

ORIGINAL ARTICLE

# The Ethical Dilemmas Associated with Working in an Immigration Removal Centre

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**Abstract:** The purpose of this paper is to share with colleagues some of the ethical problems encountered in working in an environment unfamiliar to the vast majority of psychiatrists. The author, a consultant psychiatrist with 17 plus years' experience in the NHS, spent a year working part-time in Colnbrook Immigration Removal Centre; an institution holding just over 300 men who are held in administrative detention for periods of time ranging from days to years pending decisions on their immigration status. About 50% of these men have criminal records and the turnover of detainees is fast and unpredictable. The paper describes some of the everyday ethical problems encountered by the author together with some background to the working environment and attempts to tease out some of the key pillars upon which the doctor's work is based in order to inform the limitations and challenges she/he faces.

## Introduction

At the time of writing there are 12 Immigration Removal Centres (IRCs) in the UK. They are supposedly quite different in nature from each other and there appears to be no consistency of medical provision. Although the situation is currently in flux with National Health Service (NHS) commissioning being gradually introduced, historically there has not been any requirement for psychiatric input. IRCs are run by private providers on behalf of the UK Border Agency (UKBA)\* and various services within them, notably health, are subcontracted, sometimes in a piecemeal fashion. In the author's case he was the sole employee of his company with psychiatric nurses and counsellors being provided by another company.

\* The UKBA was abolished in April 2013 and its functions were brought back into the Home Office.

## Ethical dilemmas

From the literature around the subject of detention, it is evident that there will always be ethical dilemmas associated with psychiatrists working in any custodial situation.<sup>1</sup> This is only heightened by the situation in IRCs where people are only administratively detained meaning that they may be released on the basis of representations made by various professionals.

In fact, as should become evident from what I write below, I would go as far as to say that if a doctor works in such an environment and never experiences any conflicts or tensions with the detaining authority she/he is probably not giving enough thought to her/his ethical and GMC duties as a doctor.

## The role of the doctor

My understanding is that the doctor in this situation is the personal doctor to the people she/he treats.<sup>2</sup> This,

by definition, means that she/he is not the personal doctor of the vast majority of detainees at any one time. Because of the necessary triage role inherent in the nature of the work it will also be the case that the doctor will have seen a greater number of people on at least one occasion in order to determine that that individual is not a "case". Reasons for this can include:

- (1) The person does not wish to have treatment (and has capacity and/or is not deemed detainable under the Mental Health Act). This can be the case even if the person has a mental illness.
- (2) The person's symptoms, although not trivial, do not constitute a recognised mental disorder and/or no treatment is available for them in detention.
- (3) The person has a historical condition, evident from the medical history, but has no active symptoms (with or without ongoing treatment) and is better managed by Registered Mental Health Nurses (RMNs).
- (4) The person is malingering (in the formal sense of feigning illness for a goal-related purpose – see below).

It follows that the doctor will have a small caseload, which, because of the nature of the institution, will turnover frequently.

### Advocacy

As the patient's personal doctor, it is part of the role of the doctor to advocate for him. In this role the doctor has to exercise judgment, but is not obliged to act as judge. This is very important because in a parallel sphere (the court system and the UKBA system itself) people are doing exactly that.

A classic example of this is where the patient reports being tortured. While not being naïve about this, there should be absolutely no obligation on the doctor to seek out or even believe a court's judgment, as this could very easily conflict with her/his duty to her/his patient. If the patient cannot trust his doctor to believe him, whom can he trust?

However, by the same token the patient needs to understand that the doctor cannot go beyond her/his remit as treating doctor and take on the mantle of either expert or "campaigner". Nevertheless, it may become necessary for the doctor to make

representations (with the patient's consent) based on her/his clinical observations to the detaining authority.

### Mental capacity and mental health act issues

In practice very few people have a global lack of capacity to make decisions regarding their treatment.<sup>3</sup> A few have mental illnesses which necessitate a referral to an outside hospital. In these cases, which are usually due to a lack of insight into the need for treatment, which is therefore refused, there is often an accompanying lack of capacity to consent to UKBA being informed of this referral.

