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Healthcare provision inside immigration removal centres: A social identity analysis of trust, legitimacy and disengagement

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Abstract

The stressors of immigration detention and negative host country experiences make effective access to health care vital for migrant detainees, but little is known regarding the health experiences of this populations and the barriers to health-care access. The present research investigates immigration detainees' experiences of health-related help-seeking in the distressing and stigmatised environment of UK immigration removal centres (IRCs), as well as staff members' experiences of providing help. Semi-structured interviews were conducted with 40 detainees and 21 staff and analysed using theoretical thematic analysis guided by the social identity approach. The findings indicate that the practical constraints on help provision (e.g. lack of time and resources, the unpredictable nature of detention) are exacerbated by the complex and conflictual intergroup relationships within which these helping transactions occur. These transactions are negatively affected by stigma, mutual distrust and reputation management concerns, as well as detainees' feelings of powerlessness and confusion around eligibility to receive health care. Some detainees argued that the help ignores the systematic inequalities associated with their detainee status, thereby making it fundamentally inappropriate and ineffective. The

intergroup context (of inequality and illegitimacy) shapes the quality of helping transactions, care experiences and health service engagement in groups experiencing chronic low status, distress and uncertainty.

KEYWORDS

health, help-seeking, legitimacy, social identities, stigmatisation, undocumented migrants

INTRODUCTION

Undocumented migrants are defined as 'third country nationals' who have either entered a country illegally, lack valid documents, have failed their applications of asylum or have violated visa terms (Cuadra, 2012). They are estimated as 0.5% of the EU (Vogel, 2009) and 3% of the US population (Warren, 2020). In the UK, undocumented migrants may be systematically detained at any point during their stay in the country for an undetermined time (Bosworth, 2014). Between June 2018 and June 2019 in the UK, there were around 24,052 undocumented migrants detained in immigration removal centres (IRCs) (HO, 2020).

Time in detention can range from one day to a few years, and 30%–35% are detained for longer than 29 days (Home Office, 2020). The experiences endured before and during detention put them at increased risk of poor physical and mental health (MH). Many experience conflicts in their country of origin and/or dangerous pathways of migration (Gargiulo et al., 2020). In their host countries, they can face discrimination, deportation, poverty and harsh work conditions, which also have a detrimental impact on health and well-being (Vaquera et al., 2017), while in detention, they often experience high levels of mental ill health, including anxiety, depression, post-traumatic stress, suicidal thoughts and self-harm, which remain underreported to health professionals, partly due to the stigma associated with being an undocumented migrant (Bosworth & Kellezi, 2015).

Together, the stressors of detention and the negative experiences in the host country mean effective access to healthcare services is vital for this vulnerable population. However, there is a dearth of information regarding both the MH experiences of migrant detainee populations and the barriers to healthcare access within IRCs, as most research on undocumented migrants is situated outside of detention settings (e.g. in the community). The present study seeks to address this gap by investigating barriers to and enablers of healthcare access among detainees in IRCs. It focuses specifically on how their group's stigmatised nature shapes their experiences, help-seeking motivations/behaviours and relationships with healthcare providers. To understand these dynamics and how group processes influence health-related interactions, we adopt a theoretical approach: the social identity approach.

The social identity approach

The social identity approach (SIA) argues that we derive a sense of self from the groups to which we belong to and with which we identify (Tajfel, 1981; Turner et al., 1987). As group identification (i.e. subjective sense of group belonging) increases, so does the influence of that group on our thoughts, behaviours and emotions. Group identification can lead to intergroup behaviour (i.e. how a person is treated depends on whether they are perceived as an ingroup or outgroup member), especially

when group boundaries are clearly defined (e.g. detainees versus IRC staff). SIA has been applied to health: this is the social cure approach (Jetten et al., 2012; Wakefield et al., 2019), which posits that group identification unlocks a range of health-related benefits. Specifically, identification can lead to increased trust and cooperation between ingroup members (e.g. fellow members of a religious group, sports group, hobby group) (Tyler & Blader, 2000), more effective collective coping (Haslam & Reicher, 2006), increased expectation and actual support-giving (Haslam et al., 2012).

Not all social groups benefit health, however: under certain circumstances, group membership can be harmful to group members. This harm is termed social curse (Kellezi & Reicher, 2012). Social curse processes are observed when non-dominant groups experience persistent discrimination, which negatively affects the well-being of the non-dominant group members, who see themselves as being rejected by the dominant outgroup, as outlined in the rejection identification model (RIM, Branscombe et al., 1999). This leads to members of the non-dominant group experiencing negative feelings towards members of the dominant outgroup (Tropp, 2003). However, RIM also posits that these feelings can promote increased ingroup identification, leading to the identification-related health benefits observed in social cure research. Nonetheless, prejudice and discrimination remain problematic for well-being: prejudice contributes to health inequalities through intergroup differences in (a) exposure to levels and severity of stressors, and (b) quality of healthcare experiences (Major et al., 2013).

Social curse processes can also occur when stigmatisation undermines help-seeking by transforming a cooperative intragroup relationship to an antagonistic intergroup relationship, sometimes leading to people refusing to seek much-needed help in order to avoid stigma and antagonism (Stevenson et al., 2014). Situations that require members of a lower status group to seek help from a higher status group can thus lead to experiences of exclusion, inequality and inferiority if not managed well (Bowe et al., 2019). By exploring the experiences of undocumented migrants within IRCs, the present study focuses on a context within which helping transactions involve high levels of stigma and unequal group status using SIA.

Help-seeking in the context of intergroup relations

A consistent finding from SIA research is that helping behaviour is affected by perceived group membership: people perceived to be ingroup members tend to be more likely to receive help than people perceived to be outgroup members (Levine et al., 2002). However, there may be strategic reasons why dominant ingroups (e.g. rich nations) choose to help non-dominant outgroups (e.g. poorer nations), ranging from displaying shared humanity or empathy, to demonstrating ingroup power, or protecting the group's reputation/status (Wakefield & Hopkins, 2017). The non-dominant group is likely to be aware of these strategies, leading to the help potentially being perceived as a threat to their self-esteem and a source of shame and embarrassment (Bowe et al., 2019). Nadler (e.g. Nadler et al., 2010) crystallised these ideas into the intergroup helping as status relations (IHSR) model, which posits that intergroup helping transactions are built upon these issues of power and status. Specifically, dominant groups simultaneously demonstrate and reinforce the ingroup's high status/independence and the outgroup's low status/dependence through intergroup help provision. This can lead to the non-dominant group becoming unwilling to seek/receive help from the dominant group. Such dynamics are evident in real-world contexts: for instance, perceived stigmatisation can encourage community members to disengage from services within impoverished communities and thus not receive much-needed help (Stevenson et al., 2014). This reticence to seek help can be further exacerbated if MH help is required, due to concerns regarding mental ill-health labelling and its consequences (Corrigan, 2004), especially when those in need of help internalise the stigmatising behaviours (Kim et al., 2010). These issues are particularly pertinent within IRCs, which we turn to next.

