



The United States detention system for migrants: Patterns of negligence and inconsistency

David Tellez, Lauren Tejkl, Dana McLaughlin, Maryada Vallet, Orit Abraham, Paul B Spiegel^{*}

Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health, 615 N. Wolfe Street, Room E8541, Baltimore, MD 21205, United States

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ABSTRACT

The United States of America (US) detains more migrants than any other nation. Customs and Border Patrol (CBP) and Immigration and Customs Enforcement (ICE) detain adults and families under the Department of Homeland Security, while unaccompanied minors are housed under the Office of Refugee Resettlement (ORR) within the Department of Health and Human Services. Migrants are subject to the standards and oversight of each individual agency and facility where they are detained. This paper presents an analysis of whether the current US migrant detention system upholds the standards of each agency to maintain the health of migrants. A review of peer and grey literature, along with interviews with key informants (KI) who had worked in or visited ICE, CBP, or ORR facilities since January 2018 were undertaken. Analysis of the literature review and KI interviews covered five thematic areas: health, protection of vulnerable populations, shelter, food and nutrition, and hygiene. Thirty-nine peer-reviewed publications and 28 US Office of Inspector General reports from 2010 to 2020 were reviewed. Seventeen KI interviews were conducted. Though all three detention agencies had significant areas of concern, CBP's inability to abide by its health standards was particularly alarming. The persistence of low compliance with standards stemmed from weak accountability mechanisms, minimal transparency, and inadequate capacity to provide essential services. We have five recommendations: (1) expand independent monitoring and evaluation mechanisms; (2) standardize health standards across the three agencies; (3) develop a systematic evaluation tool to help external visitors, including members of Congress, assess the degree of implementation of standards; (4) enforce consequences for private contractors who violate standards; and (5) restrict the use of waivers that allow detention facilities to circumvent compliance with standards. Ultimately, the US federal government should explore and implement alternatives to detention to maintain the health and dignity of the individuals under its care.

1. Introduction

1.1. United States of America's detention system

The United States of America (US) has the world's largest immigration detention system, having detained over half a million migrants in the 2019 fiscal year (Detention Watch Network, 2020). The number of people in detention dropped significantly due to the COVID-19 pandemic; by the end of the 2020 fiscal year, the number of people in detention fell to a daily average of 20,000 from 45,000 in 2019 fiscal year (U.S. Immigration and Customs Enforcement (ICE), 2021). This reduction was largely due to policies that expelled migrants apprehended at the border, particularly through Title 42. Title 42 was the basis for an order introduced by the Centers for Disease Control and

Prevention during the Trump Administration in March 2020 at the start of the pandemic that uses public health grounds to deny entry to migrants who seek asylum in the US (Falcone, 2021). This policy has continued during the Biden Administration (Detention Watch Network and Project South, 2021).

A wide network of federal government agencies and departments operate the US' complex immigration detention system. Customs and Border Patrol (CBP) oversees the initial detention and screening of all migrants upon arrival to the US. In CBP custody, migrants are expected to be detained for no longer than 72 h before being transferred to either Immigration and Customs Enforcement (ICE) or the Office of Refugee Resettlement (ORR). Adults and family units are housed under ICE, and unaccompanied minor children (UAC) are under the custody of ORR. CBP and ICE are housed under the jurisdiction of the Department of

^{*} Corresponding author.

E-mail address: pbspiegel@jhu.edu (P.B. Spiegel).

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Homeland Security (DHS), and ORR is within the Department of Health and Human Services (HHS). While in US custody, migrants are subject to the standards and oversight of each individual agency and facility where they are detained. Migrants apprehended at the border are processed by these federal agencies and subsequently transferred or detained while awaiting further immigration proceedings ([American Immigration Council, 2020](#)).

The three US detention agencies (CBP, ICE, and ORR) each conduct their monitoring and evaluation (M&E) operations, bound to their own set of detention standards for the populations in their respective custody. Linkages and agreements are in place to facilitate coordination and communication among these agencies. However, the immigration detention system remains complex and bureaucratic, especially given the involvement of actors beyond the federal government, such as private contractors, local county jails, state-licensed shelters, and nonprofit and for-profit organizations ([American Immigration Council, 2020](#)). Consequently, the M&E processes of detention facilities vary widely, and there are inconsistencies to inspections that often neglect the poor conditions that migrants experience while in US detention facilities ([US Department of Homeland Security, 2018](#)).

1.2. Monitoring and evaluation mechanisms of US detention bodies

Each detention agency is bound to its own set of standards intended to support and protect the health and wellbeing of migrants while they are in detention facilities. The National Standards on Transport, Escort, Detention, and Search (TEDS) standards are issued by CBP and represent the minimum standards by which the US Border Patrol and the Office of Field Operations should abide, in addition to any other policies or guidance that facilities are subject to in their respective jurisdictions. CBP's monitoring and compliance system is led by its Management Inspections Division and officials from Border Patrol and Office of Field Operations headquarters. CBP runs an annual Self-Inspection Program, which is used to evaluate holding facilities and determine compliance with the agency's detention standards; however, the specific standards that are evaluated can vary annually. This mechanism is largely internal and generally does not recruit independent, third-party, or other outside actors to assist in the evaluation process or to monitor compliance. Other regional or local evaluations may be in place, such as local field offices conducting periodic evaluations for facilities within its jurisdiction, but this process is not standardized across all CBP facilities. DHS bodies, including the Office of Inspector General (OIG), also conduct evaluations of CBP holding facilities ([United States Government Accountability Office, 2016](#)).

Due to the variety of ICE detention facilities in operation, three separate detention standards apply to different ICE facilities: the Performance-Based National Detention Standards (PBNDs), the National Detention Standards for Non-Dedicated Facilities (NDS), and the Family Residential Standards (FRS). ICE's inspections and monitoring of its detention facilities are conducted through many oversight mechanisms entailing a variety of ICE and DHS' offices. ICE facility assessments include contractor-conducted assessments, Office of Detention Oversight assessments, and self-assessments. Other ICE oversight mechanisms include internal onsite monitoring at its facilities. Beyond ICE entities, other DHS offices, including the OIG and the Office for Civil Rights and Civil Liberties, conduct their own facility inspections. Despite these extensive networks of monitoring detention facilities, numerous gaps persist given that inspection results are not comprehensively analyzed, and not all DHS offices or divisions have access to data on facility deficiencies gathered from agency inspections. Moreover, self-reported assessments are not required to be shared in an agency database, thus inhibiting the analysis of these results ([United States Government Accountability Office, 2020](#)).

