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Pushing them to the edge: Suicide in immigrant detention centers as a product of organizational failure

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ABSTRACT

In this paper, we argue that the U.S. immigrant apparatus is a racial project that jeopardizes immigrants' wellbeing through organizational failure (Omi and Winant, 2014; Meyer & Rowman, 1977; Mellahi and Wilkinson, 2004). We utilize Provine and Doty's (2011) work as a foundation to understand how this racial project is systemic and multifaceted in nature. It begins with the negative characterization and criminalization of certain immigrants, mostly Latinx, followed by a poor infrastructure of processing and detention riddled with impediments to their wellbeing, which ultimately pushes detainees to the edge, to poor mental health, and suicidality. ICE's system of detention consistently operates poorly and normalizes organizational failure, jeopardizing immigrant lives through basic human rights violations, family separation, substandard living conditions, and minimal consideration to poor mental health, suicide prevention, and prompt and adequate intervention. Utilizing qualitative data from ICE inspection reports, contracts, and detainee death reports, we examine suicide policies across 116 detention facilities in the United States to highlight how detention facilities supervised by ICE unsuccessfully prevents detainee suicide due to organizational failure. Under ICE's oversight, facilities are inadequately staffed and resourced, resulting in the failure to implement federally mandated protocols regarding detainees' well-being competently and promptly. Their organizational failure leads to unequal health outcomes for Latinxs who are overrepresented across immigrant detention.

1. Introduction

The U.S. immigration apparatus has legal and political capacity to detain and deport those they arrest and identify as unauthorized, particularly those from Mexico and Central America. In 2017, 10.5 million unauthorized immigrants resided in the U.S., many of whom are long-term residents (Passel, 2019). In the preceding three years, Immigration Customs Enforcement (ICE) remains consistent with their efforts to remove unauthorized immigrants with

240,255 removals in 2017, 256,085 removals in 2018, and 267,7258 removals in 2019 (ICE 2020). These numbers reflect a small fraction of the unauthorized population, and disproportionately feature Latin American countries (ICE, 2020). Those who faced detention experienced substantial impediments to their well-being. We focus our analysis on one of these impediments, the poor management of immigration detention facilities, which are riddled with issues such as inadequate staffing and resources. This prevents them from adequately implementing the Department of Homeland Security (DHS) mandated protocols regarding detainees' well-being. We build from theories of legal violence, racialized legal status, and system embeddedness to offer a new way to consider how organizational failure in immigrant detention undermines detainees' wellbeing. We illustrate this by analyzing data from 116 detention facilities in the United States to underscore how poor management and oversight have resulted in detainees' suicides. Thus, we argue that their organizational failure results in unequal health outcomes for Latinx detainees who are disproportionately represented in detention. In this paper, we aim to shed light on how health care, particularly psychiatric and psychological services, are organized in detention facilities.

We define ICE's organizational failure as the structural

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mismanagement of immigration detention centers and the lack of accountability they face from the DHS and other supervisory entities. ICE relies heavily on idealizing processes of inspection to justify unequal health outcomes (Mallahi and Wilkinson, 2004). As long as inspections occur and are somewhat documented, there is no corrective course of action nor penalties for failing to implement wellbeing-related protocols. In other words, poor health outcomes are rationalized through the "myth and ceremonies" of bureaucracy (Meyer and Rowan, 1977). To illustrate, we examine how employees lack adequate training in suicide prevention and intervention, consequently leading to severe failures in mental health treatment in over 50 facilities. Thus, we examine how organizational failure produces a deficit in planning and guidance regarding mental health protocols and a lack of re-evaluation of detainees on suicide watch to underscore how these practices endanger lives. Detainees are often released early to the general population without proper assessment from appropriate medical personnel. Issues with the reporting process speak to the lack of accountability and the implications of its dysfunction as serious malfeasance. Ultimately, we argue that the poor practices in immigrant detention centers are the byproduct of the current landscape of immigration enforcement, rooted in racializing and criminalizing immigrants; an immigration apparatus that endangers individuals and communities on an ongoing basis, but it is particularly hazardous to those confined in detention. Thus, ICE's organizational failure jeopardizes the wellbeing of detainees and it has cost many lives.

2. Background

2.1. Immigration enforcement as a racial project

The U.S. immigration apparatus cannot be understood without racialization. Omi and Winant's (1994) conception of the racial project is beneficial in this analysis of structures that frame racial categories and simultaneously organize resources based on these selected categories. Michael Walker (2016) defines racialization as "the increasing association of phenomena with meanings ascribed to race constructs (p. 1053)." Due to racialization, Latinx immigrants are subjected to apprehension, detention, and deportation in overwhelming numbers (ICE, 2020). Immigrants from Latin America, specifically non-disabled men of working age, are overrepresented in apprehensions and removals (DHS, 2016). Provine and Doty (2011) argued that this particular process of racialization has focused on economically marginalized Latinx groups.

