UNIVERSITY OF OXFORD

Quality of Life in Detention

Results from MQLD questionnaire data collected in IRC Morton Hall during May 2012.

Written by: Mary Bosworth, Blerina Kellezi and Gavin Slade

Date: November 2012

Executive summary

Overview

This report presents the results of a questionnaire, measuring depression symptoms and coping strategies completed by 55 men residents of IRC Morton Hall in May 2012. It also includes some observations and points drawn from interviews with staff and detainees in the wider ethnographic study in which the survey was developed and administered. The survey measures perceptions of a range of issues including immigration case, mental health and ways of coping with detention. As is standard practice with survey administration, the respondents were anonymized and their responses were not independently verified.

The questionnaire records a number of demographic variables including age, nationality, marital status, history of imprisonment, immigration status and addiction. It asks respondents to report whether or not they are currently under an ACDT plan or have been previously and how healthy they felt. The questionnaire includes also a measure of depression in an abbreviated form of the Hopkins Symptom Check-List (HSCL-D) and a measure of coping strategies using an abbreviated version of COPE.

Both these measures have had very limited use in detention. As such, the findings in this report are preliminary. However, some important issues have been identified which deserve greater scrutiny, many of which we include as a list of recommendations for further attention and research. As the questionnaire is applied further it will be extended and refined. This will be an on-going process and one that will benefit from further discussion with detainees and staff.

The men in detention who completed the questionnaire came from a variety of countries and presented with a range of family, legal and medical histories. Some of them reported that they participated in activities in the centre, but many others found being in detention very difficult and could not take part in any of the activities on offer. Some found support in each other while others felt isolated and rarely left their rooms.

The level of distress among the survey population was very high with four-fifths of the respondents, 81.8% (n=45), classified in the abbreviated form of the HSCL-D with depression.[1] Those who were more depressed were more likely to have been in living in UK for less time, to be out of contact with their family, and to report health problems. They were also more likely to feel unsafe in the centre, perceive that the centre did not care about their welfare, report that they did not trust other detainees and that they felt negative about the future. Those who were more depressed were also more likely to deny the reality of the situation confronting them, and were

[1] This result reflects similar findings in other jurisdictions, e.g. with detainees in Norway and with former detainees in Australia and findings from our research in other detention centers in the UK (Bosworth and Kellezi, 2012).

less likely to see their situation in a positive light. **This is a very high level of depression and further research is needed to try to understand it and, perhaps, to mitigate it.**

Notwithstanding such high rates of depression on the HSCL-D scale, the current ACDT plan did not extend to all participants who reported thinking about suicide quite a lot or very much. This gap (only 3 participants reported being on ACDT plan while 16 reported feeling suicidal either quite a lot or very much) could reflect communication barriers between staff and detainees or it could signal a lack of trust and willingness on the side of detainees in reporting this information to centre staff. **More research is needed on both the suicidal thoughts of detainees and the adequacy of the current ACDT plan in capturing the risks they pose. This research should also explore staff views about the ACDT process.**

Just under one third of the men who took part in the survey reported feeling unhealthy or being in poor health. While this is a cautiously positive finding, during in-depth interviews respondents consistently complained about levels of nutrition in the food available, problems with stress and mental health, and the range and distribution of medicines provided by health services in the centre. **More focused research is needed to understand the specific health problems detainees tend to face in detention and the delivery of health care services.**

Issues of safety, feeling that the centre cared about their welfare, and positive views about the future were all related to one another. Those who were positive about their future also felt safe in the centre and believed the centre cared about them. Similarly those who felt safe in the centre believed the centre cared about their welfare. Those who trusted the other detainees more, felt safe in the centre, and believed that the centre cared about them.