As long as the two are considered (separately but in parallel) it is almost inevitably going to be the case that it is in the best interest of a non-capacitous patient for UKBA to be informed of the referral, so that a hold can be placed on their removal.

The actual process of obtaining a warrant from the MoJ, under the section 48 procedure, is not controversial in itself, and enquiries from UKBA about progress can be dealt with under the same rules of engagement as outlined above. The issues of consent to communicate with UKBA, once treatment is complete, are the same as with non-"sectioned" patients and are dealt with below.

Because of the long periods people spend in detention it is not unheard of for people to relapse, often due to failure to take medication, once they have been discharged from hospital and returned to detention. In those circumstances consideration might need to be given as to their ongoing fitness for detention, given that there is no community mental health team to monitor and support them.

### Deskilling

An IRC can be a difficult environment for a psychiatrist to work in. For the experienced psychiatrist it can be deskilling for a number of reasons:

- (1) Psychiatrists are used to seeing people who present in a number of different ways but generally those with a likely psychotic illness are brought in by family who are concerned. Any corroborating evidence from family is virtually unheard of in detention.

- (2) In the "normal" world people do not actively seek a label of psychiatric illness, indeed there is some stigma associated with it. In detention a diagnosis is prized as there is a very strong shared perception that this confers benefits ranging from medication with perceived benefits (e.g. sedatives), through drugs which have currency value (e.g. antipsychotics or opiates), to delay or cessation of the removal process.
- (3) Malingering, or the deliberate feigning of symptoms to achieve such a diagnosis or treatment, is very common in people in detention and may start in the community. Symptoms of distress or adjustment can also be exaggerated to achieve similar results. All this is virtually unheard of in the community.
- (4) Language is a huge barrier to proper understanding. People with sufficient English to get by may eschew the use of an interpreter and doctors may inadvertently go along with this. Even telephone interpreting is pretty second rate compared with live interpretation which is never available.
- (5) Post-traumatic stress disorder is common (it is rarely seen in the community) and is usually worsened by detention. There is no psychologist, so little treatment is available, other than symptomatic medications and counselling.
- (6) The level of referral from RMNs and GPs is at primary care level, something most psychiatrists who work in secondary care are not used to as efficient triage systems mostly sieve such cases out.

#### Interface with the UKBA

From the personal doctor's viewpoint there can be no absolute obligation to communicate anything to the UKBA. Firstly the doctor's primary duty is to her/his patient; anything less is contrary to GMC guidelines. Secondly, the doctor owes a duty of confidentiality to the patient. While exceptions exist they are unlikely to be of relevance to this discussion. Thirdly the Data Protection Act 1998 covers the medical notes. This means that if the patient refuses (capacitously) to give permission for the release of information, it cannot be released to the UKBA. This regularly leads to tension as there is no tradition of respecting professional confidentiality and the

UKBA insists that detainees sign a "disclaimer" allowing their medical notes to be disclosed – something to which I would argue no professional can give any credence.

There are a number of reasons why the doctor may wish to communicate with UKBA (with the patient's consent). Chief among these is any reason why the patient would be deemed "not fit to fly" or "not fit to be detained". It is highly likely that a capacitous, properly informed patient will consent. The doctor's job, though, is not to positively certify people as "fit to fly". While one might hope that someone previously declared "unfit to fly" would give consent for the doctor to tell UKBA that the situation which previously pertained, no longer applies, if consent is not forthcoming then there is an ethical dilemma.

#### Courts

Advocates for the patient (usually in the form of his lawyer) frequently make applications to court for the person to be released or not removed. The information this is based on may or may not be the same medical information available to the IRC doctor. I am very clear that no doctor should produce a court report unless the following apply:

- (1) She/he has been made aware that they are being asked to report for the court.
- (2) It has been clarified if they are being asked in a professional capacity (which means they are the personal doctor of the patient) or:
- (3) In an expert capacity. Where they are being asked to see someone they have no doctor/patient relationship with for the purposes of giving an expert opinion.
- (4) Where the person's first language is not English, a competent interpreter attends (in the flesh). As mentioned above, this is something which never occurs in routine clinical practice.