Case study: Help-seeking within IRCs

Since 2013, healthcare provision in English IRCs has been the responsibility of NHS England (BMA, 2020). Although this provision should be equal to that experienced by UK citizens, a range of problems persist. These include lack of a culturally appropriate and systematic assessment of detainees' mental and physical health risks/difficulties when they arrive at the IRC; detainees lacking understanding of the UK health system and their human rights (Kellezi & Bosworth, 2016, 2017); a lack of professional translators during healthcare interactions (Shaw, 2016); and poor availability of services and staff shortages (BMA, 2020). Such issues are particularly problematic in what is already a highly stressful (and mental health-affecting) experience for the detainee, who has been separated from social groups and loved ones and has a limited sense of agency and status (Kellezi et al., 2019). Detainees talk of their struggle to cope with isolation, their own and other detainees' distress, the perceived illegitimacy of their status as detainees (i.e. lack of justification regarding their detention) and uncertainty regarding detention length and/or outcome (Kellezi et al., 2019).

Detainees are also stigmatised within the wider context of UK society. Migrants are persistently portrayed as being threats to national security and to the economy (Quill et al., 1999), leading to them being considered as undeserving and unwanted (Castañeda, 2008); ideas confirmed by the government through the creation of IRCs. Many migrants also suffer additional (or intersectional) stigma due to their experiences of deprivation and poverty (Inglis et al., 2019), thus reducing their societal status even further. This can be very damaging to detainees' MH: undocumented migrants internalise these perceptions of threat and stigma, which are compounded by the fear of being detained and deported (Kellezi et al., 2019).

The SIA posits that the chronic feelings of illegitimacy, stigma and low status that detainees experience are likely to have implications for health-related helping transactions within IRCs. Specifically, they are likely to make detainees feel distrusting towards IRC staff, thereby increasing the likelihood of them refusing to seek or accept much-needed health-related help. This prediction has been supported by research conducted with migrants outside of IRCs. Research with undocumented migrants found that many believed that 'doctors don't know anything' (Holmes, 2012, p. 874). Research with undocumented pregnant women in Germany found that they felt that seeking medical help would risk them inadvertently notifying the authorities of their undocumented status, as well as risk them being subjected to health workers' prejudices (Castañeda, 2008). While the women found it liberating to be able to choose to disengage in this manner (despite potential health-related cost), they become even more stigmatised by health professionals and immigration officials, who implicitly valued undocumented migrants 'following instructions' and engaging with services (Castañeda, 2008).

These experiences of stigmatisation, differential power dynamics and distrust are likely to negatively impact help-seeking transactions between detainees and staff (both centre staff and healthcare staff) in IRCs. However, this idea has not yet been systematically investigated from the perspective of the SIA, which is what the present study aims to do. While this research will thus lead to important practical recommendations regarding how best to deliver high-quality health care within IRCs, it will also extend SIA research by exploring helping transactions within a status-defined environment. Specifically, the confined nature of detention (where MH distress is thus invariably high), the clear status differences and psychological separation between detainees and staff, detainees' uncertainty about their rights to health care and the contested legitimacy of the detainees' status (i.e. status is unfair and unjustified) make the detention context a unique opportunity to investigate help-seeking in a context of stigma and unequal power. To explore these issues, the present study will address two research questions:

- How do the unequal status relations between detainees and staff in IRCs influence detainees' desire to seek health-related help and their experiences of that help?
- How do detainees' perceptions of being stigmatised by staff influence their engagement with health services and their experiences of health care?

METHOD

Participants, data collection and materials

Semi-structured interviews were conducted with 40 residents (15 men and 25 women) and 21 staff members (9 men and 12 women) in two IRCs (one male-only and one female-only) between 2016 and 2017 (participant details can be found in Appendix 1). Both centres cover a wide geographical area. All detainees and staff members who were willing to provide fully informed consent (verbally or written) and who were available to be interviewed during the time period within which the researcher was given permission to visit the IRCs were included in the study. We also sought to recruit detainees with a variety of experiences, including those who (a) had made substantial use of health services, (b) were known to have self-harmed or have had suicidal thoughts and (c) had not made substantial use of services (to understand reasons behind low service use). Detainee participants came from a variety of countries, background migration trajectories and time in detention. We also sought to recruit staff with a variety of experiences and professional capacities within the IRC. Staff occupied a variety of roles (custody officers, health professionals, welfare workers, education and activity team), had a broad range of contact with detainees and could refer detainees to health services.

Recruitment strategies included posters displayed around the IRCs, invitation by their manager/the researcher and snowballing. Several steps were undertaken to address bias and ensure methodological rigour. First, semi-structured interviews were chosen to enable participants to (a) report their own understandings and experiences of health interactions and (b) guide the direction of the interviews. The interview schedules were developed from thematic coding by the first author of a large data set of interviews, focus groups and ethnographic notes from 250 detainees and staff, collected for a project investigating quality of life in detention (e.g. see Bosworth, 2014). This prior research enabled persistent observation and prolonged engagement with the phenomena of interest (Nowell, et al., 2017) informing the data analysis (e.g. the lead author observed health-seeking interactions in four UK IRCs). Interview schedules focused on the impact of detention on physical and MH, accessing mental and physical health support in detention (*e.g. How do you find out about these services?)*, ways of coping with detention (*e.g. What do you do when things get difficult?*), cultural understandings of health, the nature of participants' relationships with other detainees and staff (*e.g. What are the relationships between the detainees in here?*), the nature of help-seeking transactions (*e.g. Where do you go for support when things get difficult*?) and satisfaction with current health and well-being support (*How do you feel about these services?*) (see Appendix 2 for full list).

The second step that was taken to address bias and ensure rigour involved recruiting participants from a wide variety of different backgrounds. This helped to ensure that different experiences were explored. Moreover, participants who were interviewed later in the data collection process were asked to reflect on important issues raised by participants in earlier interviews, allowing for cross-checking of the key experiences raised by participants. The third step involved the lead author engaging in extensive journaling to document and reflect on own personal values and beliefs, and how these might affect the analysis and interpretation of the data. These observations have been published in two reflective papers (Bosworth & Kellezi, 2017a, 2017b).