It was noticeable in interviews that respondents reported little tension with other detainees or groups. Institutional strategies that encouraged good relations among detainees, particularly of different ethnic or cultural backgrounds, were related to positive attitudes towards the centre. At the same time, however, in the interviews many detainees reported uncertainty about the identity of others and concern over the possibility that they were living alongside dangerous or serious criminals. **Build on examples of good practice to foster greater communication and interaction between different nationality groups and individuals.**

Perceptions of safety at Morton Hall varied among the population. Older men felt safer as did those who had family in the UK, and those who had been in the UK for longer. This relationship, between length of stay in the UK and safety, depended on the men's history of imprisonment. Those who had been in UK longer were more likely to have been in prison, and as, a result, were able to speak English and understand British culture. Interviews suggested that those detainees who had previously served a term of imprisonment, while finding the experience of prison very different to life in an IRC, felt more at ease and experienced about the context of incarceration, and thus felt better able to adjust to the everyday workings of Morton Hall.

Many detainees find it difficult to cope with detention and the threat of deportation. There are many strategies they could chose to alleviate their stress, only some of which have a beneficial effect on mental health and wellbeing while others have a detrimental effect. The men in Morton Hall had found their own ways of dealing with being detained. The most common strategies they used were: planning to do something about their situation; actively trying to do something; and using emotional support by talking to other detainees about their situation and legal cases. It should be noted that all three of these primary coping strategies related to thinking about, working on, and resisting deportation.

Though these factors were associated with coping, interviews suggested that a relentless fixation on legal issues could also generate excessive worry. Given that the activities mentioned above are major ways in which detainees spend their day it is important that they are able to access as much necessary information as possible. This is also true for equipment such as fax machines and photocopiers as well as staff to whom they can ask questions as easily as possible with a minimum amount of stress. **Revisit mode and frequency of communication with staff and UKBA at both the local level and at the caseworker level.**

The ease of asking questions and gaining information was a common source of tension and stress both observed and mentioned in interviews. In certain units (such as Fry and Windsor) staff offices are closed off from the corridor. In interviews detainees felt staff in these offices were often inaccessible. Angry flare-ups between detainees and staff were observed due to this physical separation. In contrast, in units like Torr, where staff are located in a lobby area and on open desks, detainees reported higher levels of satisfaction about staff contact. **Morton Hall might like to consider ways of mitigating the physical design of some of the wings in terms of staff-detainee contact. The amount of time staff spend engaging with detainees seems to be related to their sense of wellbeing.**

Interviews suggested that detainees perceived the staff in the Diversity centre as available and open to queries. They also valued the library and internet centre (‘The Hub’). At the same time, however, they commented that ‘the Hub’ was often overcrowded and queues formed to send faxes in the library. In ‘The Hub’ the computer space is not fully partitioned off and computer users compete for space in what could be a noisy environment with the shop and family services. Finally, detainees frequently complained of their inability to access certain websites they felt they needed to communicate with the outside world.

Interviews and surveys suggested that detainees valued activities that could take their mind off their immigration case such as work, sport, and religion, all of which were frequently listed as coping strategies. Nonetheless, and somewhat paradoxically, it was observed and noted in interviews that a general apathy prevailed regarding opportunities to engage with the centre through taking up (paid) positions on institutional committees. The lack of interest in this kind of role may relate to the (presumed) short time horizon for being at the centre. It might also be a

manifestation of fatalism and a perceived lack of control among some (see below). **More research is needed on the practical effects of centre activities and the barriers to detainee uptake of opportunities.**

Coping is, of course, not always achieved through positive strategies of self-development. Rather, people in detention and elsewhere sometimes manage difficult experiences by relying on more negative strategies. In this survey, men reported two primary strategies of this kind: denying that they were in detention and abandoning attempts to deal with it. Interviews revealed that a common negative coping response was fatalism and a wilful belief that whatever could happen in the future would have to be better than the current situation.

Though men reported relying on such negative strategies to help manage their experiences, such techniques did not seem to assist their mental health. On the contrary more positive strategies like accepting the situation and thinking more positively about it were related to lower levels of depression. Detainees have little or no control over their detention and removal or deportation so accepting the situation they are in, might make them focus and plan their return or find legal help for release.

