Harmful by Design—a Qualitative Study of the Health Impacts of Immigration Detention

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BACKGROUND: The USA has the largest immigration detention system in the world with over 20,000 individuals imprisoned by Immigration and Customs Enforcement (ICE) daily. Numerous reports have documented human rights abuses in immigration detention, yet little is known about its health impacts.

OBJECTIVE: To characterize how the US immigration detention system impacts health from the perspective of people who were recently detained by ICE.

DESIGN: Qualitative study using anonymous, semi-structured phone interviews in English or Spanish conducted between July 2020 and February 2021.

PARTICIPANTS: Adults who had been detained by ICE for at least 30 days in the New York City metropolitan area within the previous 2 years, and that were fluent in English and/or Spanish.

APPROACH: We explored participants’ health histories and experiences trying to meet physical and mental health needs while in detention and after release. We conducted a reflective thematic analysis using an inductive approach.

KEY RESULTS: Of 16 participants, 13 identified as male; five as lesbian, gay, bisexual, or queer; and four as Black; they were from nine countries. Participants had spent a median of 20 years living in the USA and spent a median of 11 months in immigration detention. Four themes emerged from our analysis: (1) poor conditions and inhumane treatment, (2) a pervasive sense of injustice, (3) structural barriers limiting access to care, and (4) negative health impacts of immigration detention.

CONCLUSIONS: The narratives illustrate how structural features of immigration detention erode health while creating barriers to accessing needed medical care. Clinicians caring for immigrant communities must be cognizant of these health impacts. Community-based alternatives to immigration detention should be prioritized to mitigate health harms.

KEY WORDS: immigration; detention; structural vulnerability; COVID-19.

INTRODUCTION

The USA has the largest immigration detention system in the world, with nearly half a million individuals detained annually by Immigration and Customs Enforcement (ICE).1-3 ICE uses databases, information-sharing systems, and raids to target people for deportation. Individuals arrested at the border or interior by local or federal law enforcement can be transferred to ICE custody. The US immigration detention system is intricately connected to the mass incarceration system. Detained immigrants are typically held in local jails or for-profit detention centers contracted by ICE that effectively operate as prisons.3 Most immigrants in ICE custody have no criminal record,4 yet as civil detainees, they have fewer legal protections than criminal defendants with no guaranteed right to appointed counsel.5

Immigrants are at risk of poor health outcomes due to their structural vulnerability,5, 6 a confluence of social, economic, and political structures (e.g., language barriers, health insurance access, and anti-immigrant sentiment) that interact to negatively impact this population.7-9 This structural vulnerability is substantially amplified for those in immigration detention where the conditions of incarceration and embedded inequities in access to medical care can exacerbate health-related harms.10-13 During the COVID-19 pandemic, their vulnerability was evident as cases and death rates in US immigration detention far outpaced national averages.14

Despite the increased use of immigration detention, ICE does not routinely collect or report data on health risks or outcomes of those in its custody. A recent study found that adults in immigration detention reported a high burden of serious health conditions including cancer, HIV, diabetes, and mental illnesses, and frequently experienced disruptions in care.15 Reports from international settings demonstrate that immigration detention is deleterious to the physical and mental...
health of those who experience it. However, research to understand the specific health impacts of detention in the US context is needed to inform national policy and interventions to mitigate harms.

We sought to characterize how the US immigration detention system impacts health from the perspective of people who were recently detained. We used qualitative interviews to gain a detailed understanding of the complex ways one’s health can be affected during detention and post-release.

**METHODS**

**Setting**
We conducted this study in the New York City (NYC) metropolitan area. We partnered with several community-based and legal organizations in NYC that work directly with persons impacted by immigration detention for recruitment.

**Participants and Recruitment**
Participants were recruited through convenience sampling. They were referred from partner organizations that provided a first name or pseudonym and phone number to study staff, who then contacted the individuals and screened for inclusion criteria. Eligible individuals were offered participation in the study without further selection. Inclusion criteria were as follows: (1) release from immigration detention within 2 years of study enrollment, (2) detained for ≥ 30 days, (3) age ≥ 18 years, (4) fluent in English or Spanish, (5) currently residing in the NYC metro area, and (6) able to provide informed consent. A total of 25 individuals were referred for the study: five declined participation, four were unreachable, and 16 completed interviews.

**Research Team**
The research team included two physician investigators with experience conducting medico-legal evaluations of individuals in immigration detention (CD, JR), a physician investigator whose research focuses on infectious disease in carceral settings (MJA), three bilingual (English/Spanish) medical students with qualitative research training (LA, JF, VO), and a bilingual (English/Spanish) doctoral student in epidemiology (EA). The interviews were conducted by LA and JF; data analysis and interpretation were done by VO, EA, MJA, CD, and JR.