Procedure and ethics

The same interviewer conducted all interviews, which were predominantly one-to-one. All interviews were recorded and transcribed verbatim. The detainee data have been used in a prior publication (Kellezi et al., 2019), focusing on different aims and subsets of the data. There are important ethical and methodological concerns relating to conducting this type of research, which were considered before the study was conducted, and are addressed in detail elsewhere (Bosworth & Kellezi, 2017a, 2017b). All participants gave informed consent and were debriefed after their interview, and it was explained that choosing to participate would have no effect on their immigration case/their job within the IRC. Ethical approval was provided by the authors' institutional ethics committee. The participant, researchers, materials and analysis details are reported following the COREQ quality assurance checklist (Tong et al., 2007).

Analytic procedure

The study utilised multiperspective analysis, which involved comparing/contrasting detainees' and staff members' perspectives on the issues relating to the phenomena of interest. This enabled exploration of complex convergent and divergent meanings and experiences from different perspectives (Kendall et al., 2009), thus providing a richer understanding of detainee/staff relations within the IRCs. The interviews were analysed using theoretical thematic analysis (Braun & Clarke, 2013) informed by SIA, which enabled examination of the intergroup barriers and facilitators to detainees' health service help-seeking. A contextualist approach, guided by critical realism viewpoints, was adapted because it acknowledges (a) the individual meanings of their experience and (b) the central importance of the context, such as social status and intergroup dynamics, in shaping this experience. Initial analysis was conducted separately for the detainee and staff interviews, before combining the data sets in order to compare/contrast accounts across the two groups.

Analytic steps

After the data *familiarisation phase* (i.e. careful rereading of transcripts, note-taking of initial descriptions and interpretations of relevant meanings), all data were coded during the *generating initial codes phase*, which involved capturing important patterns of meaning in relation to the two research questions. For example, detainee data included codes on: trust, self-reliance, genuine and non-genuine help, and stigma towards MH. During coding, which aimed to be open and inclusive, attention was paid to participants' own experiences and meanings of health interactions and experiences (e.g. understanding of rights to health access), as well as to SIA-relevant concepts and ideas (e.g. intergroup trust and helping interactions). Coding (and theme creation) aimed to capture important patterns of meaning related to the research questions and was facilitated by NVivo (version 11) software. To improve the rigour and trustworthiness of the research, the research team discussed the coding of the data in detail for nine of the transcripts (14%).

Next, during the *searching for themes phase*, codes were categorised, sorted and resorted into possible themes, which included clusters of codes that addressed similar issues and meanings (e.g. fear of talking to or approaching staff, self-reliance, issues and limitations of services, and stigma towards MH were eventually incorporated into Theme 3). In the *reviewing of themes phase*, the identification of themes was focused on data sections that were relevant to the research questions (e.g. status relations),

and the structure of the themes went through different iterations in discussion with the wider research team. The first author then revisited all the transcripts to ensure that the themes identified reflected the main patterns in the data. Attention was paid to instances where a participant disagreed with an idea that was widely accepted by other participants (negative cases), and consideration was given to how such cases fitted within the thematic structure (Guest et al., 2011). This also helped to ensure that data that might not be directly related to our theoretical framework were accounted for by the analysis. The detainee and staff themes were then compared to identify divergence and commonality in the two groups' understandings of issues (e.g. whether detainee requests for help are genuine). Attention was paid to meanings and explanations attributed by each group to similar issues (e.g. the motives attributed to detainee help-seeking and perceptions of 'legitimate' and 'illegitimate' help-seeking).

Finally, in the *defining and naming themes phase*, the thematic structure was finalised: this involved *independence* (each theme provided a unique answer to the research questions), *coherence* (the themes fitted well with each other) and *accuracy* (the themes were a good representation of the analysed data set). This was achieved through identifying the essence of each theme (i.e. what story it was telling) and revisiting all data codes under each theme to ensure the accounts were coherent, were internally consistent and represented the data set accurately. This enabled a deeper examination of how well the themes fit with each other, as well as their unique contribution to addressing the research questions. Indicative extracts for each theme are presented using pseudonyms, and omitted lines are presented with ellipsis (…) for brevity. Three themes were identified that related to *perceived detainee status legitimacy, justification and powerlessness; the intergroup context of help-seeking*; and *disengagement from services*.

RESULTS

Theme 1: perceived status illegitimacy and powerlessness

For many detainees, the very concept of help provision in detention is incongruous and inappropriate, as it cannot address their needs. They argue that their health-related needs are in large part due to their powerless group status and unjust detention. For many detainees, the distress of detention is imbedded in the socio-political inequality and injustice they are experiencing as social group, and they feel that this should be reflected in their care.

> Everyone's like, 'Hm, yeah but you know we're here to help you.' And you're like, 'Yeah, but you need to address the point. This person has been in that room for a very lengthy period. They don't know when they coming out and they don't know when they going back to their home country or whether they're going to be released. You seen this health has been deteriorating. You keep saying you're offering them help. What help can you offer when you know what's triggering the problem is him being in there?' (…) How can I improve it if I'm caught up in this predicament (…) And I ain't been convicted in a court of law?'
>
> (Ajani)

Ajani explains how it is the detainee status that is at the core of their health problems, so any help provided needs to address the cause of this suffering. For him and others, the help is not useful or sensitive to their needs, which is frustrating and disappointing. Ajani feels that the very premise of the health-related help offered to detainees is inappropriate, as it does not address the group's disadvantaged position,

illegitimacy and powerlessness that is causing much of their ill health, which, as the SIA predicts, creates even more distress:

> When you are ill you know you are ill but they keep saying it's because of your case that is why you are ill or something and it's like even when you put an animal in a cage and it's not freed definitely (...) the animal becomes unwell or funny. We are in a cage here (…) Being in here so long makes you even so unwell y'know mentally, physically it drains you a lot.
>
> (Elena)

Elena reflects on the IRC staff's acknowledgement that her distress is due to her detention, but that this neither helps the detainees face their stressors, nor changes the tense nature of the intergroup helping interactions. For Elena, distress (both physical and psychological) is a natural response to being detained, which the outgroup (i.e. staff) recognise, but fail to address. Daisy also notes the impact of detention:

> There was this one lady who for 6 months was a model resident, she would pop in the office and chat everyday, everyone really liked her (…). Then immigration told her that she had exhausted all her opportunities to challenge her removal and there was on overnight change. She started making animal noises, like a cat and dog, she started crawling around like a dog. (…) She was like that for 2 months, she did not speak
>
> (Daisy, Centre 2 staff)

Since the woman's 'overnight change' appears to have been directly caused by the change in her legal case, it is clear that any form of health-related help provision that ignores the trauma of detention and legal status is likely to be perceived as inadequate by detainees. However, this is indeed what the participants described: they felt that by ignoring their stigmatised detainee status, IRC staff are simply unable to meet detainees' needs. Staff also recognised that the traumatic nature of detention impacted provision of effective support:

> The hardest part of my job is the mental side of it, because you have absolutely no idea what's gonna happen to them. (…), they can go for bail in the morning. They can be released in the afternoon. (…) not get bail, and then their whole mental anguish starts. So it's like a roller-coaster, really. Some of them, tell you the most terrible stories, really, about what's happened to them in the past. (…). You don't, you don't make a difference. They're not interested in anything at all other than getting out. And they'll do anything to get out.
>
> (Sarah, Centre 1 staff)

Sarah explains what some of the staff struggled to vocalise: that the volatile nature of detention makes planning effective care difficult, and this hampers effective support delivery. Staff like Sarah also echo the detainees' opinion that much of the mental distress within IRCs is due to detainees' status. Sarah reflects on how the detainees' ever-shifting needs are like a 'roller-coaster' over which she has no control, meaning that she is unable to make a positive difference to detainees' lives, which frustrates her. Sarah's account also mentions a shared understanding with other staff regarding detainees' potential motivation for help-seeking ('they'll do anything to get out'). Theme 2 explores the helping transactions' motivations.

Theme 2: the vicious cycle of intergroup mistrust and suspicion

This theme focuses on how stigma associated with the detainee identity undermines detainees' willingness to seek help and satisfaction with help they receive. Although detainee and staff accounts revealed instances of positive interactions, most of the interactions by detainees were perceived as problematic and/or negative. For both sides, the helping transaction was fraught with distrust, and this was exacerbated by the perceived illegitimacy and lack of justification of the detainees' status.

> I think they will be worried [if support is offered] just in case they thinking 'ah this person is probably from immigration so I won't really be able to tell her everything' (…) There was this Chinese girl which was next door to me she was like 18, she couldn't walk at all by herself and she couldn't talk and things like that and then officers- like the officer just didn't believe her (…) anything that you do or say they'll just think you're doing it to get out of detention. Even if it's real they won't believe you so there's no point (…) some officers, a few are nice that will probably believe you but (…) once an officer thinks that the person is pretending or is just lying about something then they'll inform the other officers and then all of them will think, they're all going to back up each other because they're all officers
>
> (Lea)

Lea's experience echoes that of many other detainees, who also felt concerned that their help-seeking for physical/ MH symptoms would simply be seen as an attempt to influence their immigration status. Lea, like many other detainees, reflects on her expectation that if she seeks help, she will not be believed and not receive support; an outcome she believes is based on her stigmatised identity as a detainee, rather than on her individual characteristics. Other detainees also described being worried about not being perceived as 'genuine' in helping transactions or as being in genuine need of outgroup (i.e. staff) help. Lea's account also points to another source of distrust within helping transactions: detainees are often worried that help-seeking might have negative implications for their legal case. This can involve concern that the outgroup (i.e. staff) may be offering help as a strategic way to build up evidence against the detainee. Lea also notes that detainees can become confused regarding the role/purpose of health professionals within IRCs, raising additional concerns about the potential connection between their migration case and health rights. Legal frameworks can thus have a corrosive effect on intergroup trust within these help-seeking interactions. Just as the detainees voiced suspicion towards the staff and their motives for helping, the staff also voiced suspicion towards some of the detainees' help-seeking motives:

> I think because we do have such a bad press here (…) and I accept some of it is founded but a good deal of it is fabrication of either the media or some of the residents that are in here because obviously they've got their own agenda and want to progress their case in a certain way and will bend the truth to facilitate their remaining in the country (…) I will be completely honest, when I first arrived here I was completely naïve (…). Took everybody on face value and believed and sucked in by everything you're being told and then you learn as you go on sometimes people take your kindness as weakness and try to manipulate you or a situation to their own ends
>
> (Tom, Centre 1)

Echoing Lea's suspicions outlined earlier, Tom explains how he believes some of the detainees' mental/physical symptoms are fabricated with the aim of achieving personal benefits. This vicious cycle of

mistrust and suspicion creates conflict-ridden and unsatisfying helping transactions. Tom refers to the media's portrayal of IRCs being problematic because it misrepresents what the centres are really like and the care that staff provide to detainees. Tom's account also shows the shift that some IRC staff experience as they adapt to the demands of a job where distress and distrust are high, and resources are limited. Tom explains how he shifted his initial empathetic and open approach to a more guarded one where he perceives the detainees in terms of negative collective group characteristics ('sometimes people take your kindness as weakness'). This shared distrust is problematic, as it creates a long-lasting vicious circle of negative interactions between help-seekers and help providers, ultimately leading to service disengagement, which we address in the next theme.

Theme 3: disengagement from services

Perhaps unsurprisingly given the aforementioned issues of status legitimacy and intergroup distrust, some detainees made the decision to disengage from health services:

> I told them of my medical issue and they thought- the first doctor I saw was so horrible I had decided to not even sign or give her the authorisation to even go through my file from my GP she was so horrible but later I had to sign it
>
> (Esmir)

> I don't think I have anything to do with the officers because urm I don't trust anyone, yes. (…) officer will tell you I'm afraid can do nothing. (…) I don't go to them because I don't know what they can do. I don't trust any of them
>
> (Enam)

Both Esmir and Enam show the different ways in which they disengage from health services, due to their feelings of distrust and their perception that staff members are either unwilling or unable to help. Esmir explains her negative interaction with a doctor and her initial resistance to allow her medical notes to be shared with them despite her medical condition. Enam describes her refusal to seek help from the centre officers, who often serve as gatekeepers and referrers to health services, and her reasons for this refusal highlight a lack of trust, a belief that any help offered would be inappropriate/ineffective and limited awareness of what the staff can offer ('don't know what they can do'). Esmir's account also shows how stigma awareness can lead to service disengaged or careful identity management. A longer term resident (5 months) explains how and why his eventual disengagement was influenced by his strained relationships with the centre staff, leading him (and other detainees) not to seek help or attempt to challenge their detainee status:

> But it's just a matter for my own pride, so I don't want to fall in that category. Because a lot of people do it to end up, (…) .if we have obviously mental issues, there are a lot with real mental problems. So I don't want to be (...), 'cause if we have mental problems around depression (…) psychotic episodes in the past, but in here try to keep everything under control. This is kind of a structured environment where you are not allowed to break down. If you break down here, you're broken. I am not giving the satisfaction to them. No. I don't want to be seen like, 'Oh my God, this guy is trying to (...) he's trying to milk it. (...) he's pretending that he's depressed.' You know. Because a lot of people they do, I mean I don't know why they do it you know, general thing, (...) I don't want to come

> across as someone who's doing that. So I try to keep my chin up and crack on. It is what it is. It is unfair, but it's life, you know.
>
> (Carlos)

For Carlos, showing/admitting that one is experiencing MH issues is to be avoided for several reasons: first, as we saw in Theme 2, because seeking help for those issues could be perceived as being motivated by desire for personal gain ('trying to milk it'), leading to any requests being ignored; second, because there is no support if one experiences a genuine mental breakdown ('If you break down here, you are broken'), which, as highlighted in Theme 1, points to the inadequacy of the support provided in IRCs; and third, Carlos' account highlights the animosity between the detainees and staff and his attempt not to show weakness ('I am not giving the satisfaction to them'), where perceptions of dependency would be confirmed via help-seeking. For Carlos, help-seeking would symbolise defeat and would confirm and reinforce the unequal intergroup status relations. Moreover, Carlos' desire to avoid confirming the out-group's (i.e. staff) perception of detainees as dependent through his (lack of) help-seeking behaviour can also be interpreted as an active attempt to distance himself from a stigmatised group (fellow detainees) in order to protect his personal well-being. Carlos' account is a good example of how different barriers to help-seeking can interact in order to promote service disengagement, even in a case of genuine need (he refers to his previous psychotic episodes), which are likely exacerbating his psychological distress. Similarly, Kalifa's story shows how experiences of discrimination and inequality inform her reticence to seek help. Kalifa explains the reasons behind her lack of help-seeking one after the other, uninterrupted, through her friend who translated the interview:

> She is scared and she knows people who went to talk to the doctor but they didn't listen, so that is the reason she don't do it (…) she don't say anything to them and sometimes she is scared of them. Maybe they will think bad about her (…) She is scared to go there, when she is going to talk to them she will cry because it hurts, so she doesn't know how they will react. (…) they won't understand her because they are not in her situation. (…) She said that she is scared that maybe that she is going to disturb them. Maybe they are busy doing something. (…) She said she don't do it because they are working.
>
> (Kalifa)

Kalifa's account illustrates a variety of reasons for her reluctance to seek help, which are embedded in her uncertainty about her rights as an undocumented migrant (worried about disturbing staff, or whether they would even listen to her) and fear of what the implications of the help-seeking might be. Kalifa's account also refers to a more general concern that many migrants feel, which involves a fear of how professionals might react to them and concerns with expressing distress (e.g. crying) in front of professionals. Her fear of expressing vulnerability, even though she is living in an environment that strengthens this vulnerability, reflects the problematic power imbalances between detainees and staff, and how lack of trust and awareness of each other's experiences leads to detainees perceiving staff as lacking humanity and empathy (they will think bad of her). Staff also reflected on detainees' motivations for engagement/disengagement with services:

> Sometimes people are obviously stressed. In my experience in a detention centre, people who have a mental health issue don't tend to talk about it, particularly to other men. And it's obviously a macho environment. The people who do talk about it often use it as a tool, because they think they're going to gain something by it. So it makes it very difficult for staff. You become conditioned to that type of behaviour (…) You always

> have to pull yourself back and think, 'No, he could be poorly.' Because we see mental health issues brought up time and time and time again to influence their case, let's say. (...) don't talk about their mental health, there is a stigma attached to it. It's almost as if you're not coping, particularly in a place like this, filled with macho men and, (...) But of all the detainees that you come into contact with, even if they hate authority – and a lot, you know, not best pleased with it (…) Most of them have someone that they think, 'Oh, he's all right, or she's all right (…) it does come down to relationships between staff and detainees. Force of your personality. Because at the end of the day – and this is an example I always give – at the end of the day, we lock up three hundred and eighty men who don't want to be locked up.
>
> (Emma, Centre 1)

Emma reflects on her belief that those in genuine need do not talk about their MH issues, especially in a 'macho environment' where such issues are stigmatised. She further notes how staff are aware ('conditioned to that type of behaviour') that these help-seeking behaviours are not genuine (supporting Theme 2). However, on occasion she does recognise that she must not generalise and that the need is sometimes genuine. She shows that the barriers can be overcome by staff members building positive individual relationships with the detainees. She believes that although intergroup distrust cannot be overcome at the group level, there are individual staff who can break some of the intergroup barriers through the 'force of personality'. While this is a positive approach, it does not reflect the wider social context of detention, which Emma recognises to be important in terms of detainee distress ('we lock up three hundred and eighty men who don't want to be locked up'). An individual approach also does not address the sociopolitical realities of the inequality and injustice they experience in detention (Theme 1); or issues around stigmatisation and intergroup distrust (Theme 2). Such problems are inherently group-related and require group-related solutions.

DISCUSSION

Summary of findings

Our analysis shows that in the context of detention, distress and health concerns are an unsurprising response to conditions of perceived unpredictability, unfairness and powerlessness. For many detainees and some staff, the very premise of healthcare help provision in detention is perceived as inappropriate, because it cannot address the detainees' needs, which they perceive as deriving from their illegitimate detainee status (i.e. the fact that they are being detained unfairly), as well as the powerlessness associated with this status. For both groups, helping transactions were fraught with distrust: detainees were concerned that their help-seeking for physical/ MH symptoms would be perceived as evidence of them possessing ulterior motives and as confirming their dependent status, while staff were concerned about being misled by detainees. This distrust was based on both groups' awareness of the stigmatised status of undocumented migrants inside (and outside) IRCs.