When participants were asked to report any other issues and concerns their responses focused on the justification of detention itself and the emotional impact of being confined awaiting removal/deportation. When asked directly in the interviews to compare with experiences of prison, they often explained that while prison might be a physically tougher environment, they could understand the justification for their imprisonment in contrast to their detainment in the centre. A further common complaint focused on the lack of definite time frame for being released or deported, which again was compared negatively with prison. During the interviews, detainees (and some staff) frequently complained about the lack of information or clarity surrounding detention in general, a problem that was perceived to be primarily the fault of the UKBA. Detainees also challenged the legitimacy of detention and the impact that deportation would have on their lives. **UKBA and the IRC estate should continue to develop a dialogue over matters of legitimacy, decency, service provision.**

In interviews, some men favourably compared Morton Hall to other IRCs. In particular, those with experience of other IRCs mentioned the rural setting favourably and the presence of trees and nature nearby. Though men appeared to value the environmental conditions, some expressed concern about the prison uniforms worn by the guards, claiming it reinforced the notion that detainees were prisoners in contrast to privately run IRCs where staff wear less formal clothing. **Morton Hall might like to consider altering the uniforms of the staff.**

Conclusion

The issues faced by the men in detention are complex and need to be understood in more depth. This survey attempts to gather information on their needs and experiences in a systematic fashion. Low levels of trust and high levels of depression, alongside language barriers and varying times in detention present significant challenges to administering a survey of this nature. It worked best, with a high rate of response, when administered as part of an ethnographic project that allowed detainees to become well acquainted with the researchers.

It should be noted that the staff at Morton Hall, and in particular the centre manager, welfare team and diversity unit, were highly supportive, open and helpful in allowing the researcher access. They advertised the research to detainees and gave up time to talk about their experiences and make suggestions to help the research process. This was very much appreciated and enabled a much more rapid period of data collection than we were able to do in other IRCs earlier in the project.

The purpose of this survey was to explore mental health and coping strategies used to deal with the stress of detention. This study was exploratory in its method of data collection as it tested a new questionnaire on coping strategies. Establishing trust with detainees was crucial in enrolling them to complete questionnaires on sensitive topics. The survey, which was designed on ww.surveymonkey.com could be administered online by the centre/UKBA themselves to monitor health and well being in detention. Due to the exploratory nature of this work, abbreviated version of existing measures on depression and coping strategies were used. Considering the high completion rate, it is likely that the full measures can be used successfully in the future.

Recommendations

1. **The high levels of depression found in the detainee community are a cause for concern and need further research to explain and mitigate.**

2. **In particular the gap between the self-reporting levels of suicidal thoughts and those on ACDT is worrying and needs urgent consideration.**

3. **Specialist research on the health needs of detainees and their perceptions of the health care is needed.**

4. **Build on examples of good practice to foster greater communication and interaction between different nationality groups and individuals.**

5. **Revisit mode and frequency of communication with staff and UKBA at both the local level and at the case worker level.**

6. **Morton Hall might like to consider ways of mitigating the physical design of some of the wings in terms of staff-detainee contact. The amount of time staff spend engaging with detainees seems to be related to their sense of wellbeing.**

7. **More research is needed on the practical effects of centre activities and the barriers to detainee uptake of opportunities.**

8. **UKBA and the IRC estate should continue to develop a dialogue over matters of legitimacy, decency, service provision.** What would constitute a 'decent' IRC? What do staff, as well as detainees, perceive the purpose of detention to be?

9. **Morton Hall might consider changing the uniforms of the staff.**

1. Method

The aim of the current project is to explore detainee mood and ways of coping with detention. It is the first project of its kind in the UK and as a result is necessarily somewhat exploratory. This report details findings from the survey administered at Morton Hall immigration removal centres to a convenience sample of 55. Part of the survey on mood disorder was piloted beforehand at IRCs Yarl's Wood, Brook House, Tinsley House, Campsfield House and Colnbrook.

The survey was administered while the researcher spent considerable time in the centre talking informally to staff and detainees. As a result, the response rate was very high for those approached, at around 90%. This rate reflects the mixed method approach and may not be replicable under different circumstances. Though the ethnographic method enabled a high response rate it may also have contributed to the relatively small sample size, as the researcher tried out various techniques of data gathering to capture more representatives, wide and systematic accounts of life in Morton Hall immigration removal centre, rather than focusing narrowly on just the survey.

