COVID-19 and the coming epidemic in US immigration detention centres

Lancet Infect Dis 2020
Published Online
April 15, 2020
https://doi.org/10.1016/S1473-3099(20)30295-4

Individuals in US Immigration and Customs Enforcement (ICE) detention are at risk from serious consequences resulting from the rapid spread of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and inadequate access to appropriate medical care. This situation represents a moral and public health imperative for rapid action by the US Department of Homeland Security (DHS) to mitigate the human toll of the pandemic.

SARS-CoV-2 emerged in late 2019 in Wuhan, China, causing coronavirus disease 2019 (COVID-19), which has been rapidly spreading across geopolitical, social, and economic boundaries around the world. In the USA, a rapid increase in SARS-CoV-2 infections in every state of the country has resulted in a growing number of hospitalisations, admissions to intensive care units, and deaths in specific age groups and in many people with underlying medical conditions.[1]

Individuals who are incarcerated, including immigrants in ICE detention, are among the most vulnerable to infection and complicated disease because of existing drivers of inequality.[2–3] The incarceration of undocumented immigrants is a relatively new phenomenon in the USA. The annual average daily population in ICE detention has risen more than seven times in the past 25 years to a peak of more than 50 000 individuals in 2019.[4] Many individuals in ICE detention have never been charged with a criminal offense. Immigrants in ICE detention around the country have expressed panic over conditions that put them at exceptionally high risk of an outbreak of COVID-19 and proposed an immediate humanitarian response to mitigate the risk of infection.[5] Rapid implementation of infection prevention and control measures in immigration detention is essential to the wider national public health response. Although people who are incarcerated are confined, a high degree of interaction occurs between people in facilities and the community, including people being transported between facilities, releases and new intakes that generate a population turnover, and the comings and goings of staff, visitors, vendors, and contractors. Inadequate implementation of infection prevention strategies will affect the spread of COVID-19 in the community and burden an already stretched health-care system.

Because the transmission of SARS-CoV-2 is predominantly from person to person through droplets, a pillar of infection prevention is social distancing and disinfection, which is antithetical to closed detention settings. Incarceration requires large groups of people to be held together in confined and often poorly ventilated spaces. Many areas within the facility are communal, including housing, waiting rooms, eating areas, recreation spaces, and classrooms. Disinfection and decontamination practices are also complicated by the ability of SARS-CoV-2 to survive for extended periods on materials that are highly prevalent in detention settings, such as metals and other non-porous surfaces.

From a public health perspective, mitigation strategies in detention facilities should be complemented by routine screening and containment procedures. These entail screening all people who enter facilities, including individuals in detention, staff, visitors, and vendors, and quarantining those who screen positive for COVID-19 exposure. People who screen positive for symptoms on intake or develop symptoms during detention must be medically isolated and receive appropriate medical care. ICE facilities do not have the staffing capacity or facilities to screen, quarantine to monitor for symptoms, isolate infected individuals, or deliver medical management in a setting with high rate of infection.[6]

Clinical deterioration, often rapid with COVID-19, will require the rapid transfer of individuals with COVID-19 to local medical facilities for specialised care that might exceed the capacity of local health-care systems, particularly in the rural and semi-rural settings where many ICE detention facilities are located. The combination of a captive population exposed to a highly infectious disease and substandard care has the potential to increase the incidence of infection and case-fatality rates among detained individuals, put the public at greater risk, and consume substantial medical and financial resources.

Because of the existing barriers to adequate mitigation, containment, and provision of medical care in detention facilities, the policy response to this crisis

must involve the release of individuals in ICE detention and a halt of ICE enforcement action in the community. These actions should include the immediate release on humanitarian parole of individuals at risk of severe disease and death due to COVID-19 infection. An even more robust and effective response would be to release all individuals who do not represent a threat to public safety. This does not represent amnesty, but rather the use of existing structures within the DHS and the US Department of Justice to enforce immigration laws in the community setting.

As physician advocates, we believe that prompt action in this brief and rapidly closing window represents not only the humanitarian and moral course, but also the best public health intervention to prevent unnecessary deaths.

We declare no competing interests.

*Jaimie P Meyer,*Carlos Franco-Paredes, Parveen Parmar, Faiza Yasin, Matthew Gartland*
Carlos.franco-paredes@cuanshutz.edu

Yale University School of Medicine, AIDS Program, New Haven, CT, USA (JPM); Division of Infectious Diseases, Department of Medicine University of Colorado, Anschutz Medical Center, Aurora, CO 80045, USA (CF-P); Hospital Infantil de México, Federico Gomez, Mexico City 06720, Mexico (CF-P); Division of Global Emergency Medicine, Keck School of Medicine, University of Southern California, Los Angeles, CA, USA (PP); Department of Infectious Diseases, Yale University School of Medicine, New Haven, CT, USA (FY); and Massachusetts General Hospital Asylum Clinic, Department of Medicine Brigham and Women's Hospital, Department of Pediatrics Newton Wellesley Hospital, and Harvard Medical School, Boston, MA, USA (MG)

1 CDC COVID-19 Response Team. Severe outcomes among patients with coronavirus disease 2019 (COVID-19)—United States, February 12–March 16, 2020. *MMWR Morb Mortal Wkly Rep* 2020; published online March 18. DOI:10.15585/mmwr.mm6912e2.

2 Farmer P. Social inequalities and emerging infectious diseases. *Emerg Infect Dis* 1996; **2:** 259–69.

3 Edge CL, King EJ, Dolan K, McKee M. Prisoners co-infected with tuberculosis and HIV: a systematic review. *J Int AIDS Soc* 2016; **19:** 20960.

4 US Immigration and Customs Enforcement. US Immigration and Customs Enforcement fiscal year 2019 enforcement and removal operations report. 2019. https://www.ice.gov/sites/default/files/documents/Document/2019/eroReportFY2019.pdf (accessed March 25, 2020).

5 Team B Bristol Count Correctional Center of North Dartmouth, Massachusetts. Letter to US Immigration and Customs Enforcement Office of Detention and Removal. 2020. https://assets.documentcloud.org/documents/6816564/Bristol-County-letter.pdf (accessed March 25, 2020).

6 Office of Inspector General. Concerns about ICE detainee treatment and care at four detention facilities. 2019. https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf (accessed March 25, 2020).