Helping transactions were also negatively affected by detainees' confusion regarding the purpose and role of health professionals and whether their rights to health care were reduced because of their reductions in legal rights (e.g. freedom of movement). Our analysis thus recognises that the inequalities and challenges that detainees face because of their membership of this stigmatised and disadvantaged group are in part due to their key identity attributes (i.e. being confined and under state care) making them feel unentitled to access services (i.e. their legal right to health

access). Detainees reported fear of expressing their vulnerability to staff, even though (and because) they live in an environment that creates this vulnerability. This reflects the problematic power imbalances between the detainees and staff and ultimately decreases the likelihood of detainees successfully seeking and receiving help, thereby reinforcing their perception of the staff as lacking feelings of humanity and empathy towards their situation. These multiple issues led to detainees refusing to seek help when it was needed. Similar service disengagement (although for different reasons) is reported in other stigmatised help-seeking contexts, where support-seekers are aware of the stigmatising views held (and sometimes expressed by) by support providers (Stevenson et al., 2014).

Additionally, some detainees felt that the act of seeking help would confirm staff members' negative views of them, leading to them disengaging with services as a way to retain a sense of control in a context that is defined by a profound loss of agency (Kellezi et al., 2019). In SIA terms, this act of defiance reflects detainees' desire to disconfirm their dependent status and lack of power (Bowe, 2019; Nadler, 2010). While resistance and sense of control are likely to be beneficial for well-being (Haslam & Reicher, 2006), disengagement from health services in a context where incidences of self-harm and attempted suicide are frequent could mean that the costs of choosing to refuse support are very high. Furthermore, service disengagement could be interpreted as detainees choosing to disobey authority (Castañeda, 2008), which could lead to punishment. Finally, staff reflected on potential strategies that could be used to break down some of the barriers to detainees' health access, but these were based on interpersonal rather than intergroup perspectives, which are unlikely to adequately address the group-related challenges identified by detainees.

Contribution to theory and practice

One of the main contributions of the present research is that it has highlighted the important role played by the intergroup context in determining detainees' satisfaction with the healthcare support they receive (if indeed they choose to seek it at all). Prior SIA research has emphasised the importance of the perceived legitimacy of the status differential for determining the behaviour of both the high-status group and the low-status group (Tajfel, 1981). Our research shows that since detainees dispute the fairness and legitimacy of their detainee status, they consider the support they are offered to be inadequate and inappropriate, because it fails to address the injustice which they perceive to be the source of the distress. Most research focusing on status legitimacy has considered the impact of stigmatisation on help-seeking interactions (e.g. Stevenson et al., 2014), but not how help provision can be perceived as inappropriate when given in a context which ignores that stigma and associated feelings of powerlessness. Our research further shows that in the confined context of the IRC, knowledge of legal rights is important, with detainees often being unsure of their right to health access. For helping transactions to be successful within IRCs, detainees must not feel that their need for healthcare is dissimilar with how staff expect them to behave as detainees.

Our results are consistent with a range of prior studies investigating help-seeking in stigmatised contexts. For instance, they support findings from Stevenson et al. (2014), who show socio-economically disadvantaged community members suspected that they were perceived in a negative and stigmatised manner by service providers (i.e. stigma consciousness, Pinel, 1999) and that the service providers' accounts confirmed these suspicions. Thus, stigmatisation is reflected in the perceptions and behaviour of both help-seekers and help providers, and this leads to a perpetual cycle of distrust and disengagement (Stevenson et al., 2014). Additionally, the findings highlight how members of stigmatised groups actively manage important aspects of their identity (e.g. rejection of membership of the

group to which they must admit belonging to access services; Walter et al., 2015), which in detention predominantly involves how one interacts with the outgroup (i.e. staff).

Our research additionally shows that the help providers' stigmatised view of help-seekers may sometimes be overcome through interpersonal strategies (e.g. individual staff members making friends with individual detainees), but that this strategy is not applied consistently by all staff members or during every interaction. Moreover, such a strategy fails to address or challenge the perceived unfairness and illegitimacy of the status hierarchy within IRCs. A group-based strategy is thus required in order to overcome the social curse derived from membership of a stigmatised and powerless group. Specifically, help-giving should be based on a shared sense of humanity and potential common fate (e.g. help should be given with the attitude that detainees are fellow humans and that anybody could become a migrant in the aftermath of a crisis, even the help-giver; Bowe et al., 2019). Unfortunately, these elements are generally missing from the helping transactions that take place inside IRCs. Indeed, stigmatisation was so embedded within staff members' views (e.g. the widely held belief that detainees are confined because they cannot be trusted in the host country's communities was commonplace) that staff members may well perceive empathic treatment of detainees as wholly inappropriate, leading to uncertainty about how to interact with detainees who seek support. This uncertainty is exacerbated by the practical constraints of the IRC context, with the high levels of detainee distress and the unpredictable nature of detention meaning that staff feel unable to provide adequate care.

Our research also highlights that detainees and staff members exist within a socio-political context and that both groups may be concerned about managing their ingroup's reputation through engaging (or not engaging) in the helping transaction. Staff members may wish to give help in order to highlight their generosity and to challenge the detainees' perceptions of them as lacking empathy (see Hopkins et al., 2007, for an experimental exploration of this phenomenon), while detainees may choose to avoid seeking help in order to challenge staff members' perceptions of them as dependent (see Wakefield & Hopkins, 2017, for further discussion). Our research shows that staff were concerned with how IRCs were portrayed in the media. Past research has shown that migrants have also been portrayed poorly in the media (Quill et al., 1999), so there are reputational concerns on both sides of the helping transaction. Indeed, it is likely that the mutual feelings of distrust between detainees and staff are due in part to the largely negative portrayal of migrants in the media, including political/social discourses of scrounging/criminal migrants (Sonfield, 2007), as well as in negative media portrayals of IRCs. These findings thus support the IHSR model's premise that groups (regardless of their status) are motivated to use helping transactions as a tool for maintaining/enhancing collective self-esteem (Nadler et al., 2010).

Our research supports additional predictions of the IHSR model, particularly regarding low-status group members' desire to be perceived as legitimate recipients of help, rather than as 'scroungers' who are 'undeserving' (Bowe et al., 2019). This desire to be perceived as legitimate could be observed in detainees' help-seeking (or refusal to seek help), but its implications went far beyond this. For instance, detainees were concerned that being perceived as a malingerer by staff members might negatively affect their immigration status, thereby creating a situation where a simple act of help-seeking could have far-reaching negative consequences. Indeed, previous research has provided evidence of community-dwelling undocumented migrants experiencing similar fears regarding their help-seeking leading to them being reported to authorities or impacting on their legal case, thus creating significant barriers to health access (for a review, see Woodward et al., 2013). This, coupled with the fact that the only people from whom detainees can seek support (staff members) are generally perceived as being the people who are to blame (in part) for their low status and suffering, highlights the multiple vulnerabilities detainees experience and the complex array of stigmas they must navigate in order to obtain much-needed support.