As is standard practice with survey administration, the respondents were anonymized and their responses were not independently verified. For the majority of information, like time in the UK, contact with family and friends, and medical concerns, there were no independent reliable sources to verify the information. In addition, the sensitivity of the information gathered in an environment where it was very difficult to establish trust, required the researcher to offer assurances that staff would only be informed if the information they provided suggested they were a risk to self or others, or planned to escape from the detention centre. However, when completing the questionnaire with the help of the researcher, efforts were made to establish veracity of information in the questionnaire with information previously reported to the researchers during qualitative work. Though efforts were made to obtain a wide-ranging and random sample, we make no claim that it is statistically representative. Indeed, we are aware that, given that the majority of surveys were completed in English, that non-English speakers are under-represented. In the future we hope to translate the survey into high-frequency languages and to make greater use of interpreters in its administration.

Structure and content of the questionnaire

The questionnaire was composed of initial demographic data (age, nationality, religion, ethnicity family status and structure), information on previous periods in immigration removal centres and/or terms of imprisonment, legal status, a health questionnaire, information on their privilege

level in the current removal centre, the level of contact with family and others while in the current centre, health, and a questionnaire on ways of coping with detention. The participants were given the opportunity to add any other comments that could have arisen from completing the questionnaire.

The health questionnaire was an abbreviated version of Hopkins Symptoms Checklist (HSCL-D). That measure is a self report checklist that aims to detect symptoms of anxiety and depression in a 4 point Likert-type scale ranging from 1='not at all' to 4='extremely'. The items included 'Crying easily' and 'Blaming yourself for things'. The original checklist has 25 items and the one used in this study had 13. The items were chosen due to their appropriateness in the context, and because the participants were already completing a lengthy questionnaire. The 13 items retained in this study measured depression.

The questionnaire used to measure the coping strategies detainees chose to deal with the experiences of detention is the abbreviated version of the Cope Inventory. Each of the 14 sub-scales contains two items and it measures one coping strategy. Each coping strategy is conceptually different from the others. Each items was rated on a 4-point scale (where 1 = "I haven't been doing this at all" and 4= "I've been doing this a lot "). In the present study only part of the survey was used retaining 14 of the original items. This shorter version was necessary due to length of time required to complete the full questionnaire and concerns about overlap between the questions.

Administering the questionnaire

In less than one third of the total cases, one member of the research team read the questionnaire to the participants allowing him to clarify the questions if needed. This approach was taken to address the residents' low literacy rates and their mixed levels of proficiency in English. The remaining participants preferred to read the questionnaire themselves next to the researcher or in the privacy of their own rooms and at their own time. Overall, the questionnaire took between 30-40 minutes to complete. The questionnaire had a number of spaces where the answers to the open questions could be recorded.

Participants: Numbers, Language, and Recruitment

The questionnaire was administered to 57 participants, although only 55 participants completed the questionnaire in full. A total of 55 cases were retained for analysis based on having completed either the health questionnaire or the abbreviated COPE questionnaire in full.

Prior to completing the questionnaire, all participants were given an information and a consent form to read, or had them read aloud by the researcher. All participants were given the option to

sign the consent form though no attempts were made to persuade the participants to sign it if they were hesitant to do so. Verbal consent was obtained from all participants.

All questionnaires were administered in English.

The questionnaires were administered as part of an ethnographic study, meaning that participants were only approached after relationships of trust with the researcher had already been established. The researcher had free access in the centre to all parts of the building, carrying keys for most of the time he was present. He was also assisted by the centre staff who advertised the project, putting up posters and encouraging participation.

2. Results

- **Demographic data**

The nationalities of the participants are presented in table 1. The participants came from 17 different nationalities. These are categories suggested by the participants themselves.

Table 1. Nationalities of participants

Nationality	Frequency	%
Indian	12	21.8
Pakistani	11	20.0
Bangladeshi	7	12.7
Zimbabwe	5	9.1
Algeria	3	5.5
Afghanistan	2	3.6
Gambian	2	3.6
Iranian	2	3.6
Lebanese	2	3.6
Bosnian	1	1.8
Chinese	1	1.8
Congolese	1	1.8
Egyptian	1	1.8
Greek	1	1.8
Iraq	1	1.8
Nigeria	1	1.8
Somalian	1	1.8
Trinidad and Tobago	1	1.8
Total	**55**	**100**

The ethnic identities are presented in table 2, and religious identities in table 3. The participants chose the categories themselves.