We use Provine and Doty's (2011) influential work on the evolving trends in immigration enforcement as a foundation to our understanding of unequal racialized outcomes. They focus their analysis on the criminalization of immigrants by examining the fortification of the border with Mexico, partnerships with the local police, and federal initiatives to enhance interior enforcement. However, we center our attention on the consequences of racialized tactics upon those who have been successfully apprehended by ICE. Provine and Doty (2011: 273) argue:

The federal government's current approach to immigration enforcement, in our view, favors the white supremacist side by targeting Mexican immigrants, a group that has been the victim of past discrimination and harsh treatment, much of it legal in an earlier era of racial apartheid. Race thus continues to maintain an intimate relationship with the nation-state, limiting options for a more effective, just, and humane policy.

The normative practices within the immigration system, particularly in detention, are racialized tactics that can ultimately lead to death through suicide. The mismanagement of immigration detention is legitimized, despite its history of dangerous practices, because the racialized exclusion of Latinx immigrants or those of "Mexican appearance" has already shaped the racial identity of detainees as worthy of limited rights Due to racialization, being a Latinx immigrant, particularly unauthorized, deems them worthy of punishment and suffering. The current immigration system is thus, a racial project that robs the Latinx immigrant community of their so-called unalienable rights, including, in the worst cases, the right to life. Furthermore, the racialized identity of detainees does not incentivize corrective actions within the system. ICE's organizational failure is justified on the basis of this racial project.

Scholars use distinctive concepts to explain elements of the immigration apparatus and how it affects immigrants. De Genova and Peutz (2010) describe the emphasis on immigration policy as a "deportation regime." This regime focuses on increased border security, expansion of deportable offenses, individualization of deportation procedures, normalized negligence in detention facilities, and the dehumanization of those in custody. Menjívar and Abrego (2012), describe it as "legal violence," which generates violent effects from federal, state, and local level policies, affecting everyday lives and long-term incorporation processes. Laws and policies that influence and control immigrants, particularly poor and marginalized, often derail an immigrant's ability to integrate into their surroundings fully, and the threat of deportation increases this damaging effect.

Immigration enforcement has severe consequences in the lives of immigrants and their communities regardless of legal status. Deportation fears due to growing national awareness of deportation policies and practice since the 2016 election has even extended to U.S. citizens of Latino origin, despite their once assumed exemption (Asad, 2018). The psychological distress and feelings of vulnerability related to immigration enforcement have a spillover effect. They affect entire communities as the native-born and authorized worry for loved ones, friends, and neighbors (Szkupinski et al., 2014). A study on the mental well-being of immigrants found that authorized and unauthorized immigrants report high levels of stress due to deportation fears and an undermined trust in community (Hacker et al., 2011). After immigration raids, a Latinx community reported high levels of stress and low self-rated health scores associated with immigration enforcement (Lopez et al., 2017). Health care providers have observed adverse mental and physical health outcomes among their patients due to ICE activity (Hacker et al., 2012). A systematic review of the effects of anti-immigrant policy on health found a consistent pattern of difficulties accessing health services and poor mental health outcomes, including depression, anxiety, and post-traumatic stress disorder (Martinez et al., 2015). Latinxs report more poor mental health days if they live in states with exclusionary immigration laws and are life changing for families with children with legally vulnerable members (Hatzenbuehler et al., 2017; Brabeck and Xu, 2010). Other spillover effects include a decline in health care and Medicaid utilization (Rhodes et al., 2015; Watson, 2014), a general distrust of authorities, and caution in navigating institutions (Pedraza et al., 2017; Nichols et al., 2018).

Furthermore, Asad (2020a,b) uses "system embeddedness" to describe how individuals interact with institutions to maneuver visibility, and how visibility, or the lack of thereof, creates feelings of risk and safety among immigrants. For instance, when navigating our healthcare system, immigrant patients take into account current policy to make clinical decisions. Rather than making decisions based solely on their medical needs, they assess the risk of detention and deportation through interactions with medical providers. Unauthorized immigrants see healthcare as a "potential tool for federal biopolitical surveillance" (p.1) and make treatment decisions based on that assessment; Van Natta calls this "medical legal violence" (2019). Finally, Asad and Clair (2018) argue that immigrants are granted a "racialized legal status," a devalued social position based on legal categorizations, presumably race-neutral. This status has the potential to produce health disparities as a direct result of policies that limit economic opportunity and access to health-related resources, as well as discrimination-related stress, including the fear of detention and deportation. Not every immigrant is unauthorized, nor every unauthorized immigrant will be detained, yet in Latinx communities across the country, ICE surveillance and tactics weighs heavily on all.

