Out of sight, out of mind: that is the unfortunate reality broadly for the health of people who are incarcerated and specifically for the health of immigrants who are detained in the United States. In the last several decades, journalistic exposés, anthropological ethnographies, and public health research have increasingly attempted to shed light on the health and health environment of persons in carceral settings in this country, but there is still so much we do not know. This is not due to a lack of scientific understanding or a dearth of information. The information is there. It is simply not accessible because prisons, jails, and detention centers continue to publish only minimal and incomplete data about the health of individuals in their custody. Federal inspection mechanisms have been insufficient to improve data accessibility and overall conditions in immigration detention. Thus the state of California passed AB 103, mandating that the state attorney general review conditions in all California immigration facilities.

The study by Dekker et al1 used this enhanced access to detention condition data in California to study emergency medical system (EMS) responses (ie, 911 calls) at 3 Immigration and Customs Enforcement (ICE) detention facilities in their state. Research about immigration detention centers often looks at topics such as the epidemiology and responses to infectious disease outbreaks2,3 and the frequency and types of deaths among immigrants while in detention4; however, the study by Dekker et al1 is a rarity in its exploration of EMS response activation by, and response to, ICE detention centers.

Dekker et al1 assessed 1224 EMS reported emergencies across 3 centers over the 5-year study period ending December 31, 2022. Notably, only 48 of those emergencies were psychiatric or behavioral in nature, with a mean (SD) of 0.52 (1.13) incidents per month per center. This stands in stark contrast to ICE’s own reported mental health encounters per month per center during that same period, with mean (SD) monthly incidence rates of 7.13 (9.38) for mental health observations, 6.91 (8.57) for suicide watches, and 0.53 (1.26) for suicide attempts.1 Rates of completed suicide in ICE detention have increased in the last decade4,5 and the Office of Inspector General has repeatedly reported the lack of sufficient mental health resources in ICE facilities. These facts combined with the findings of Dekker et al1 suggesting high ICE reported rates of mental health emergencies compared with the much lower frequency of calls to EMS for mental health emergencies is concerning.

Particularly disturbing is the finding that 42 of 338 emergencies in female immigrants who were detained (12.4%) were pregnancy-related.1 On the surface, this may not seem interesting, but it is less the medical facts that are striking and more so the procedural ones. On July 1, 2021, ICE issued directive 11032.4 limiting the administrative detention and arrest of pregnant, postpartum, or nursing individuals to “exceptional circumstances.”6 Yet 1 detention center, Otay Mesa, continued to detain exactly this population of immigrants after the directive, in direct violation of the order.

Many researchers working in immigrant health know the long and often unfruitful process of submitting Freedom of Information Act requests in attempts to obtain more complete data about the health of individuals detained by ICE. By strategically placing immigration detention centers in remote areas and continually minimizing transparency about health protocols and detained persons’ health, ICE successfully keeps the state of this population’s health out of sight and thus out of the mind of the greater medical community and the US public.

The findings in this study by Dekker et al1 are important in and of themselves: the high rates of ICE-reported medical emergencies compared with EMS-reported emergencies, the low rates of EMS...
utilization for mental health emergencies, the high rates of pregnancy-related calls in a population that should be essentially devoid of pregnant persons, and the types of medical emergencies encountered. But perhaps the most important take-away from this study by Dekker et al is the importance of policy for influencing the ability to conduct high-quality research in public health. Whether such policies open up funding on gun-related violence and its health implications or mandate additional layers of oversight of immigration detention centers, researchers and the clinicians who rely on that research need such policies to ensure access to complete, timely, and accurate data. All states should pass similar legislation to that of California so we can better understand EMS responses in all ICE facilities, more rigorously assess ICE’s adherence to its own medically related directives, and thus continue to work slowly but surely to improve the health of this population.

ARTICLE INFORMATION
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