

The Impact of COVID-19 on ICE Detention Facilities

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Introduction

The last three decades have displayed significant growth in U.S. migrant detention. The COVID-19 pandemic intensified fear of SARS-CoV-2 outbreaks in approximately 130 facilities owned by the U.S. Immigration and Customs Enforcement (ICE). Immigration detention facilities were ill-equipped and unprepared to manage the pandemic's challenges. Bergen, Essex, and Hudson County Jails, along with the Elizabeth Detention Center (EDC), are four facilities in New Jersey's most populous counties close to New York City. The DHS Office of the Inspector General discovered Essex County Jail violations, including "...segregation, inadequate medical care, unreported security incidents, and significant food safety issues" (Tosh *et al*). These pre-existing issues question ICE's ability to manage migrant detention during a public health crisis. The example does not reflect all ICE detention centers; however, their overall conditions raise concerns regarding disease prevention amongst undocumented immigrants and asylum refugees detained during the COVID-19 pandemic. This research paper aims to report the general physical conditions, monthly SARS-CoV-2 rates amongst migrant detainees and ICE employees, and proposed responses and consequences regarding COVID-19 prevention in ICE detention facilities.

Physical Conditions of ICE Detention Centers

Implemented measures to contain the spread of COVID-19 are challenging to implement in ICE detention facilities. Migrant detention centers compose of a highly dense infrastructure for aiding in surveillance. In addition, ICE detention facilities require large gatherings of people to be placed in poorly ventilated spaces. There exist areas designed to be communal, including housing, waiting rooms, eating areas, recreation spaces, and classrooms (Openshaw). Another significant issue regarding ICE detention conditions is their constructed materials. The more extensive detention facilities tend to be operated by prisons or county jails (Lopez). Disinfection efforts of SARS-CoV-2 are complicated due to the virus's nature to survive extended periods on non-porous metallic surfaces (Openshaw). The effects of ICE's poor infrastructure extend further than endangering a migrant detainee's physical health. There exists a detrimental impact on the mental health of migrant detainees due to some facilities' prison-like environments. Most migrant detainees have no criminal background and largely include asylum seekers fleeing their home country due to increased violence. The prison-like environments may traumatize asylum seekers, resulting in severe psychological

distress, including depression and post-traumatic stress disorder (Keller). Despite living in confined spaces, migrant detainees experience a higher degree of interaction with ICE employees. These situations include transportation between facilities, the release and acquisition of new detainees that generate a population turnover, and the comings and goings of staff, visitors, vendors, and contractors (Meyer *et al*). Higher interaction rates endanger not only migrant detainees but ICE employees to COVID-19 infection as well. In 2020, approximately Forty-four ICE employees at detention centers in 9 states were diagnosed with COVID-19 (Openshaw). Ultimately, SARS-CoV-2 containment and prevention measures are challenging to implement due to the underdeveloped conditions in ICE's highly populated migrant detention centers.

Monthly COVID-19 Rates

The poor living conditions and lack of COVID-19 prevention employed in ICE detention facilities have resulted in numerous outbreaks of the SARS-CoV-2 virus. In 2020, There were 1,200 reported cases across 52 facilities operated by ICE (Openshaw). The number of reported cases rose significantly in the following year. As of February 2021, 9,411 confirmed COVID-19 cases were reported by ICE among the 95,967 migrant detainees tested (Tosh *et al*). Although SARS-CoV-2 viral outbreaks may be concentrated in a handful of detention centers, the rate of confirmed cases is relatively consistent across most ICE detention facilities. Returning to the example of the ICE detention facilities in New Jersey, three recorded instances have been at Bergen County Jail, 24 at Essex, 14 at Hudson, and 39 at EDC as of February 2021 (Tosh *et al*). Not only did the rate of COVID-19 cases increase, but the death rate of migrant detainees in ICE custody also jumped significantly during the pandemic years. The death rate per detainee was approximately 2.303 in 2018 and 1.499 in 2019, but it significantly jumped to 10.833 detainees in 2020 (Terp *et al*). Although the data does not directly correlate the increased death rates to the SARS-CoV-2 virus, a fair percentage of deaths resulted from