ORR care providers must follow its *Children Entering the United States Unaccompanied (CEUSU) Guidance*, which outlines minimum standards for providing care and services to UAC in US custody. The monitoring

system used by ORR is composed of desk monitoring, routine site visit monitoring, requested site visits, and monitoring visits. Desk monitoring, led by an ORR Project Officer Team at headquarters includes periodic review of facility reports and records, communications review, and analyzing budget statements or other financial documents. Routine site visits consist of either announced or unannounced monthly site visits by an independent Contractor Field Specialist (CFS) Team to monitor compliance of individual facilities to ORR standards. CFS Teams provide technical assistance and oversight support, with each CFS assigned to specific care providers and must report to regional ORR Federal Field Specialists (FFS). FFS Teams are ORR field staff that operate as liaisons between care providers and stakeholders, make decisions regarding the transfer or release of UAC, and can issue corrective actions. Requested site visits, similar to routine site visits, occur in response to a specific facility being investigated or for a corrective follow up plan. Finally, monitoring visits are in-depth week-long inspections done every two years led by an ORR Monitoring Team to extensively evaluate a facility through interviews, review of case files and reports, and the development of corrective action plans, if needed ([Department of Health and Human Services, 2015](#)). Despite the various types of visits, serious gaps remain which implies that comprehensive monitoring of these facilities is not occurring; these include several ORR facilities going years without on-site monitoring visits, frequent out-of-cycle visits, and failure to document provision of services to UAC ([United States Government Accountability Office, 2020](#)).

Current research on the topic of migration and detention illustrates the wide-ranging issues migrants face while detained, including the increasing suicide rates of migrants, experiencing abuse and mistreatment while in detention, and the effects of forced family separation, particularly on migrant children's mental health ([Marquez et al., 2021](#); [Becerra et al., 2022](#); [Erfani et al., 2021](#); [Hampton et al., 2022](#); [Hampton et al., 2021](#); [Wood, 2018](#)). The COVID-19 pandemic further exemplified the risk of rapid transmission of communicable diseases while living in overcrowded facilities, indicating the need to consider alternative measures to detaining migrants to prevent outbreaks and avoid infection and death ([Casanova et al., 2021](#); [Tosh et al., 2021](#); [Lopez et al., 2021](#)). Existing literature on US detention often explores individual agencies, particularly ICE, or specific subpopulations, such as unaccompanied minors ([Grassini et al., 2021](#); [Mishreki et al., 2021](#); [Singer et al., 2022](#); [Coulter et al., 2020](#); [Song, 2021](#); [Foppiano Palacios et al., 2022](#)). However, a qualitative comparative analysis of the three major detention agencies responsible for processing and detaining migrants (ICE, CBP, and ORR) is needed to determine the extent to which care, treatment, and access to services are provided to migrants and if there is consistency in delivery of services across the different agencies. In the current national environment where migration is at the forefront of political discussion and debate, understanding the current conditions of US detention facilities and their impact the health and well-being of migrants is critical when considering or proposing immigration policy measures. Through review of peer and grey literature and interviews with key informants, this study aims to analyze whether the current US detention system upholds the various standards of each agency to maintain the health of migrants.

2. Materials and methods

A peer and grey literature review and analysis were conducted to assess the monitoring and evaluation process of US detention agencies, with an emphasis on key standards related to health, hygiene, shelter, food and nutrition, and protection of vulnerable populations. This review of literature was supplemented by key informant (KI) interviews with professionals who have worked in or visited ICE, CBP, or ORR facilities.

2.1. Peer-reviewed literature

Three searches for peer-reviewed literature were conducted. The first search included all search terms from the research project proposal through the Johns Hopkins Welch Library and yielded 7 results, of which 1 was relevant. The search terms from this search were simplified in PubMed in the second search, yielding 8 results, of which 3 were both new and relevant. The third-round PubMed search excluded the term “standard” from the prior search, yielding 54 results, of which 28 were new and relevant. The three systematic searches yielded a total of 32 peer-reviewed papers. Additional 7 relevant papers were included after review of the reference lists of those sources, resulting in 39 peer-reviewed sources. See Fig. 1 for a summary of the search terms used in each search.

2.2. Grey literature

DHS’ OIG database was used to collect audits, inspections, and evaluation reports with issue dates between January 2011 and December 2020 (DHS Office of Inspector General, 2022). All reports published during this timeframe from ICE and CBP were screened for content. Only reports with specific mention to US national detention standards or monitoring and oversight of DHS detention facilities, including border patrol stations, ports of entry, were selected and reviewed in-depth. These detention standards include ICE’s PBNDS, NDS, and FRS, as well as CBP’s TEDS. Inspection reports for ORR were similarly extracted from the HHS’ OIG database (HHS Office of Inspector General, 2022). Only reports released between 2011 and 2020 were screened. Similarly, only reports with specific mention to ORR’s CEUSU or discussion of monitoring and oversight of care provider facilities were

selected and reviewed in-depth. All evaluation and inspection reports from DHS and HHS meeting their respective criteria were collated and examined to identify evaluation and compliance of standards relating to the domains of health, hygiene, shelter, food and nutrition, and protection, in addition to agency oversight mechanisms.

2.3. Key informant interviews

Qualitative in-depth interviews were conducted from April to May 2021 with the purpose of understanding the implementation of detention standards and the compliance mechanisms that exist in migrant detention facilities. The primary informants who were recruited were persons with direct experience previously working in or visiting migrant detention centers, including ICE and CBP facilities (including processing and border patrol stations), and ORR shelters and facilities. Participants must have visited or worked in a detention facility from January 1, 2018 to the time of the interview to be eligible. Some KIs had extensive years of experience visiting or working in detention facilities that extended before 2018. These experiences were discussed in the interviews and included in the analysis. The recruitment process consisted of identifying contacts of the research team, sending inquiries to relevant organizations, and snowball sampling in which respondents were asked to refer other relevant contacts. All KIs were asked to share their experiences solely in their professional capacity. Current ICE, CBP, or ORR employees were not recruited due to confidentiality and non-disclosure agreements to which they may have been bound. For the purposes of this study, persons who are or have been detained were not contacted or interviewed.