Table 2. Ethnic identity

Ethnic identity	Frequency	%
Asian	37	67.2
Black	10	18.2

White	1	1.8
Mixed race	1	1.8
Total	49	89.1
Missing	6	10.9
TOTAL	55	100.0

Table 3. Religious identity

Religious identity	Frequency	%
Muslim	33	60.0
Sikh	7	12.7
Christian	7	12.7
Atheist/none	3	5.5
Buddhist	2	3.5
Apostolitic	1	1.8
Punjabi	1	1.8
Hindu	1	1.8
TOTAL	55	100.0

Information on age and marital status was requested from all participants. The majority were between 31-40 years old (n=23, 41.8%) and 21-30 years old (n=22, 40%). A few were between 41-50 years old (N=8, 14.5%) and two participants between 10-20 years old (3.6%). Marital status is presented in table 4.

Table 4. Marital status

Marital status	Frequency	%
Single	34	61.8
Married/ In a relationship	14	25.5
Separated/divorced	4	7.2
Widowed	3	5.4
TOTAL	55	100.0

The amount of time participants claimed to have lived in the UK varied enormously, from 18 months to 31 years; averaging out at 84 months (7 years). The veracity of their claims cannot be verified.

The majority (n=37, 67.2%) stated they had family members in the UK, with 31% (n=17) reporting no family members is the UK and 1.8% (n=1) failing to answer this question.

Just over two-thirds (n=37, 67.2%) of the detainees had children and of these, 14 (39%) lived in the UK.

- **Detention and imprisonment history**

The length of time (in months) detainees claimed to have spent in each centre varied from 15 days to over 6 months with the average being over 100 days.

A good proportion 23 (41.8%) of the men reported having been held in other detention centres.

The participants were asked how long overall they had spent in UK IRCs. Their responses can be found in table 5.

Table 5: Length of stay in the UK

Previous centers	Frequency	%
Less than 6 months	30	54.5
Between 6-12 months	15	27.3
Over 24 months	4	7.2
Between 12-18 months	3	5.5
Total	52	94.5
Missing	3	5.5
TOTAL	55	100.0

- **Previous prison sentence**

The participants were asked to report whether they had been in prison before being detained in removal centres and, if so, their length of prison sentence. Forty-nine per cent (n=27) of the participants stated that they had been in prison. The data on the length of sentences for those who were in prison is presented in table 7.

Table 7. Length of prison sentences

Previous centers	Frequency	%
Less than 1 year	11	40.7
1 year but less than 2 years	11	40.7
2 years but less than 4 years	5	18.5
TOTAL	27	100.0

Those who were in prison prior to detention were more likely to have been longer in detention.

- **Current and previous legal status in UK**

The participants were asked whether they are currently appealing their immigration/asylum case and 43 (78.2%) answered yes. Eight participants (14.5%) had their removal directions set. Their reports of their immigration status were not independently verified.

- **Life in the present detention centre**

The participants were asked to record their residential unit whilst in IRC Morton Hall. The answers can be found in table 8.

Table 8: Unit of residence while in Morton Hall.

Unit in YW	Frequency	%
Fry	17	30.9
Johnson	16	29.1
Windsor	13	23.6
Sharman	7	12.7
Torr	2	3.6
Total	55	100.0

The participants were also asked to report their level of incentives and privileges (IEP) at the present removal centre. Amongst those participants who completed the questionnaire with the help of one of the researchers, few were aware of the different possible levels of incentives and privileges that were available to them. After the researcher explained the differences they chose categories, which do not necessary reflect their true level, since their understanding of the topic was limited. It is not possible to comment on the understanding of the different levels of privileges and incentives amongst those participants who completed the questionnaires on their own.