A final observation to make is that the SIA predicts that when group members are unable to better their status by leaving the low-status group (i.e. impermeable group boundaries), they tend to address their social inequality and perceptions of injustice (e.g. lack of effective health care) via collective action (Haslam & Reicher, 2006). This was not a common response within the IRCs. This may be because the nature of detention (consequences for perceived non-compliance, lack of agency, high levels of shared distress and unpredictability) does not foster the conditions that are required for collective responses aimed at challenging the status quo. Future research should investigate the conditions under which low-status groups can effectively address inequalities in a collective manner.

Limitations of present research

The present study is likely to reflect the specific socio-political context of IRCs within the UK, and this context may differ in other countries. Moreover, the present research was affected by the physical and practical constraints of the IRCs (e.g. limited physical access, limited space available to conduct the research and the structured regime). This affected who was available to participate in the study and for how long. The participants were self-selected, and many had to overcome issues of trust and language barriers to participate in the study. For instance, some of the detainees did not speak English as first language, two required a translator, and two interviews were conducted in the detainees' first language by the first author. While these language issues might have limited the words and phrases that the interviewer and the participants could use, they helped better understand the detainees' lived experiences of help provision within the IRCs, which tend to take place in English.

These issues notwithstanding the range of experiences reflected in the interviews, as well as diverse characteristics of participants, suggest that an appropriate sample was obtained. While there were some differences between the male-only and female-only IRCs, these are outside of the scope of the present study, which aimed to identify participants' shared experiences, based on their membership of the detainee group/staff group.

The identities of the researchers are important for the data collection and analysis of this work. The lead author (who conducted all the interviews) is White, from a migrant background, has experienced the UK visa system and possessed the same nationality as many of the UK detainees, but none of the researchers had worked in or personally experienced immigration detention. Trust is difficult to establish in IRCs, but the presence of negative and positive accounts within the interviews (accounts that are consistent with the year-long ethnographic observations preceding the present work) suggests the participants' data provide an appropriate reflection of the complexity of life within immigration detention.

Implications for practice

Current health provision in IRCs is generally perceived to be inadequate and to be based on short-term symptom-relief interventions, thereby falling short of best practice care provision (Heeren, 2010). The focus on physical complains while ignoring the fact that psychological distress exacerbates (or even causes) those complaints (Saraceno et al., 2007) and the specific inequalities that undocumented migrants face inside and outside of IRCs becomes a cultural and structural barrier to health access, meaning that health care is physically present but practically unreachable and inadequate. For as long as detainee/staff distrust persists and detainees perceive the support available to them as being inappropriate and inadequate, service disengagement and dissatisfaction will remain. Moreover, the fact

that detainees are often unsure whether they are even eligible to receive healthcare highlights the need for immediate changes to the policies that determine how detainees are informed of the healthcare and other rights that are available to them. There are also ethical issues to consider: medical/psychological interventions delivered in legal institutions must meet key ethical principles, such as the care provider being clearly independent from the institution (Patel et al., 2016), which is not how detainees described the support available to them in the present study. This again suggests that the way in which healthcare provision is framed and delivered within IRCs is in urgent need of an overhaul.

The care provided within IRCs must thus move away from the medical model of health and instead address these more holistic predictors of well-being. This alternative model would also enable an appreciation of the complex and unequal intergroup context within which the help is exchanged.

CONCLUSION

The present research investigates detainees' experiences of help-seeking in the distressing, unequal and stigmatised environment of the IRC, as well as staff members' experiences of providing help to detainees. The findings indicate that the practical constraints on help provision (e.g. lack of time and resources and the unpredictable nature of detention) are exacerbated by the complex and conflictual intergroup relationships within which these helping transactions occur. Specifically, evidence was obtained regarding how these transactions are negatively affected by stigma, mutual distrust and reputation management concerns, as well as detainees' feelings of powerlessness, confusion around their eligibility to receive health care and their belief that the support available to them was inappropriate due to it ignoring the systematic inequalities inherent within IRCs. These results have important implications for how health-related help should be provided to vulnerable individuals experiencing low status, distress and uncertainty.

CONFLICT OF INTEREST

The authors declare that they have no competing interests.

ETHICAL STATEMENT

Ethical permission was obtained from Nottingham Trent University Research Ethics Committee.

DATA AVAILABILITY STATEMENT

Due to the sensitivity of the material and impossibility of anonymisation, the data will not be made available online.

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APPENDIX 1

Participants' details

Table A1 Detainee (top portion) and staff (lower portion) characteristics

Pseudonym	Nationality/Region	Gender	Months in IRC	Detainment cause	Age	IRC
Abdul	Asian	M	2	Asylum-seeker	Mid-30s	MH
Andrew	European	M	2.5	Prison sentence	Late 20s	MH
Irfan	Asian	M	2	Visa overstay	Mid-40s	MH
Seij	Asian	M	0.5	Visa overstay	Mid-20s	MH
David	Central American	M	5	Visa overstay	Mid-20s	MH
Aki	Asian	M	1	Visa overstay	Mid-50s	MH
Aroon	Middle Eastern	M	1.5	Asylum-seeker	Mid-20s	MH
Ajani	Unknown	M	24	Prison sentence	Early 30s	MH
Bao	Central American	M	12	Prison sentence	Mid-40s	MH
Carlos	Central American	M	2	Prison sentence	Mid-30s	MH
Simon	Asian	M	5	Prison sentence	Mid-30s	MH
Roman	African	M	7	Prison sentence	Mid-20s	MH
Adisa	West African	M	3	Asylum-seekers	Mid-30s	MH
Eduardo	South American	M	15	Prison sentence	Mid-50s	MH
Dara	Middle Eastern	M	1	Asylum-seeker	Early 40s	MH
Elena	African	F	11	Asylum-seeker	Mid-40s	YW
Tila	African	F	0.7	No information	48	YW
Alecia	Asian	F	2	Visa overstay	32	YW
Tara	African	F	9	Asylum-seekers	Mid-40s	YW
Esmir	West African	F	5	Visa overstay	Mid-30s	YW
Enam	East African	F	1.5	Visa overstay	Mid-30s	YW
Eva	Southern African	F	1	Visa overstay	32	YW
Lea	Central African	F	8	Prison sentence	20	YW
Edith	Asian	F	1	Asylum-seekers	Late 20s	YW
Mara	European	F	0.5	No information	Mid-40s	YW
Baez	Central American	F	1.5	Asylum-seeker	Mid-30s	YW
Alma	American	F	0.5	Passport issues	Early 50s	YW
Maria	African	F	8	Prison sentence	Mid-30s	YW
Ode	African	F	6	No information	40	YW
Haji	African	F	2	Visa overstay	Mid-20s	YW
Sabra	African	F	0.5	No information	Mid-30s	YW
Zane	West African	F	1.5	Asylum-seeker	Mid-30s	YW
Ali	Asian	F	1	Asylum-seeker	Late 20s	YW
Kalifa	African	F	1	Visa overstay	Mid-20s	YW
Celeste	African	F	20	No information	Early 40s	YW