Participants were informed of the study’s primary objectives and the interview consent statement was read orally before starting the

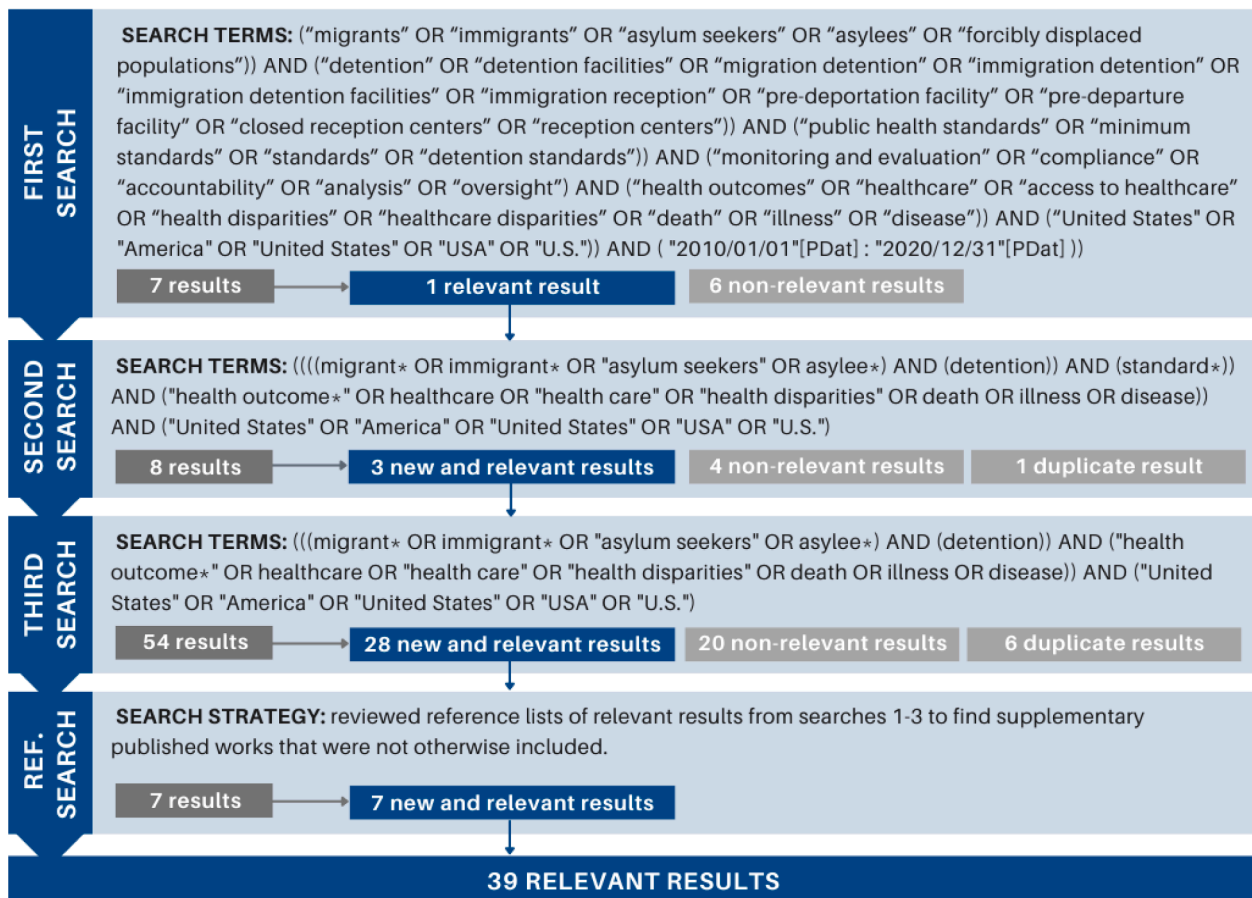


Fig. 1. Search terms and results of 3 searches for peer reviewed literature.

recording of the interview. KIs agreed to be interviewed, for the session to be recorded, and were allowed time for questions or concerns to be raised. After any queries were answered and verbal consent was received, the video recording began and an audio transcription was automatically produced using Zoom Video Communications, Inc. (Zoom). Video recording was optional. Informants were asked if their answers could be attributed to their organization of employment at the time of their visit to a migration detention facility, and anyone could refuse this direct attribution.

The interview guide covered six domains pertinent to the health and safety of migrants: (1) health; (2) hygiene; (3) shelter; (4) food and nutrition; (5) protection; and (6) M&E. Domains were adapted from the Sphere humanitarian response technical areas: health; hygiene; shelter; food and nutrition; and protection (Sphere Project, 2018). Informants were able to select domains based on their professional expertise, background, and familiarity with the subject. For example, physicians and mental health experts often selected the health domain. Because of this approach, not every informant was asked the same standardized questions. However, all informants were asked basic questions regarding their professional background and perspectives on alternatives to detention.

Thematic analysis was done using an inductive coding framework based on the six health domains and KI interview data. While the M&E domain was included in this analysis, it was considered supplemental to the results from the other 5 domains. Each domain had 4-16 themes (47 themes total). Each informant was asked to reflect and comment on alternatives to detention and overall U.S. migration detention policies. All domains and areas are listed in Appendix 1. Saturation was reached around the most common themes informants discussed for each domain, which are the focus for the results section below.

At the summation of the interview, the audio transcription was copied into a separate document. The transcription was checked according to the video or audio recording and edited to accurately reflect the discussion with the KI. The full transcription was then coded to highlight how the responses aligned with specific themes across the domains (health, hygiene, protection, food and nutrition, shelter, M&E). All information relating to the KIs' first-hand experiences, second-hand insights, and general knowledge were recorded.

3. Results

3.1. Peer-reviewed literature

Of the 71 sources identified across the three rounds of peer-reviewed literature search, a total of 39 peer-reviewed papers were reviewed in detail and coded for their relevance to the standard areas. The peer-reviewed literature on U.S. migration detention was general in nature, referring to ICE, CBP, or DHS detention conditions overall. Only six papers referenced facilities in specific states, and two articles discussed ORR child detention practices. One-third of the peer-reviewed literature (13 papers) presented results from primary data collection, largely from non-probabilistic sampling; 18% (United States Government Accountability Office, 2016) provided analysis from secondary data; and 49% (Lopez et al., 2021) were characterized as discussion, commentary or policy papers. The peer-reviewed literature mostly covered themes related to health conditions or medical care practices in detention. The two most pronounced themes discussed in this set of literature were communicable disease control, medical evaluation/screening, and mental health. A detailed list of other topics discussed in the peer-reviewed literature are outlined in Appendix 2. The peer literature review informed the development of the key informant interview guide questions and helped the research team develop questions that addressed gaps and topics which were missing in literature among other priority issues and concerns with the key informants.

3.2. Grey literature

A total of 27 DHS and HHS OIG reports were extracted from their respective databases. These OIG reports varied in terms of how many facilities and which detention standards were evaluated. Most of the reports evaluated 4-5 facilities. A few reports evaluated one single facility, particularly when it was an egregious violation necessitating a more in-depth OIG evaluation (e.g., Adelanto ICE Processing Center in California and Essex County Correctional Facility in Newark, New Jersey). Other reports reviewed the oversight mechanisms of each detention agency broadly, identifying gaps and inconsistencies at the system-level rather than at the facility level. Appendix 3 details a summary of OIG reports by agency and major findings, including violation of standards. Among these reports, more facilities in Texas were evaluated compared to any other state. Louisiana was only evaluated in one ICE report despite its high concentration of migrants in detention centers. Health-related standards were often evaluated in conjunction with other standards related to nutrition, education, or environmental safety. Standards related to hygiene, including access to toilets, showers, and clean clothing, were amongst the most consistently evaluated areas. Conversely, evaluation of standards related to sexual and reproductive health was essentially absent. The grey literature review supported and informed the formation of the key informant interview guide questions and helped prepare the research team for the conversations with key informants (Fig. 2).