A report can only be produced with the patient's informed consent. So if the doctor has triaged out a patient because she/he does not feel they have any symptoms which are treatable, or decided that the person is malingering, it would be a foolish or improperly informed person who would give the doctor consent to write a report stating this, when they may well have other evidence which supports their

case. In short, quite apart from the very significant time constraints there is very likely to be a conflict of interest between the role of treating doctor and report writer such that it is better routinely avoided.

Unfortunately, because of the culture pertaining in the institution I have often experienced significant problems at this interface. Examples include:

- (1) Information offered to UKBA (with the patient's consent) for the purposes of day to day management – often in the form of brief comments in an email – was routinely put before courts as evidence to support the UKBA's case, whatever that was.
- (2) The UKBA had a belief that I should assess anyone for whatever purpose they deemed appropriate (notwithstanding the fact that I was employed by a company subcontracted to their health contractor). They had no concept of the role of treating doctor or of patient confidentiality.
- (3) The UKBA did not understand the concept of the expert or professional report and had no tradition of requesting one to counter that offered by the detainee's lawyer. It had to be explained to them repeatedly that it was not appropriate to expect a treating doctor to provide information of this nature without the rules above being applied.
- (4) The UKBA did not understand that a professional report can never be "required" even of a treating doctor, as this is subject to the patient's consent which may not be forthcoming for any number of reasons (bearing in mind that mental capacity allows someone to make unwise as well as wise decisions).

### Training and support

Generic training alone does not prepare the psychiatrist for work in an IRC. Employers and doctors (as part of their CPD) need to think about what specific training is available and avail themselves of it. Organisations such as Medical Justice provide training courses which all immigration detention doctors could benefit from.

Doctors should make sure that they have a robust support network, from their CPD group, through

effective supervision and appraisal to their line managers. There is also an online forum for prison and detention psychiatrists. They should have a low threshold for seeking advice from colleagues, managers and their defence organisation as many problems can be confusing, complex and an objective adviser can be very helpful.

Because the doctor is first and foremost the personal doctor of her/his patient, it is important that she/he should be protected from taking too great a political role in the "system". Careful consideration should be given by both the doctor and her/his employer as to which meetings she/he should be involved with and it may be more appropriate for these to be dealt with by her/his manager instead. Her/his employer needs to be in a position to advocate for the role, as described, while simultaneously maintaining the customer relationship. The doctor herself/himself can neither do this nor is it appropriate for her/him to do so.

### Conclusions

Working in immigration detention is ethically challenging and it is important that the doctor is always alert to ethical issues when requests are made of her/him by the detaining authority or its agents. She/he must be willing to say "No" and take the consequences if any requests cross an ethical line (or at least to create breathing space to seek advice).

It is equally important for managers to be aware of these issues and to be willing to back up the doctor. Ultimately no doctor can act outside GMC guidelines with impunity and it would be a short-sighted policy to expect them to do so for the sake of commercial interest. Consideration needs to be given by employers to appropriate induction and training and as to whether doctors should work solely in this environment for protracted periods of time.

It is evident that there is a poor understanding of ethical issues within the UKBA and even careful education over a protracted period of time may be insufficient to change the culture. Collectively doctors who work in immigration detention should be willing to state that the current system does not work in the best interests of patients and to work with the authorities to effect positive change. In this context the advent of NHS commissioning is to

be welcomed, but much more needs to be done to bring standards up to even those we currently have in prisons.

#### DECLARATIONS

Competing interests: DA no longer works at the Immigration Removal Centre but does occasional pro bono work for Medical Justice, a charity which helps detainees with medical problems.

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- 3 Wilson S, Cumming I. *Psychiatry in Prisons*. London: Jessica Kingsley, 2010:147