Over half (n=32; 58.2%) claimed they were on an 'enhanced' level, 7.2% (n=4) reported they were on standard, 12.7% (n=7) on basic and 18.1%(n=10) did not know what level they were on. At the time of the research, none of the centres ran a basic regime on the main living units where the participants were interviewed.

- **Passing time in detention**

The participants were asked to indicate from a list a pre-selected activities how they spend each day in the removal centre. Amongst the most common activities listed were sports, working, praying, internet, and library.

- **Contact with family and visits at the centre**

The participants were asked about being in contact with family and receiving visits. The majority were in contact sometimes or regularly 70.1% (n=39) with their families and a small proportion were never in contact (n=9, 16.4%). The full results amongst those who received visits on who visited them can be found in table 9.

Some of the detainees explained that they preferred not be in contact with the family because they did not want to upset them or tell the family that they were detained.

Table 9: Contact with family

Visits	**Frequency**	**%**
Never in contact	9	16.4
Contact rarely	7	12.7
Contact sometimes	16	29.1
Contact regularly	23	41.8
TOTAL	55	100.0

Over one third of participants never received visits (n=21, 38.2%) and a similar amount received visits regularly or sometimes (n=21, 38.2%). Full results can be found in table 10.

Table 10: Visits received at the centre

Visits	Frequency	%
Never receives visits	21	38.2
Receives visits sometimes	12	21.8
Receives visits rarely	11	20.0
Received visit regularly	9	16.4
Total	53	96.4
Missing	2	3.6
TOTAL	55	100.0

- **The Hopkins Symptoms Checklist (HSCL-D)**

The HSCL-D was administered to all participants. HSCL was developed to identify persons with suffering from Depression and Anxiety. The original scale was developed in the early 1950s by a group of researcher at Johns Hopkins University in the USA. Since then the measure has been translated into many languages and used with a varied range of population including individuals undergoing difficult live events (including war and torture), prisoners, detainees, and immigrants. The scale contains 15 items on depression and 10 on anxiety. Only 13 of the depression items were included in this study: the item on depression investigating changes to sexual life was excluded as was 'Feeling everything is an effort'. The focus on depression was purposeful as the participants were already completing a lengthy questionnaire.

Depression is a mental disorder characterised by low mood, low self-esteem, diminished cognitive abilities, problems with sleep and appetite, and loss of interest in activities individuals use to enjoy before feeling depressed.

HSCL-D is a self-report measure (where the participants can read the questions themselves) but an interviewer can also administer it in a context where there is low literacy. The participants were asked to read a list of problems and complaints and select one of the descriptions (ranging between 'not at all' to 'extremely') that best described how much discomfort that problem had caused them in the past seven days. The list of problems included feeling low in energy, blaming themselves for things, crying easily, poor appetite, difficulty falling and staying asleep, feeling hopeless about the future, thoughts about ending their life, feeling trapped or caught, worrying to much about things, feeling no interest in things, and feeling worthless. Participants had to indicate the level of discomfort for each problem (full details on the answers can be in table 12).

The higher the mean the more the participants were likely to report experiencing the particular depression symptom. A mean of 1.75 or above is considered as a diagnosis of major depression. The majority 45 (81.8%) scored over 1.75 on HSCL-D overall.

The high proportion of detainees who scored over 1.75 on the HSCL-D overall was one of the key findings of the survey. As a comparator, it is similar to findings from research with individuals in detention in Norway and with refugees who had been detained upon arrival in Australia. It is also similar to research we have conducted in IRCs Yarl's Wood, Brook House and Tinsley House (Bosworth and Kellezi, 2012). Since our sample comes from a diverse cultural background, cultural differences in reporting of symptoms needs also to be investigated further.

The item ‘feeling sad’ had the highest mean, meaning the majority of the participants reported feeling sad quite a bit, or extremely. The other most frequently reported depression symptoms were, ‘worrying too much about things’ ‘feeling lonely’, ‘feeling of being trapped or caught’, ‘feeling low in energy and slowed down’ and ‘difficulty falling and staying asleep’.