3.3. Key informant interviews

Of the 17 interviews that were conducted, nine informants discussed their experiences visiting or working with people who were detained in CBP facilities, 12 informants recounted their experience visiting and or working with people who were detained in ICE facilities, and five informants addressed their experiences visiting or working with minors in ORR facilities. Eight of the informants had experiences in multiple agencies. All experiences discussed by KIs were included in the analysis. The most common states where KIs mentioned visiting detention facilities were Texas, Arizona, and Virginia. Informants included individuals such as previous employees of detention facilities, physicians, mental health experts, lawyers, non-profit organization staff and volunteers, a Congressman, and journalists (Appendix 4). One KI (KI 10) had extensive experiences with ICE prior to 2018, which were included in this analysis. Collectively, across the 17 interviews, nearly half of the discussions were focused on the health standards.

3.4. Thematic results

3.4.1. Health

Health was the most covered area across the relevant literature and interviews (Fig. 3). The most common issues addressed in the literature and interviews addressed general issues with adhering to health standards including for medications, inadequate medical screening or evaluation upon intake, provision of mental health services, and infectious disease prevention and control measures.

General issues with medical screening/intake and standards: In ICE facilities, multiple KIs described the initial intake for physical and mental health as brief, non-comprehensive, highly varied, and primarily based on self-reporting by those detained, thus relying on the migrants to know and remember past diagnoses, vaccinations, or medications (KIs: 2, 3, 4, 6). Published literature describes shortfalls in ICE facilities, including reporting delays in medical care and screening, denial of medical care, miscalculation, staff shortages, and lack of accountability to medical evaluation standards that exist (Inda, 2020; Therrien and Mattie, 2011; Ohta and Long, 2019).

ORR facilities that serve as regular shelters were characterized as having more consistent medical evaluations than ICE and CBP facilities, though with some challenges, including delays in initial intake

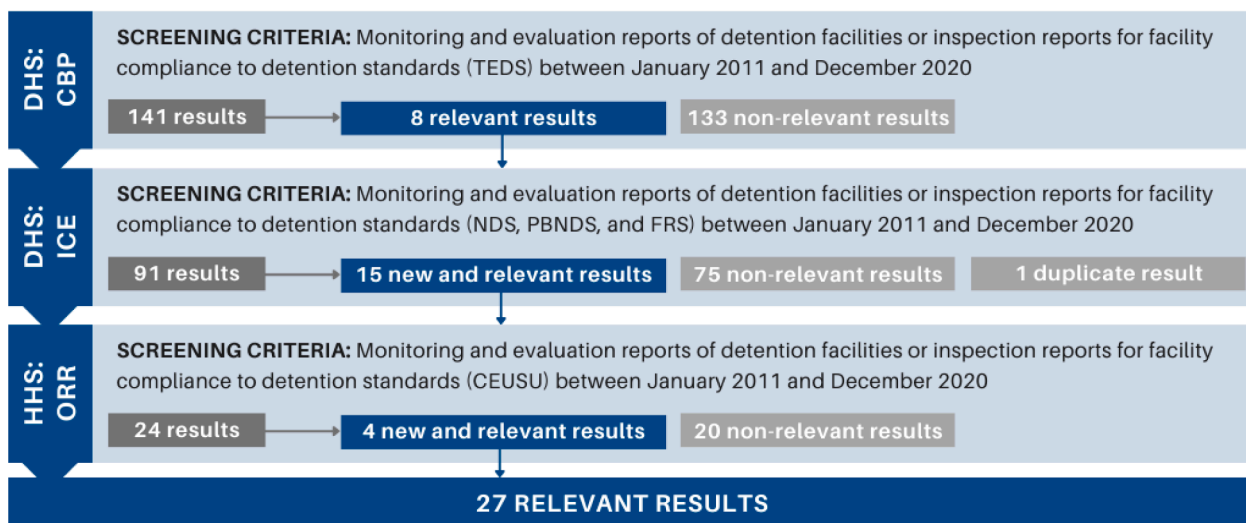


Fig. 2. Search criteria and results for Office of Inspector General reports
 DHS=Department of Homeland Security, OIG=Office of Inspector General, CBP=Customs and Border Patrol, TEDS=National Standards on Transport, Escort, Detention, and Search, ICE=Immigration and Customs Enforcement, PBDNS=Performance Based National Detention Standards, NDS=National Detention Standards, FRS= Family Residential Standards, HHS=Department of Health and Human Services, CEUSU=Children Entering the US Unaccompanied.

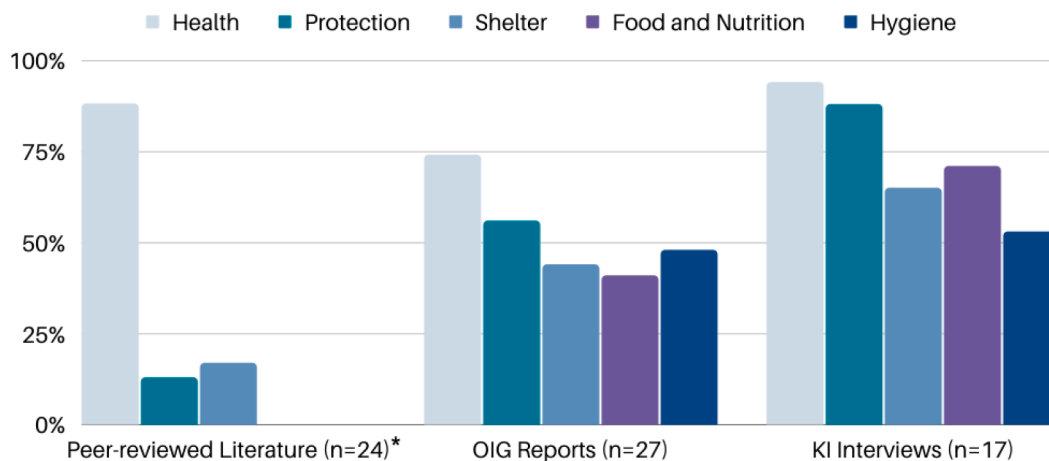


Fig. 3. Proportion of documents/interviews covering thematic areas (health, protection, food and nutrition, hygiene, shelter).
 *Only the peer-reviewed publications that covered at least 1 thematic area were included in this overview. The papers that did not cover a thematic area (15/39) provided general background on an issue but were excluded from area specific analysis.

assessments as cited in a 2019 OIG report (U.S. Department of Health and Human Services, 2019). One KI explained that medical and mental health evaluations were mandated within a specific number of hours of the child’s arrival and conducted by health providers (KI: 7). Similar to issues with self-reporting noted for ICE facilities, another KI explains that the medical evaluation relied on self-reported health history by the children (KI: 9).