**Interviews**
We conducted in-depth interviews by phone in the participants’ preferred language (English or Spanish). Interviews were audio recorded using an encrypted application and professionally transcribed for analysis; interviews conducted in Spanish were professionally translated and transcribed simultaneously. To ensure confidentiality, verbal consent was obtained, no personal identifiers were recorded, transcripts were de-identified for analysis, and recordings were destroyed after the transcription was reviewed for accuracy. Interviews lasted approximately 1 hour.

A 17-question interview guide (Supplementary File 1) was developed to elicit participants’ health-related experiences during and after detention. We explored the development of physical and mental health conditions during detention, barriers to and facilitators of receiving medical care during and after detention, perceptions of health care quality, and experiences related to the COVID-19 pandemic. The interview guide was piloted with 3 study participants and iterative revisions to the interview guide.

**Data Analysis**
Preliminary analysis of interviews was carried out concurrently with data collection. Reflective thematic analysis was used to identify repeated patterns across interviews. The process of analysis was inductive: we reviewed the initial transcripts, wrote memos reflecting on emerging themes, and then met to draft a codebook. We used Dedoose Version 9.0.17 (2021) to manage the data coding. Each transcript was coded independently by at least two analysts. We met regularly to discuss provisional themes and further refine the codebook until the salient patterns repeated across and within transcripts were identified and agreed upon. Discrepancies in coding were discussed and resolved by consensus. Throughout the analysis, we were reflexive about how our assumptions and experiences may affect our interpretation of the data. Saturation was reached when the three coding authors agreed that no new themes emerged from analysis of the final transcripts. The quotes presented have been edited slightly with some punctuation added to facilitate reading. This qualitative study followed the COnsolidated criteria for REporting Qualitative research (COREQ).

**Ethical Considerations**
Ethical approval for the research was granted by the Albert Einstein College of Medicine Institutional Review Board. To ensure anonymity, quotes have not been attributed to specific participants.

**RESULTS**
Of 16 participants, 13 identified as male; five as lesbian, gay, bisexual, or queer; and four as Black; they were from nine countries (Table 1). They had spent a median of 20 years living in the USA (IQR 8.5, 26) and had spent a median of 11 months in immigration detention (IQR 6.5, 16.5). Fourteen experienced prolonged detention (≥ 6 months). Nine
experienced solitary confinement while detained, and twelve were detained during the COVID-19 pandemic.

Four themes emerged from our analysis: (1) poor conditions and inhumane treatment, (2) a pervasive sense of injustice, (3) structural barriers limiting access to care, and (4) negative health impacts of immigration detention. We created a conceptual model of the negative health impacts of immigration detention (Fig. 1) that highlights the salient themes and their directionality based on our interviews.

**Poor Conditions and Inhumane Treatment**

Participants described how the physical conditions of immigration detention (such as nutrition, overcrowding, lack of sanitation) and the inhumane treatment they experienced (including prolonged confinement, isolation, discrimination) impacted their physical and mental health.

Participants recounted unpalatable and unhealthy food, crowded dorms that lacked ventilation and facilitated the rapid spread of infections, and freezing temperatures that made it difficult to rest. They reported lack of soap and toilet paper and unclean conditions. Recreation time was limited and there was little or no access to outdoor spaces. One participant reflected, “you’re locked up in a box... you don’t even get sunlight. You’re begging for sunlight, imagine that.”

Many of the participants that were detained at the beginning of the COVID-19 pandemic reported that they had little ability to socially distance due the overcrowding, and that they felt more isolated once facilities implemented measures confining them to their cells for most of the day. Participants mourned the loss of what few distractions they had before the pandemic, such as bible study, visitations, and socializing with others inside.

“Then they put us in cells, that was even worse, to me it was like torture because there were 2 of us in each box. And do you know how much time we spent outside? Half an hour every 24 hours... I’d call my mom for 15 minutes, take a bath, get my clothes on and cook, all within those 30 minutes.”

Some participants had no prior experiences with the criminal justice system and felt unsafe being incarcerated with individuals charged with violent crimes. Participants recounted witnessing and/or experiencing violence, often without intervention by corrections officers. One individual that was frequently targeted by other detainees because of their sexual orientation described: “There were times when the detention officers they would have been helping by giving stuff for the beating.” Another participant sought care after being assaulted by an inmate, only to have their injuries minimized by staff.