COVID-19-related complications. Out of 26 medical deaths, approximately 8, or 30.8%, were attributed to SARS-CoV-2-related complications, with most of those deaths reported as of April 2020 (Terp *et al*). Most deaths resulting from COVID-19 infection come from individuals with a higher risk of illness or death to the SARS-CoV-2 virus. COVID-19 deaths occurred in male migrant detainees of older age, with the average as 56.9 years, and who suffered from

presupposed medical conditions such as diabetes, chronic kidney disease, or lymphoma (Terp *et al.*). However, migrant adults were not the only victims of SARS-CoV-2 viral outbreaks. Children were immune to outbreaks of COVID-19 infection as well. For example, one facility in Chicago where the DHS's Office of Refugee Resettlement places unaccompanied migrant minors had reported 42 children who tested positive for COVID-19 as of April 2020 (Openshaw). Based on the data provided, the rate of confirmed cases of COVID-19 rose drastically among detainee populations in ICE detention centers, and the rise in death rates is attributed directly to COVID-19 outbreaks.

Responses and Consequences of COVID-19 Prevention

The most debated proposed response to COVID-19 containment and prevention in ICE detention facilities was the release of detainees. The basis for the decision was the fear that further detention efforts would overwhelm local healthcare systems. For example, within 80 miles of the 1000-bed Pine Prairie, Louisiana, detention facility, there only exist eight ICU beds (Keller). ICE facilities would have to rely on support from community hospitals and other medical centers, which would contribute to the stress of COVID-19 treatment in those institutions. However, the strategy would help reduce the likelihood of physical contact and effectively implement social distancing and hygienic practices advised by the CDC. This approach does not imply the encouragement of selective release of detainees, as the process can be discriminatory and arbitrary (Lopez *et al.*). Although the selective release of migrant detainees was not an ethical solution to COVID-19 prevention, neither is large-scale migrant deportation. Mass deportation is not encouraged because of inhumane treatment and the potential to increase the risk of SARS-CoV-2 viral outbreaks in vulnerable communities (Lopez *et al.*). The transfer of migrant detainees to different detention facilities was not recommended either. For example, both New Jersey and New York facilities contributed to the spread of the SARS-CoV-2 virus to a facility in Farmville, Virginia, that went on to experience one of the worst outbreaks in the country — with at least 339 detainee cases and one death as of February 2021 (Tosh *et al.*).

Ultimately, the release of detainees was recommended to be done with the detainee's safety in mind. For example, in collaboration with Physicians for Human Rights and Freedom for Immigrants, the Women's Refugee Commission provides ICE and other communities guidelines for the legal implications of detainee release during the COVID-19 pandemic.

These procedures include preparing medical documentation, health and treatment summaries, communication with lawyers and sponsors about symptoms, suggestions for appropriate preventive measures before release, safe transportation from detention to community settings, and risk mitigation strategies at the final destination (Lopez *et al.*). The safe release of migrant detainees was already underway. As of April 2020, ICE has released 900 detainees at high risk for severe disease

(Openshaw). Returning to the example in the paper's introduction, Essex county jail in New

Jersey saw the removal of two dozen migrants in the same month and the removal of more than 50 more detainees from the same facility as of September 2020 (Tosh *et al.*) Even if a detainee showed symptoms of the virus, such guidelines would ultimately prevent the spread of COVID-19 amongst ICE detention centers and local communities nearby.

Conclusion

The rate of confirmed COVID-19 cases among migrant-detainee populations of undocumented immigrants and asylum seekers grew due to the pre-existing poor infrastructure and systems implemented in ICE detention facilities. The inability to properly implement preventive measures such as social distancing along with the SARS-CoV-2 virus's ability to stick to metallic surfaces left highly-dense migrant-detainee populations vulnerable to contamination and infectious outbreaks of COVID-19. The significant amount of interaction between ICE employees and migrant detainees during transportation procedures made the possibility of spreading the disease across local communities a more substantial threat. A large proportion of detainee hospitalizations was attributed to COVID-19-related symptoms. The bulk of deaths due to the SARS-CoV-2 consisted of detainees of older age and suffering from other predisposed diseases. Arguably, the best approach to preventing further significant outbreaks of COVID-19 was the imminent and procedural release of detainees for additional isolation and to prevent the spread of the SARS-CoV-2 virus in ICE detention facilities and local communities. The release of migrant detainees benefits local communities near ICE detention centers or local communities in border states because the approach decreases the possibility of spreading COVID-19 to vulnerable populations native to the U.S. The data raises awareness for updated living conditions and a significant effort for the cleaning and sanitation in ICE detention facilities if such massive migrant detention rates continue during and following the COVID-19 pandemic.

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