Mental health services: An inspection report indicated egregious treatment of migrants with mental health issues, such as ICE officials laughing at migrants who had attempted suicide and referring to them as ‘suicide failures’ (US Department of Homeland Security, 2018). KIs specified several mental health violations, including detention officers purposefully withholding bipolar medications (KI: 5), unwarranted solitary confinement conditions (KIs: 6, 17), and delayed access for mental health evaluations (KIs: 3, 4, 11). Often, mental health was not treated with the level of concern needed, as expressed below:

“A lot of mental health symptoms are treated as just disciplinary, as bad behavior instead of clear mental health symptoms. And then that often results in people being put in segregation.”

KI 4

Contrary to ICE and CBP, UAC in ORR custody received more access to mental health services provided by licensed social workers and counselors (KIs: 7, 9, 15). However, the long-term mental health impacts for children and adolescents in detention are of increasing concern as the separation of children from their parents, the uncertain length of time in detention, and the continuous threat of deportation put them at risk for long-term trauma, post-traumatic stress disorder, anxiety, and suicidal ideations (von Werthern et al., 2018; MacLean et al., 2019). Published literature cited the need for independent health advocates to accompany UAC, noting the various ethical issues of informed consent and coercion, providing an example of overmedication of youth with psychotropic medication in ORR shelters (Malina, 2019).

Infectious disease prevention and control: Informants highlighted that the low levels of compliance with the existing infection control and management of communicable disease standards resulted in widespread outbreaks of highly contagious yet preventable disease in ICE facilities (KIs: 3, 5, 11). KIs noted that compared to ICE and ORR facilities, the implementation of infectious disease control measures and prevention of

communicable diseases in CBP facilities was the most limited and problematic. From inadequate screening processes for and diagnosis of communicable diseases to the inability to provide appropriate health attention to migrants who were sick while they were in CBP custody, CBP's inability to contain the spread of infectious diseases, especially during the COVID-19 pandemic, was alarming.

"I've heard tons of stories about people being sick and not being isolated from other people. Before COVID, no one got masks and everyone's just in there coughing together in the 'hielera' [or "icebox", term used for CBP holding cell]. Scabies, bedbugs, you know, those are all things that just, you're just exposed to and people are going to get sick."

KI 14

Informants raised concerns about the continuity of care for individuals with communicable and/or infectious diseases as they were moved from CBP processing centers to ICE or ORR facilities, as mentioned in the above quotation (KIs: 14, 16).

3.4.2. Protection

Migrants with special needs or with specific vulnerabilities such as persons with disabilities, LGBTQ+, and migrants who have experienced abuse (e.g., trafficking, torture, sexual violence) faced additional challenges while in detention, according to KIs and the literature.

Special needs: Although there is little discussion on protection in the peer and grey literature, one OIG report highlighted a case where a blind and limited English proficient migrant was placed in disciplinary segregation without any auxiliary aids nor translated materials for documents he was provided (US Department of Homeland Security, 2018). Several KIs identified cases where migrants with physical disabilities in ICE and CBP custody experienced egregious treatment and had difficulty in accessing basic services and care (KIs: 1, 4, 5, 11, 16). This included cases where migrants were stripped of essential belongings they already possessed for their disability.

"We've had clients with wheelchairs, and they were released without wheelchairs, we've had to figure out that situation for them"

KI 1

as well as cases where services were continuously denied altogether:

"Before we started working with [one migrant with cerebral palsy], he had asked three times for a shower chair. And they never gave it to them, so once we started representing him, I helped him write out a request, citing the Americans with Disabilities Act, which still applies to anyone in the US, and applies to them and the Rehab Act. Once I did that, then they paid attention a little more..."

KI 4

KI 11 explored the case of migrants with mental disabilities, indicating instances where migrants with paranoia and schizophrenia did not receive necessary mental health services and whose conditions worsened in detention. None of those interviewed described encountering minors with disabilities in ORR custody, though one KI highlighted their experience working with CBP indicating they did not believe neither adults nor children with special needs had their needs met (KI: 16).

Transgender populations: Transgender migrants were often housed or detained according to their sex assigned at birth, rather than their gender identity, according to KIs who visited ICE or CBP facilities (KIs: 3, 11, 14, 17). From the grey literature, grievances from Cibola County Correctional Center in New Mexico indicates transgender migrants reported verbal abuse from ICE staff, including homophobic slurs (US Department of Homeland Security, 2020). Of concern, no documentation on subsequent investigative steps into these allegations was provided to the OIG. Regarding specific protections for trans migrants, two KIs indicated solitary confinement or isolation was used as an alternative

and as a form of protective custody (KIs: 3, 17).

Survivors of violence, trafficking, or torture: KIs described how, although questions about history of sexual violence were asked during CBP and ORR intake and screening processes, migrants, especially migrant youth, may have been hesitant or refused to answer these questions due to fear, distrust, and trauma (KIs: 1, 2, 7, 16). Regarding victims of trafficking and torture, KIs 3 and 5 with knowledge on ICE and/or CBP facilities indicated they did not witness special protections for this population. KI 1 reported that ORR staff demonstrated heightened awareness in the screening process and post-release after detention, as highlighted below:

"I know, at ORR facilities, they, especially after some earlier incidents where kids wound up in the hands of labor traffickers after release, they're very, very attuned to those situations."

KI 1

3.4.3. Shelter

KIs touched upon topics such as the state of living quarters and the length of stay in facilities within shelter (KIs: 1, 4, 7, 8, 10, 12, 13, 14, 15, 16, 17). KIs noted that access to facilities was restricted, limiting their ability to comprehensively tour or review all parts of facilities. The peer and grey literature frequently indicated cases of prolonged detention, overcrowded conditions that exceeded maximum occupancy limits, and failure to provide minimum space requirements, including for UAC in ORR shelters (U.S. Department of Health and Human Services, 2019; US Department of Homeland Security, 2020; US Department of Homeland Security, 2020; US Department of Homeland Security, Office of Inspector General, 2019; US Department of Homeland Security, 2019; U. S. Department of Health and Human Services, 2019). In addition, the inappropriate use of waivers allowed facilities to be excused from meeting standards deemed critically important, by ICE, related to facility security, quality of life in detention, and health and life safety, including, for example, emergency and evacuation planning standards (US Department of Homeland Security, 2018).