“I told the doctor... they didn’t check it, they just give me the ice pack. But the officer say, it’s okay, you’re not going to die, and I was really surprised, like he’s really thinking about me like that, like I’m not worthy, like I’m really not [a] human being...”

Participants felt that they were treated with a callous disregard because of their immigration status that made them feel less than human. Corrections officers deprived some participants of their rights, for example with retaliatory use of solitary confinement or withholding of commissary funds, and subjected them to humiliating treatment.

“Most of the C.O.s [corrections officers] they treat us like we’re garbage. They treat us very bad. And they treat the criminals better than us. We get treated like you have no rights worse than animal and it’s terrible. And they tell you right on your face, ‘Yeah, you ain’t got no rights.’”

**Pervasive Sense of Injustice**

Almost every participant described their detention as unjust. This sense of injustice often exacerbated the emotional distress participants experienced due to the chronic/sustained uncertainty of detention.

Most participants had no criminal histories, and they often perceived their non-criminal detention as arbitrary and unfair, adding to the psychological burden of being detained.

“I was traumatized with all that and I think it harms you morally, psychologically, physically, what immigration officials do to you, there shouldn’t be immigration jail, really, why don’t they let you go through the process while you’re free...”

Participants who had served time in prison prior to being in ICE custody described worse conditions in immigration detention where they felt “more imprisoned than prison itself.”

### Table 1 Study Participants’ Characteristics: a Qualitative Study of the Health Impact of Immigration Detention, New York City, 2020–2021.

| Participant characteristics | No. (%) |
|----------------------------|---------|
| Age, median (IQR)          | 35 (31.5, 42.5) |
| Gender                     |         |
| Male                       | 13 (81) |
| Female                     | 2 (13)  |
| Non-binary                 | 1 (6)   |
| Identified as lesbian, gay, bisexual, or queer | 5 (31) |
| Country of birth           |         |
| Dominican Republic         | 4 (25)  |
| Jamaica                    | 2 (12.5)|
| Trinidad and Tobago        | 2 (12.5)|
| Honduras                   | 2 (12.5)|
| Mexico                     | 2 (12.5)|
| Guatemala                  | 1 (6.25)|
| Pakistan                   | 1 (6.25)|
| Russia                     | 1 (6.25)|
| Kazakhstan                 | 1 (6.25)|
| Self-identified as Black   | 4 (25)  |
“It’s the worst experience that I’ve been through in my life was being detained. Not even the three-and-a-half years that I did [in prison] had me overwhelmed and stressed out the way being detained for 13 months did. And I’ll tell you why, because when I was incarcerated, in my head I convinced myself that I’m in prison because I put myself in this predicament because I put myself in this predicament...”

Participants described a persistent state of uncertainty, both with respect to how long it would take to resolve their immigration case and whether they would be released. The fear of what would happen to them if they were ultimately deported was omnipresent. The uncertainty about both the length and outcome of their detention, as well as the potential for deportation, led to high levels of anxiety. As one participant explained, “You’re on death row... You’re a chicken right, waiting to get slaughtered any second.”

Some participants felt that immigration officials and officers in the jails created a false distinction between immigration detention and prison. There was a common perception that the goal of detention was deportation at any cost. Participants felt detention was “designed to... break one down,” exploiting their fears to exert pressure to self-deport. They faced an impossible choice:

“I told them, you say that I am not a prisoner here, and they said, you are not because you can go back to your country. And I told them, the problem I have in my country is worse than being here because they will kill me there.”

“I think they want people to become desperate... so they’ll sign their deportation and leave... officials from ICE would come and ask how are you doing, and they’d say, the food is awful, I haven’t seen a doctor... and they’d say, okay step in line and sign this deportation form and it’ll all be over.”

**Structural Barriers Limiting Access to Care**

Multiple systemic barriers prevented access to needed care and led to delays in medical attention that impacted individuals’ health. Evaluation by the medical team typically meant submitting a written request, which required literacy and fluency in English. Individuals with limited English proficiency were routinely denied access to interpreter services during medical visits. Participants often had to submit multiple sick call requests before they were called, sometimes waiting weeks.

“I’d write on the screen, I need to talk to the psychologist, please, it’s urgent, I feel depressed, please help me... when you write sometime like that it’s because you really have a serious problem... 2-3 weeks later they’d say, okay, come over here.”

Participants reported barriers to receiving care for more urgent medical needs. One participant with HIV experienced delays in receiving their medication when they entered detention, and frequent unexplained interruptions to therapy. Overall, participants perceived the barriers to getting needed medical and mental health care were insurmountable.
“In fact, the doctor told me pretty much, "You're not dead yet, so there's no reason for us to help you yet."