Table A1 (Continued)

Pseudonym	Nationality/Region	Gender	Months in IRC	Detainment cause	Age	IRC
Anna	South African	F	1.5	Prison sentence	43	YW
Efa	West African	F	2	Visa overstay	Mid-40s	YW
Uma	Unknown	F	25	Prison sentence	Mid-40s	YW
Aimar	South American	F	2	Visa overstay	Mid-40s	YW
Tina	European	F	0.5	Illegal entry	23	YW

Pseudonym	Nationality	Gender	Job	IRC
N/A	N/A	M	Mental health Team	1
N/A	N/A	F	DCO	1
N/A	N/A	F	DCO	1
N/A	N/A	F	DCO	1
N/A	N/A	M	DCO	1
N/A	N/A	F	DCO	1
N/A	N/A	M	DCO	1
N/A	N/A	F	Manager	1
N/A	N/A	M	Manager	1
N/A	N/A	F	Education	1
N/A	N/A	M	Education	1
N/A	N/A	F	Welfare	1
N/A	N/A	M	Induction	1
N/A	N/A	M	Security	1
N/A	N/A	M	Kitchen	1
N/A	N/A	M	Activities	2
N/A	N/A	F	DCO	2
N/A	N/A	F	DCO	2
N/A	N/A	F	DCO	2
N/A	N/A	F	DCO	2
N/A	N/A	F	DCO	2

Note Most staff information has been redacted to preserve anonymity.

Abbreviation: DCO, Detention Custody Officer.

APPENDIX 2

Interview schedules for staff and detainees

INTERVIEW SCHEDULE: FOR STAFF

Thank you for agreeing to take part in this interview.

ROLE AND EXPERIENCE

Can you please tell me a little bit about yourself? (age/marital status)
How long have you worked in this IRC and under what capacity?
What previous experience do you have in custodial institutions?
What previous experience do you have in mental health settings?
What motivated you to choose working in this IRC?
What are your main duties in this IRC?

RELATIONSHIP WITH DETAINEES

How do you find working with detainees in general?
How do you find working with detainees who have mental health problems?
Is there anything you find especially difficult? Can you tell me why?
Who do you believe are the most vulnerable detainees? Why?
How do you usually come in contact with these groups of vulnerable detainees?

CURRENT IRC SERVICES AND PRACTICES

What services are available in IRCs to deal with detainees who have mental health problems?
How are detainees referred to these services?
Are the detainees aware of mental health services in this IRC?

- How do they find out about the services?

Do detainees engage with these services?
If yes, what enables the engagement of detainees with these services?
How easy it is for staff to work with detainees to implement the services?

- Are there any barriers to these collaborations? Examples?

What types of relationships are required for these collaborations to be successful?
What would happen if you hear someone talk about themselves or others being upset?
What would happen if you a detainee talk about their or others suicidal thoughts?
What would happen if you a detainee talk about their or others self-harm?
Who is responsible for monitoring mental health issues among detainees?
Do you believe anyone else should also be responsible?
If yes, for what reasons?

RISK FACTORS AND RESILIENCE FACTORS

According to your experience, what are the most common indicators of MH/Suicide/Self-Harm?
Are there any factors that make certain detainees more vulnerable to harm/MH problems?
Are there any resilience factors? Strong connection to others, successful coping strategies?
How can you balance between risk factors and resilience?

TRAINING

What training have you received prior to working in this IDC?
Did you receive any training on mental health or ACDT?
What did you think of the training? What aspects did you find most useful/least helpful?
What other training would you have liked to have received?

What training do you think would be useful to you now to support your work with the vulnerable detainees?

Is there anything else you would like to add that we have not covered so far?

INTERVIEW SCHEDULE: FOR DETAINEES

LIFE BEFORE DETENTION

Can you tell me a little bit about yourself? (for example your age, gender, nationality, relationship status, whether you have children?)

How long have you been in this IRC?

What are the reasons you are in this IRC?

How long have you been in the UK?

What were the reasons you left your country of origin?

REGIME

How do you spend your time in this IRC?

What services are offered to detainees in this centre?

What health services are offered to detainees in this centre?

How did you find out about these services?

How do you feel about these services?

What do you think of these services?

Do you know of detainees who use these MH services?

If yes, how did they find these services?

What did they find most helpful/unhelpful?

SUPPORT

Where do detainees go if they feel upset?

What services are available for those who need help or support?

Do detainees use these services?

How are these services advertised around the centre?

Are there any particular persons of contact?

How important is the person of contact for detainees?

Can person of contact make a difference on how these services are used?

Are the relationships with staff important when talking about mental health/suicide/self-harm?

If yes, why are they important?

TALK ABOUT MENTAL HEALTH

Do detainees talk about mental health issues?

What issues do they talk about?

Are there any issues they find difficult to talk about?

Are there any cultural/religious barriers to talking about mental health?

Are there any cultural/religious barriers to talking about self-harm or suicidal thoughts?

What would happen if you hear someone talk about mental health?

Would there be a particular member of staff that would be the first point of call?

What would happen if you hear someone talk about self-harm?

Would there be a particular member of staff that would be the first point of call?

What would happen if you hear someone talk about suicidal thoughts?
Would there be a particular member of staff that would be the first point of call?

COPING WITH DETENTION

How do you find the detention experience in general?
What do you do to help you pass the time?
What do you find helpful to feel better about the time in detention?
What is the most difficult thing to deal with?
How do you find the relationships with other detainees? Centre staff?
What is the role of relationships with detainees? Why are they important?
What do you have in common?
Does a shared background help?
Do you feel threatened at any point?
Do you feel uncomfortable around others at any point?
Do you trust other women?
Do you feel safe?
Do you have anyone to turn to when upset?
Is there anything else you would like to add that we have not covered so far?