Shelter conditions: Concerns regarding the state of the living quarters spanned all three agencies (KIs: 1, 4, 7, 8, 12, 13, 15, 16). These concerns largely focused on the overcrowding across all agencies and the lack of privacy in CBP and ICE facilities. Influxes in the number of migrants in detention significantly strained CBP's capacity to meet shelter standards. This was specifically focused on in an OIG report evaluating 21 CBP facilities in New Mexico, Arizona, and Texas during the 2019 migrant surge (US Department of Homeland Security, 2020). Likewise, both KIs 1 and 16 articulated concerns about CBP facilities' capacity issues:

"This was the area where Customs and Border Protection a couple of months earlier had forced people to sleep outside on rocks under the bridge, because they didn't have capacity inside. By the time we visited in July there was still a lot of people there, but the capacity issues had been largely resolved at that point."

KI 1

Length of stay: Many KIs noted that migrants in CBP facilities were detained for far longer than the maximum 72 h before they are supposed to be transported to an ICE or ORR facility (KIs: 1, 8, 10, and 14). KI 8 explained that CBP facilities are not able to process migrants within the 72-h time period:

"These facilities are intended to keep [...] single male adults for 24 h until they're quickly expelled. And not intended to house people for lengthy periods of time, especially children and vulnerable populations."

KI 8

These accounts are supported by findings from peer-reviewed and grey literature, as issues with the sheltering of migrants can have

particularly negative effects on the mental health of children (von Werthern et al., 2018; MacLean et al., 2019).

3.4.4. Food and nutrition

ICE inspection reports identified numerous food and nutrition violations in a variety of detention facilities including expired and moldy food, limited provision of hot meals, unsafe food handling, and unmet medical and religious diets (US Department of Homeland Security, 2020; US Department of Homeland Security, 2020; US Department of Homeland Security, 2019; US Department of Homeland Security, 2017). KIs primarily provided knowledge on food services and nutrition from migrants who had shared their own experiences while in detention (KIs: 2, 4, 5, 7, 8, 10, 12, 13, 14, 15, 16, 17).

Access to timely and adequate food: A primary concern identified by KIs included sporadic mealtimes. Similarly, in one ICE facility in Louisiana, KI 17 shared migrants reported not enough to eat, unhealthy foods (lack of fresh produce), and wide gaps between mealtimes. In CBP facilities, the quality and access to food varied considerably according to KIs and the literature. OIG reports evaluating CBP facilities found meals, snacks, and infant formula were generally available, though providing hot meals was a challenge in two of four reports (US Department of Homeland Security, 2020; US Department of Homeland Security, Office of Inspector General, 2019; US Department of Homeland Security, 2020; US Department of Homeland Security, 2018). Furthermore, KIs 13 and 16 reported migrants in CBP facilities in McAllen, Texas were fed and had access to meals, though KIs with experience in other CBP facilities, such as San Ysidro in California, indicated that there were limited hot meals and poor-quality food:

“I mean, everyone gets that nasty, ham/turkey whatever that sandwich that tastes like fish that everyone always complains about. [...] Everyone gets this nasty ass burrito. The food is really horrific. People really can’t eat it. Most kids stop eating.”

KI 14

Only two KIs were able to discuss food and nutrition in ORR shelters, however, both indicated meals were provided to UAC, though some complained of taste and/or limited food options.

Dietary accommodations: Additional concerns included persons who required dietary accommodations due to medical reasons (e.g., diabetes, allergies) or other conditions (e.g., pregnancy) were not always granted these special diets, and sometimes had to buy their own. One egregious case, as presented by KI 5 highlights a dangerous life-threatening example:

“I was involved several years ago, [in the case of] a young detainee [...] who had life threatening allergies to like peanuts and strawberries and [...] he would routinely like go into life threatening shock and they [ICE officials] would take him to the emergency room, sometimes, but then they would keep exposing him again and again.”

KI 5

Women with young children faced challenges according to KIs, as women were yelled at for breastfeeding in public (KI: 2), told to cover up (KI: 14), and not provided enough water to make breastmilk (KI: 12).

3.4.5. Hygiene

Across all agencies and sources, hygiene was generally considered to not meet existing standards.

General conditions and cleanliness: KIs reported specific CBP facilities as being clean or showing signs of improved cleanliness throughout their visits (KIs: 1, 7, 13). All eleven KIs who spoke to hygienic standards reported poor cleanliness in facilities, with specific complaints of bugs and pests noted (KIs: 3, 4). Out of 26 ORR facilities reviewed in a 2019 OIG report, 17 were found to have at least one issue with cleanliness or safety. These instances of uncleanliness included reports of unclean bathrooms and poor ventilation (U.S. Department of Health and Human

Services, 2019).

Toilet facilities: The access to toilets in CBP and ICE facilities was noted as concerning. One KI detailed how toilet privileges were used as punishment for migrants in CBP detention facilities (KI: 9). KI 17 detailed how commissary funds would go towards buying necessities like toilet paper and feminine hygiene products in ICE facilities. While women seemed to be supplied feminine hygiene products in both CBP and ICE facilities, four KIs mentioned that it was not enough (KIs: 1, 8, 11, 17). The toilets in CBP facilities were described as a porta-potty or being a toilet and sink combination in the holding room, with the sink on the back of the toilet intended for hand washing and drinking water (KI: 1, 8, 13). KI 8 compared the conditions to torture.

“This was torture, these people were tortured. They could not use the like indoor bathrooms. They had porta-potties. They couldn’t shower. They couldn’t brush their teeth.”

KI 8

Shower facilities: The access and state of showers in CBP and ICE facilities seemed similar. One OIG report included pictures of showers in a maximum-security jail housing ICE detainees covered with mold and mildew (US Department of Homeland Security, 2017). There have also been concerns about the capacity of ICE and CBP facilities to provide shower access to the number of migrants in facilities (US Department of Homeland Security, 2020; US Department of Homeland Security, 2019). It was clear that the access to showers and toilets was hindered by limited capacity being commonly seen as the underlying issue (KIs:1, 8, 13).

“The children would often go several days between showers because there was so many of them and just not enough agents to be able to take them to the shower facilities. A very similar situation at the Paso del Norte facility where the adults are being held there’s just very little access to showers.”

KI 1

One OIG report listed access to showers as limited at an overcrowded CBP facility in Texas (US Department of Homeland Security, 2019). Questionable practices such as handcuffing migrants in detention while moving them to shower facilities were detailed in a report on ICE facilities (US Department of Homeland Security, 2020). Alternatively, another report that evaluated access to toilets and showers for UAC in CBP facilities found that access was substantial (US Department of Homeland Security, 2018). Children seemed to be granted consistent access to toilets and showers in CBP and ORR facilities, especially when compared to their adult counterparts in CBP and ICE. (KIs: 1, 7, 13). This finding was supported by the literature, regarding access to toilets and showers and general sanitation (U.S. Department of Health and Human Services, 2020).