As expected, the lowest mean (i.e. the least frequently reported depression symptom) was ‘thoughts about ending your life’. Nonetheless, a considerable number of participants (12.7%; n=7) reported thinking about ending their life ‘extremely’ while 16.4% (n=9) reported thinking about ending their life ‘quite a bit’. Taking into account that not all participants were willing to report thinking about suicide for cultural reasons (in certain cultures these thoughts are associated with being crazy) or for privacy (did not want the researcher to report the information back to staff), the number 29.1% (n=16) is very high and worrying. Full results can be found in table 11 and more detail about the individual responses for each item can be found in table 12.

Table 11: Mean scores for each HSCL-D item across the sample.

Item	YW Mean	SD
Feeling low in energy, slowed down	2.76	1.06
Blaming yourself for things	2.11	1.06
Crying easily	2.11	1.06
Poor appetite	2.06	1.06
Difficulty falling, staying asleep	2.75	1.13
Feeling hopeless about the future	2.38	1.22
Feeling sad	3.05	.97
Feeling lonely	2.78	1.13
Thoughts of ending your life	1.90	1.09
Feeling of being trapped or caught	2.78	1.22
Worrying too much about things	3.00	1.04
Feeling no interest in things	2.43	1.14
Feelings of worthlessness	2.43	1.25

Table 12: Frequency of response and percentage for each HSCL-D item on Morton Hall IRC

Item	Not a all	A little bit	Quite a bit	Extremely	Missing
Feeling low in energy, slowed down	16.4%	20.0%	32.7%	29.1%	1.8%
Blaming yourself for things	38.2%	21.8%	27.3%	10.9%	1.8%
Crying easily	34.5%	32.7%	16.4%	14.5%	1.8%

Poor appetite	38.2%	27.3%	18.2%	12.7%	3.6%
Difficulty falling, staying asleep	20.0%	18.2%	29.1%	32.7%	-
Feeling hopeless about the future	34.5%	20.0%	18.2%	27.3%	-
Feeling sad	5.5%	27.3%	23.6%	43.6%	-
Feeling lonely	18.2%	20.0%	25.5%	34.5%	-
Thoughts of ending your life	50.9%	20.0%	16.4%	12.7%	-
Feeling of being trapped or caught	23.6%	14.5%	20.0%	40.0%	1.8%
Worrying too much about things	9.1%	25.5%	20.0%	43.6%	1.8%
Feeling no interest in things	27.3%	25.5%	21.8%	23.6%	1.8%
Feelings of worthlessness	30.9%	20.0%	12.7%	29.1%	1.8%

Correlations

Bivariate correlations were run among demographic data, legal, family and medical information and health outcome. Those who were more depressed had been living in the UK for less time, reported being less healthy, were more likely to deny being in the situation they were in, were less likely to see things from a positive perspective, were less likely to accept the reality of their situation and to accept whatever happens, and were more likely to have given up attempts to deal with their situation. Those who were more depressed felt more negative about the future, felt unsafe in the centre and felt the centre did not care for their welfare. They trusted other detainees less, were not in contact with their families, and did not receive visits or received visits very rarely.

- **ACDT**

The participants were asked to indicate whether they had ever been on an ACDT plan whilst in detention. The results can be found in table 13. **Only 3 participants reported being on an ACDT plan when 16 on the HSCL-D reported thinking about suicide.**

This discrepancy is concerning, at the very least on the ability of IRC staff to recognise or identify such cases by using different methods of data collection. The more worrying issue is the potential to miss a high number of residents who need help. There was some indication during the qualitative data collection that residents preferred not to talk about self-harm/suicide because they found being 'on the watch' very invasive. Further research is needed.

Table 13: ACDT plans in each centre

ACDT plan	Frequency	%
No, Never been on ACDT	32	58.2
Yes, in this removal centre	3	5.5
Yes, in another removal centre	1	1.8
Don't know	20	35.1
TOTAL	55	100.00

- **Problems with drug and alcohol**

Most participants reported no problems with drugs or alcohol. The results can be found in table 14.

Table 14: Drug and alcohol problems

Drug and Alcohol Misuse	Frequency	%
No problem with either	40	72.7
Yes, only with drugs	4	7.3
Yes, both with drugs and Alcohol	4	7.3
Yes, only with alcohol	7	12.7
TOTAL	55	100

- **Health problems and medication**

The participants were asked whether they felt physically healthy. Thirty-one per cent (n=17) reported feeling not healthy, and 38.1 (n=21) reported feeling very healthy. The remaining reported being either moderately or slightly healthy.

