggests that perceived racial and religious identity are often important factors in informing health workers' judgements about what potentially constitutes "extremism" or "radicalisation" and can therefore critically influence decisions about when to make a Prevent referral. Race, religion, mental health conditions and age all appear to be important factors.

15. Research shows that people of Asian ethnicity and Muslim faith are disproportionately referred to Prevent via the NHS. Data on religion from six NHS trusts found that Muslims were referred to Prevent eight times more than non-Muslims and disproportionality was a consistent pattern across all trusts. These figures show that Prevent in the NHS mirrors the racial and religious disproportionality observed in other sectors where Prevent operates, and constitutes a form of Islamophobic discrimination.

Physical and mental health harms

16. Despite being labelled as a safeguarding programme, Prevent may actually harm the vulnerable, rather than helping them. Research has found evidence that Prevent referrals can damage the physical and mental health of the individuals concerned, as well as their families, in a variety of direct and indirect ways.

17. Prevent referrals of people already being treated for pre-existing mental health conditions damaged therapeutic relationships between health practitioners and patients, setting back recovery, interrupting care, causing patients to disengage, and limiting the support which health services can provide due to erosion of trust.

18. Some case study evidence suggests Prevent referrals can trigger mental health problems, including in individuals with no prior reported history of psychiatric illness.

19. Given the disproportionality noted above, these negative effects are likely to be impacting the health and mental health of Muslim communities more than others.

20. Data suggests that people with pre-existing mental health conditions, including schizophrenia, depression, and bipolar disorder, are disproportionately referred to Prevent. Despite official claims that people with mental health conditions are more likely to be drawn into terrorism, the evidence is not robust enough to support this, therefore this disproportionality may merely be a result of unwarranted suspicion stoked by this stigmatising claim, and compounded where the patient concerned is also perceived as Muslim.

Confidentiality, securitisation and health inequalities

21. Prevent training materials strongly emphasise the importance of disclosure, or even discourage consent-seeking, as well as conflating safeguarding with public protection and failing to distinguish between “vulnerable” patients and patients lacking capacity.

22. This has caused widespread confusion among health workers and damaged presumption of patient consent and confidential medical care, leading to many non-consensual referrals.

23. Prevent is an instance of a damaging “whole society” approach to counter-terrorism which securitises increasing areas of society. This has eroded trust in the medical profession, likely most intensely amongs Muslim communities.

24. Given pre-existing health inequalities experienced by Muslim communities, currently being exacerbated by the COVID-19 crisis, it is extremely concerning that Prevent may be exacerbating the problem and worsening existing health inequalities.

Part 4: Recommendations

25. Repeal the Prevent policy in healthcare in light of the lack of evidence of efficacy and documented evidence of harm.

26. Refocus counter-terrorism efforts on combating violence instead of arbitrary concepts like “extremism”, while healthcare and safeguarding should be ring-fenced from counterterrorism work.

27. Adopt evidence-based public health policies based on a holistic understanding of security, which address broader, long-term determinants of violence, including policies which drastically reduce inequality and reallocate funds towards mental health services, youth services, and drug and alcohol dependency services.

28. Take steps to address the harms caused by Prevent and rebuild trust in confidential, non-discriminatory healthcare services, especially amongst Muslim communities.

29. End lack of transparency and accountability including by immediately publishing historic data on the religion and ethnicity of people referred under Prevent, proportion of non-consensual Prevent referrals and evidence underpinning the ERG 22+.

Dr Hilary Aked
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