4. Discussion

The experiences shared by KIs in this study across the domains of health, hygiene, shelter, food and nutrition, and protection, and reinforced by examples in both grey and peer literature, show frequent patterns of abuse and negligence across the US migrant detention system. This pattern of abuse and neglect stem from three underlying areas: weak accountability mechanisms, minimal transparency, and limited capacity to provide essential services. Together, these root factors undermine the US migration system’s ability to protect and uphold the health of migrants and create a system that perpetuates negligence, abuse, and inconsistency.

4.1. Infectious diseases in detention facilities

Prior to the COVID-19 pandemic, CBP and ICE shared an extensive history of refusing to provide vaccines that would mitigate the spread of

communicable diseases like the seasonal flu, mumps, measles, or the chickenpox in detention facilities (Foppiano Palacios et al., 2020; US House Committee on Oversight and Reform and Subcommittee on Civil Rights and Civil Liberties, 2020; Lo et al., 2020). The pre-pandemic observations and concerns of KIs are mirrored by more recent congressional and whistleblower reports that have shone a spotlight on the failure of detention facilities across the country to limit the spread of COVID-19 and provide proper care and treatment for those who are sick (Government Accountability Project, 2020; Project South. Lack of Medical Care, 2020).

The COVID-19 pandemic illuminated the already limited ability of the US migrant detention system to protect health and wellbeing of the people in its care by implementing infection control measures. The dearth of comprehensive and consistent vaccine standards in ICE, CBP and ORR's public health standards, and low levels of compliance with the existing standards, have resulted in widespread outbreaks of highly contagious yet preventable disease in ICE and CBP facilities (Patel and Jawetz). Between 2018 and 2019, 900 migrants in 57 ICE detention facilities across 19 states contracted mumps (Leung et al., 2019). Informants noted the absence of protective measures for infectious diseases like masks, soap, and adequate spaces for quarantine as one of the greatest health risks faced by migrants in ICE facilities.

Since the onset of the pandemic, detention facilities have become hotspots for COVID-19 outbreaks, further emphasizing the negligible, inconsistent, and poor implementation of infectious disease control measures across the US detention system (Openshaw and Travassos, 2020). Under its PBNDS (Standard 4.3), ICE detention facilities are obligated to comply with federal, state, or local plans that address specific health concerns, such as the Centers for Disease Control and Prevention's (CDC) COVID-19 guidelines (Centers for Disease Control and Prevention, 2022). Yet, from April to August 2020, the COVID-19 positivity rate among migrants in ICE facilities nationwide was 13 times the rate of the general U.S. population at that time (Uppal et al., 2022). Throughout the COVID-19 pandemic, migrants have continued to report lack of access to masks, soap for handwashing, spaces for infected or exposed individuals to quarantine, limited testing, delayed access to COVID-19 vaccines, and inadequate medical treatment (Government Accountability Project, 2020). The impact of ICE's failure to prevent COVID-19 outbreaks in detention facilities has not only violated the human rights of migrants detained in facilities but has also been estimated to have caused nearly a quarter of a million infections nationwide in 2020 due to transfers of migrants in detention and outbreaks within detention staff that contributed to community transmission (Detention Watch Network, 2020). Equally concerning is the paucity of public data and information about the transmission of COVID-19, including the number of cases, deaths, hospitalizations, vaccine availability for individuals detained in ORR and CBP facilities. Very little is known about the management of COVID-19 in these facilities because, compared to ICE, neither CBP nor ORR have publicly reported COVID-19 statistics to the CDC or public since the beginning of the pandemic (Smart et al., 2021). In March 2021, 17 US senators introduced bill S.681 - COVID-19 in Immigration Detention Data Transparency Act to address CBP and ORR's insufficient sharing of COVID-19 data. As of October 2022, this bill is still with the Committee on Homeland Security and Governmental Affairs (Detention Watch Network, 2021).

4.2. Mental health crisis in detention facilities

KIs and the literature underlined how the current system is often unable to meet the psychological and mental health needs of individuals in detention facilities, creating a silent epidemic. Our findings reveal there are numerous factors limiting migrant's access to mental health care screenings and services. ICE has struggled with securing mental health care personnel and has placed migrants in solitary confinement or misused segregation practices (US Department of Homeland Security, 2020; US Department of Homeland Security, 2017; US Department of

Homeland Security, 2016).

Reports of excessive use of solitary confinement and staff conducting inadequate medical checks on migrants, such as when they are sleeping or without physically speaking with them, raises concerns on the oversight, accountability, and compliance to basic health standards (US Department of Homeland Security, 2020). Experiences from KIs visiting ICE and CBP facilities reveal the issues are not simply a lack of mental health services but are also exacerbated by staff responding to mental health issues with disciplinary measures, dismissing them entirely, or worse, ridiculing migrants. These accounts of abusive behavior reveal a potential systemic problem within the detention system, particularly as officers may perpetuate this culture of abuse. Despite the challenge of quantifying the impact of detention on migrant's mental health, the negative consequences are clear and pervasive, as evidenced by a 2018 Freedom for Immigrants report, which found 1695 issues related to detention isolation among 2055 people surveyed in detention (Merton et al., 2019). Though ORR informants and the literature indicate UAC have better access to mental health services, the long-term mental health impacts are of concern, especially due to prolonged duration of stay in detention and family separation. Many of these factors are inherent to the detention system, as they are in pursuant to immigration policies, highlighting that as long as they remain in place, the mental health of migrants will continuously be at risk.

4.3. Inadequate provision of basic necessities

Beyond access to health services, even basic provisions of food, water, sanitation and hygiene services, and shelter are often not adequately and consistently provided to migrants in detention. Migrants often endure unhygienic sanitation facilities, unhealthy and limited food options, and overcrowded living conditions. Limited capacity and a lack of accountability prevent these basic necessities from being consistently provided. By placing migrants in crowded and unsafe living quarters, they are at a greater risk of contracting infectious diseases. Poor nutrition and inadequate diets, especially for those with medical dietary needs, place them at elevated risk for medical emergencies and illness. Lack of proper hygiene and sanitation services is not only an environmental hazard, but also strips migrants of their dignity.

Failure to provide adequate hot meals per day and compliance with dietary requirements have been attributed to the detention facilities inability to consistently track migrants who require special medical diets, requiring migrants to purchase special meals themselves, when they can afford it. These issues the overall limited availability to provide healthy and safe food options occur in many facilities, according to KIs. Regarding basic hygiene supplies, migrants are not always provided or replenished with hygiene items they are entitled to under PBNDS and FRS sections "4.5: Personal Hygiene" standards. Staff indicate migrants are often required to purchase their own hygiene items, such as soap, toothpaste, and shampoo, contradictory to ICE standards (US Department of Homeland Security, 2019). Overcrowding in facilities has partly been a result of limited transfer options and capacity constraints, revealing how CBP, especially, is poorly prepared to respond to varying degrees of migrant influxes (US Department of Homeland Security, 2020).