During the COVID-19 pandemic, participants described inconsistent and concerning practices around isolation that increased the spread of infection (such as cohorting symptomatic and asymptomatic cellmates) and increased their risk of poor outcomes from COVID-19. For example, some individuals experiencing COVID-19 symptoms were placed in solitary confinement rather than transferred to hospitals, regardless of the acuity of their illness or underlying risk.

“He had the COVID full blown, you could say that it was so bad he couldn't walk. Instead of them sending him to a facility where they could provide better care for him, they kept him in the box, which is solitary confinement, and just fed him aspirins.”

Barriers to accessing health care often persisted after release due to lack of health insurance and inadequate discharge planning, particularly for patients with chronic conditions, including serious mental illness. Nonetheless, with navigation support from community-based organizations, several participants were able to enroll in insurance and access health services after release. Some participants felt their health needs were only met after they were released.

“After I was released, I spent like 4 months without being able to see a doctor because I didn’t have insurance... I needed psychological help because I felt really bad and so [my social worker] helped me out... the first thing I did, the day after I got my insurance is go in for a physical.”

Negative Health Impacts of Immigration Detention

Participants reported chronic medical conditions prior to their detention. They described how conditions of confinement, inhumane treatment, distress associated with the injustice of detention, and the multiple barriers they encountered when seeking care negatively impacted their overall health. In addition to the sequelae of violence, treatment interruptions, and COVID-19 infection, previously healthy participants directly attributed the development of obesity, high cholesterol, and/or high blood pressure to the unhealthy food and lack of physical activity in detention.

Every participant described how immigration detention deeply impacted their mental health. Their time in detention was characterized by a sense of isolation, overwhelming loss, and emotional pain. Many participants reported developing symptoms of depression and anxiety; some also had thoughts of suicide. Experiencing solitary confinement heightened their distress.

“I spent 15 days alone, alone, alone, without even being able to read a book, without being able to read anything. I mean, I was there alone[...] I got desperate and again I wanted to take my own life...”

Family separation further contributed to worsening mental health. Some participants described an irreparable harm to familial bonds, including divorce/separation from spouses. Children could not understand why their parent had disappeared. The pain of separation was sometimes worse during visitations, as those detained were forced to maintain physical distance from their loved ones. The economic consequences of detention, whereby families were left in more precarious financial circumstances because a primary breadwinner was detained, added to the psychological distress participants experienced.

“I never had suicidal thoughts. I never had depression. I never had anxiety... I did not know what that felt like or what it meant until I was detained—just constantly thinking about my case, and my family, and constantly hearing negative things, my mom going through it, and my wife not having enough to pay the rent one month—just all of that hit me at once and became overwhelming.”

Participants that were detained during the COVID-19 pandemic recalled feeling even more isolated from their loved ones and afraid, as they lacked information and personal protective equipment while COVID-19 rapidly spread in the detention facilities. Immigration officials seemingly prioritized incarceration over health and failed to allocate needed resources to reduce the spread of infection. Thus, many were exposed to COVID-19 and developed symptoms, though few were tested for COVID-19. Participants expressed they were only able to protect themselves from COVID-19 after release.

“They didn't come and ask people, "Hey, do you feel any symptoms? Are you okay, do you want to get tested?" There were no proper tools given like hand sanitizer, Clorox... [no] masks given out or gloves given... we barely had toilet paper and soap.”

Many participants expressed that their time in immigration detention left a “mental scar.” They were dealing with the sequelae of trauma long after their release, which included a persistent sense of insecurity.

“Those kind of traumas don't go away overnight... I am walking down the street and I am afraid that immigration could come at any moment to get me... I've just leveled off a little bit mentally, and I've stopped having those dreams of imprisonment, those nightmares. But you keep thinking that immigration may come any time. You don't feel free.”
DISCUSSION

In one of the only US studies examining the health impact of immigration-related confinement in the current era of mass detention, participants described how systemic features of detention eroded their health. Participants were young and healthy with few chronic medical conditions prior to detention. Yet they described how the physical environment of detention, neglect of basic human needs, and the dehumanization they experienced undermined their well-being. Most were subjected to prolonged detention. During this time, poor access to medical and mental health care created a major barrier to addressing pre-existing health conditions and new medical problems arising from their time in detention.