- **Life in the current centre**

The participants were asked how they felt about the future. Over half of the participants felt either positive or very positive (n=31, 56.3%). Seven (12.7%) felt negative or very negative and the remaining 17 (30.9%) felt neither positive nor negative.

When asked whether they felt safe in the centre, the responses were varied. Full results can be found in table 15.

Table 15: Feeling of safety in the centre

Feeling of safety	**Frequency**	**%**
Very unsafe	8	14.5
Quite safe	4	7.3
Neither safe nor unsafe	17	30.9
Quite safe	14	25.5
Very safe	11	20.0
Total	54	98.2
Missing	1	1.8
TOTAL	55	100

Participants were asked if they felt the centre was interested of their welfare whilst in detention and again the responses were varied and can be found in table 16.

Table 16: Centre's interest in the welfare

Care for welfare	**Frequency**	**%**
Strongly disagree	5	9.1
Quite disagree	7	12.7
Neither agree nor disagree	19	34.5
Quite agree	15	27.3
Strongly agree	8	14.5
Total	54	98.2
Missing	1	1.8
TOTAL	55	100

The detainees were asked if they trusted other detainees. The responses were very varied with just under one fifth not trusting anyone and over one third trusting some or many other detainees

(Table 17). Trusting others is a very personal choice and our ethnographic work has indicated that many detainees did not trust us as researches even after being guaranteed anonymity.

Table 17: Trust in other detainees

Trust other detainees	**Frequency**	**%**
There is no detainee here who I can trust	10	18.2
There are one or two other detainees here who I can trust	14	25.5
There are few other detainees here who I can trust	12	21.8
There are some other detainees here who I can trust	14	25.5
There are many other detainees here who I can trust	5	9.1
TOTAL	55	100

Correlations

All these aspects of detention were related to each other. Thus, those felt positive about the future , also felt safe in the centre, and believed the centre cared about their welfare. Similarly those who felt safe in the centre, believed the centre cared about their welfare. Those who trusted more detainees, felt safe in the centre and believed the centre cared about their welfare.

Feeling safe was also related to being in regular contact with the family: (those in contact with family felt safer), length of stay in the UK (those who had been in UK longer felt safer), and age (older men felt safer).

- **COPING**

Coping strategies can be very important for how individuals deal with difficult situations. Being in detention presents many challenges for the detainees and it is important to understand what coping strategies they use and whether these strategies affect mental health. The COPE scale measures a number of strategies outlined in table 18. Some strategies are considered more healthy than others like positive reframing, or humour, while other strategies like denial and blame have been found to have a negative impact on health and well being. The most commonly used strategies reported by the detainees were planning to do something about the situation, actively trying to do something about their situation, and using emotional support by talking to other detainees. Distraction activities like work and sport and religion were also frequently cited. Full results can be found in table 18.

Table 18: Means and standard deviations of coping strategies used by detainees

Strategies	**Frequency**	**%**
Planning	2.77	1.04
Active coping	2.53	1.07
Using Emotional Support	2.52	1.03
Self-Distraction	2.50	1.10
Religion	2.50	1.14
Positive Reframing	2.46	1.09
Denial	2.34	1.15
Acceptance	2.19	1.17
Using Instrumental Support	2.17	.96
Humour	2.12	1.03
Behavioural Disengagement	1.77	1.14
Self-blame	1.96	1.07
Substance Use	1.27	.79

As reported in the HSCL results certain coping strategies were related to the worst mental health levels. These included denying that they are in the particular situation, and giving up any attempts to deal with it. In contrast, those who reported that they accepted their situation and were thinking more positively about it, presented with lower levels of depression.

Other comments

The participants were also asked to report any other comments or issues they would like to raise and did not have a chance to during the questionnaire. Most comments were negative and focused on the problems with immigration system in the UK and criticism towards life in detention. They emphasised their distress about being in detention and life in detention.