4.4. Agency comparison

Although all three detention agencies (ICE, CBP and ORR) present significant areas of concern, CBP's current system particularly fails to provide basic services for migrants. Its 72 h maximum length of detention policy is cited by the agency as a reason for not providing various services, such as vaccinations, sanitation, and personal protective equipment (Foppiano Palacios et al., 2020). However, migrants are often detained for much longer, as exemplified by an OIG report that determined that of the nearly 8000 migrants held in custody across 7 CBP facilities, roughly 3400 had been held longer than 72 h at the time

of evaluation (US Department of Homeland Security, Office of Inspector General, 2019). During these periods, migrants are vulnerable to infection of communicable diseases, mental health crises, and are without clean clothing and access to clothing (US Department of Homeland Security, Office of Inspector General, 2019; US Department of Homeland Security, 2019).

ORR fares considerably better than ICE and CBP, generally providing more consistent access to health services and basic necessities. Yet, this does not absolve it from the direct impacts it can have on UAC, as detention places children at risk for long-term mental health issues. ICE's monitoring system also lacks robust compliance and enforcement regulations. Its provision of waivers and exemptions for unmet standards is not consistently regulated, and inadequate follow-up inspections allow for deficiencies to persist (US Department of Homeland Security, 2018). Although this study did identify cases of detention facilities that were compliant with the respective agency's minimum standards, the detention system continues to foster an environment of poor treatment and inadequate conditions that often fail to meet the basic needs of migrants.

4.5. Putting research in context

Building upon existing literature and inspections, this study emphasizes the US migration system's inability to uphold the rights and protect the lives of the thousands of migrants it detains across the U.S. The lack of adherence to and implementation of the public health standards adopted by US migration agencies violates the health and dignity of detained persons. The purpose of this study is to translate and inform findings that provide meaningful recommendations to improve the US migrant detention system. This study intends to pave the way for future advocacy actions and national policies that reflect the need to implement stronger monitoring and accountability mechanisms that can better protect the health and dignity of all migrants, and to expand alternatives to detention. As the COVID-19 pandemic and other diseases continue to spread in detention centers across the US and threatens the health of migrants in detention, we call for the DHS and HHS to strengthen its prevention, preparedness, and response interventions to protect the health and rights of all migrants detained in the U.S.

As long as the detention of migrants continues to be a core component of the US immigration system, it is critical for the current Administration and Congress to adopt and implement the following time-bound recommendations. First, the implementation and expansion of external evaluation and monitoring mechanisms to introduce and demand greater accountability for all entities, private and public, who operate migrant detention facilities. Second, the standardization of public health standards across the three agencies, ICE, CBP and ORR, to guarantee a high degree of continuity and complementary preventative and curative health services as migrants move from facilities run by one agency to another. Third, a systematic evaluation tool to help people visiting these facilities, including members of Congress, to assess the degree of implementation of standards and quality of care for migrants. This evaluation tool should be used regularly when visits to detention facilities are conducted. Fourth, strict consequences for privately contracted organizations that operate migrant detention facilities where standards are violated or unfulfilled, such as loss of contracts and financial penalties, should be enforced. Fifth, restrict the issuance of waivers that allow detention facilities to circumvent compliance with detention standards, and ensure any waivers previously granted have a definitive end date. These waivers may be issued for a variety of reasons, such as if complying with a standard creates a hardship on the facility or if a specific standard conflicts with a state law or local policy. Yet, there is still a lack of formal policies and procedures guiding the waiver process, leading to an inconsistent and flawed system with a high rate of waiver approvals. Such recommendations need to be evaluated in terms of costs and personnel that will be needed to implement them in a meaningful way.

Finally, based on the well-documented failures of the current detention system to uphold the health and dignity of migrants in detention in the US, new alternatives to detention must be explored and implemented, especially for vulnerable persons (e.g., UACs, pregnant women, LGBTQI, differently-abled individuals, victims of sexual abuse or trafficking, individuals with mental health and other persons with serious medical conditions). KIs were asked on their recommendations for alternatives to detention, with the majority supporting a community-based release program (Appendix 5). These alternatives should be paired with the perspectives and expertise of medical and legal professionals, and subject matter experts, such as non-profit, religious, and other humanitarian actors who have first-hand experience caring for migrants.

4.7. Limitations

Findings from the KI interviews were limited by the limited sample size. KIs had more knowledge on DHS agencies (ICE, CBP) than HHS (ORR). Their responses are not representative of all detention facilities in the US, as they can only speak to those they have visited and are familiar with at specific moments in time. There is recall bias as some participants discussed facilities that they visited years prior. Participants were only able to provide information on topics in which they had professional experience working; as a result, more KIs were able to speak on health-related topics, as many had medical or mental health backgrounds. Additionally, snowball sampling was utilized for recruitment of KIs, which may oversample peers from similar networks. Discussion on protection for vulnerable populations (e.g., LGBTQ+, migrants with disabilities, victims of trafficking/torture) was limited in the findings from the literature review and KIs, revealing a gap in evidence on these populations. Numerous oversight mechanisms and detention bodies are involved in conducting various inspections of detention facilities. Consequently, OIG reports were selected as both HHS and DHS operate their own respective OIG, both of which conduct and release monitoring and evaluation reports of conditions in their facilities. A greater number of DHS' OIG reports were collected and reviewed than ORR reports due to reports Available from their respective databases.

5. Conclusion

The analysis of the current system of detention in the US has raised serious concerns over the treatment of migrants, both adults and minors, while in US custody. Improved systems for monitoring and evaluation of migrant detention standards seek to increase the accountability, transparency, and consistency of implementation across the three U.S. detention bodies, while also addressing the underlying issues of poor management that riddle the current network of detention facilities across the country. An external monitoring system, managed by an outside party, would ensure that standards intended to support the wellbeing of migrants in detention are upheld. When grievances from migrants or formal internal reports of a facility's failure to uphold and maintain the standards are observed and reported, a thorough external investigation should be conducted. It is the responsibility of ICE, CBP, and ORR to properly enforce the standards that exist, and failure to do so should have consequences. Our literature review and KIIs reiterate concerns regarding the low levels of consistency and compliance to standards within and among agencies.

Many of the detrimental health effects of detention could be averted altogether if alternatives to detention were implemented in place of the current detention system, such as community-based supervised release, release with or without conditions, or other less restrictive and more humane measures. From a human rights and public health-centered perspective, the detention of migrants is not conducive to supporting their physical, mental and emotional health. However, until detention is no longer practiced, except in the rarest of circumstances that are in the best interest of the migrant, we recommend the creation of an independent oversight mechanism across these detention facilities that

ensures accountability and compliance to an improved version of the agency's minimum standards.

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Declaration of Competing Interest

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Supplementary materials

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