Our data point to several mechanisms by which immigration detention can uniquely increase structural vulnerability. A study of detained immigrants in California found that conditions of confinement cumulatively worsened perceived health status, increased stress symptoms, and were associated with a greater likelihood of a mental health diagnosis. Participants in our study also described how food insecurity, lack of recreation, overcrowding, inadequate hygiene, solitary confinement, and discrimination negatively impacted their health. Some participants attributed the development of obesity, hypertension, and prediabetes to lack of nutritious foods and recreation, which is supported by studies on food insecurity. Similarly, solitary confinement is known to lead to deterioration of mental health and increases the risk of self-harm, and suicide rates are rising in ICE detention.

Advocates have long documented problematic conditions in immigration detention. Prior to the COVID-19 pandemic, frequent outbreaks of infectious diseases were attributed to overcrowding and unsanitary conditions. The pandemic led to immigration court shutdowns, facility lockdowns, and suspension of visitation by attorneys, advocates, and families. Our findings describe conditions that facilitated the spread of COVID-19 and placed those detained at increased risk during the early months of the pandemic, including lack of access to personal protective equipment and basic sanitation. These results are consistent with published reports of COVID-19 infections in immigration detention that identified systemic shortcomings in mitigation and containment strategies, and deficient medical care during the pandemic. As a result, the death rate among individuals in ICE detention increased sevenfold between 2019 and 2020 while the population decreased by nearly a third.

Underlying the significant psychological toll of immigration detention was a sense of arbitrariness, injustice, and uncertainty. Though under US law immigrants in detention are considered civil detainees, participants experienced detention as punitive. Thus, a pervasive sense of injustice, or moral injury, emerged as a potent mechanism for traumatic stress. Moral injury refers to the lasting psychological impact that can result from experiencing or “bearing witness to acts that transgress deeply held moral beliefs and expectations.” Developed in the military context, the concept has also been applied to refugees. Studies suggest that these moral wounds have long-term implications for one’s health. A recent study evaluating the psychological impact of US immigration detention on Latinx transgender immigrants found that the dehumanization, abuse, and transphobia they experienced in detention led to trauma, anxiety, depression, suicidal ideation, and a preference to self-deport. Similar to our study, they found detention facilities failed to address the mental health needs of participants.

Legal scholarship has examined how US immigration laws and policy choices have led to a reliance on immigration detention as a default. These narratives demonstrate that detention can be so intolerable that some individuals feel pressured to surrender their right to have their immigration case decided in a court even if they have valid claims to relief from removal. Yet evidence suggests that detention does not significantly deter migration and is not necessary to ensure people appear in court. Pilot programs testing alternatives to immigration detention in several countries, including the USA, have been found to be cost-saving and effective. Clinicians also have an important role to play. Medical-legal-community partnerships exist in the USA that link lawyers and advocates to volunteer clinicians to support clients with serious health issues held in immigration jails. Clinicians review medical records and visit detained individuals, writing medical affidavits and reports that are used to advocate for their release or access to care.

This study has several limitations. First, we interviewed a sample of formerly detained individuals referred by legal partners in NYC, a city with the first program that provides residents guaranteed right to counsel in immigration cases. Therefore, our findings may not be representative of detained individuals in other locations, or those who lack legal representation. We did not ask where participants had been detained to protect confidentiality. Although thematic saturation was reached during the interviews, the relatively small sample size did not allow for comparisons of subgroups of participants, such as across genders or facilities. Though only 13% of our sample identified as female, this is close to the proportion of women detained by ICE. Finally, interviews were only conducted in English and Spanish.

These findings have significant public health implications for immigrant communities as, on any given day, thousands of immigrants are held systematically and unnecessarily in punitive conditions. Evidence is mounting that the negative consequences of immigration enforcement and detention extend beyond detention, to impacted families and communities. An estimated 16.7 million people in the USA share a home with a family member who is unauthorized. By depriving individuals of their freedom and ability to work, detention also deprives families of economic stability. This study contributes to the growing body of literature demonstrating the health risks associated with immigration enforcement policies.
In conclusion, the participants’ powerful narratives illustrate some of the negative impacts of immigration detention on the health, the lives, and the families of detained immigrants. Overall, the systems put in place to detain immigrants were perceived to be designed to cause harm. Clinicians caring for detained, or formerly detained, immigrants must be cognizant of these health harms. Our work further emphasizes the need for post-detention care that is trauma-informed and focuses on ameliorating the psychological harms caused by detention.

Supplementary Information The online version contains supplementary material available at https://doi.org/10.1007/s11606-022-07914-6.

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Declarations:

Conflict of Interest: The authors declare that they do not have a conflict of interest.

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