Once apprehended, detainees with no criminal proceedings are

subjected to hazardous conditions that have adverse effects on their overall health and sometimes lead to their untimely deaths (Hernandez et al., 2018). Detainees, once in immigration detention, are expected to comply entirely with detention regulations and standards, even if these procedures are deadly or violate their rights. Hernandez (2005) argues that legal practices often serve to highlight the reduction of immigrants' rights and civil liberties during detention, a process he called "undue process." Detainees are subjected to verbal and physical abuse, restraints, solitary confinement, poor nutrition, overcrowding, poor sanitation, poor air, and water quality, among other negligent conditions (Morey, 2018; Alexander, 2000; Keller et al., 2003; Franco, Patler, and Reiter, 2020). Accountability is minimal despite regular inspections, thus normalizing these dangerous practices as standard and acceptable operation.

According to Golash-Boza (2015), immigration detention is designed to push detainees out of the country, despite many wanting to fight their cases. Detainees either get sicker the longer they wait to hear from an immigration judge or exhaust their financial and emotional resources and it is not uncommon for detainees to give up their right to a hearing and self-deport to get out of detention (Mukhopadhyay, 2008). The functionality of immigration detention, doubling as local jails in some cases, remains obscure under the jurisdiction of ICE, and only ongoing efforts by immigration activists and journalists have exposed a small number of their dangerous practices such as use of excessive force, sexual assault, and death (Hernandez et al., 2018). While ICE has an audit process run by the Office of Detention Oversight (ODO) and Enforcement and Removal Operations (ERO) in place to keep immigration detention facilities accountable for the services they provide with the use of federal funds, our study reveals that those entities systematically waive any penalty or disciplinary action, giving them freedom to continue mismanaging facilities and jeopardizing detainee's wellbeing. Their organizational failure faces no consequences.

The conditions of detention are often compounded by the mental distress of being unauthorized or by the issues they could have faced in their country of origin, including violence and persecution (Alexander, 2000; Keller et al., 2003). All of these elements push immigrants in detention to poor mental health and suicidality. These trends have also been documented in other nations that employ similar detention practices. In Australia, the leading cause of premature death for those in detention is suicide (Procter et al., 2013). Our case focuses specifically on suicide prevention and intervention policies and procedures in U.S. immigration detention. We carefully examine their failure to prevent potentially fatal practices in detainment.

2.2. *Organizational failure: suicide prevention and intervention in detention*

There is a strong record of inconsistent policies and practices within immigration detention centers (Hernandez et al., 2018; Hiemstra, 2014: Patler et al., 2018; Das, 2013). This record of inconsistency and inadequacy in daily operations is one of the structural impediments to detainees' wellbeing. As a result, organizational failure occurs because it *allows for* the normalization of neglectful and hazardous practices, despite ICE's assertion that they implement strict guidelines for facilities under their control. ICE's idealization of their immigrant detention system is overvalued and is often stripped of any negative features, despite evidence to the contrary (Mellahi and Wilkinson, 2004). While most intergovernmental service agreements (IGSA) or contracts with ICE stipulate that facilities found non-compliant are subject to either funding termination or fines, there is no record of such sanctions (Hernandez et al., 2018). Deportation is also lumped with the criminal justice system because detainees are removed from greater society due to the rapid convergence of criminal and immigration law (García Hernández, 2017). As stated previously, the racial project of criminalizing immigration cannot be removed from this discussion, as it justifies the punitive nature of ICE's activities in the court of public opinion.

The examination of daily detention operations reveals the pressing and dangerous conditions of these facilities. Since ICE or private companies operate 33% of immigration detention centers, many immigrants are detained in county and city jails contracted by ICE to house detainees (Hiemstra, 2014). The complexity of how ICE establishes "custody" creates inconsistencies because facilities are likely to adopt the bare minimum of ICE's recommended guidelines, just enough to be compliant to receive funding from the DHS. This allows some facilities to explain away majorly dangerous practices while also strengthening the racialized framing of detainees as unworthy of rights, dignity, and deserving of punishment. Hence, ICE's organizational failure relies on the myth of a functional immigration detention, one that is safe for all detainees (Meyer and Rowan, 1977). This illusion of bureaucratic functionality is possible because of the performativity of inspections, reports, and threats of losing funding. They change nothing but allow ICE to frame their activities as compliant despite their widely documented negligence. Unchecked, they continue their poor operations normalizing organizational failure; over time, threats to immigrant wellbeing have become standard practice in immigrant detention.

Performance-Based National Standards (PBNDS) were issued in 2000 to "establish consistent conditions of confinement, program operations, and management expectations within the agency's detention system (ICE, 2014). Revisions of these standards in 2008, 2011, and 2016 focused on improving safety, security, medical, and mental health services as well as the addition of other services in a commitment to reform immigration detention. The implementation of standards in these facilities is not uniform, leaving many to operate dangerously without legal repercussions. While there is a push for health care improvements in immigration detention, audit reports continue to show a pattern of negligence because organizational failure has become embedded and normalized in how immigration detention is managed (Tovino, 2016).

In the case of suicide prevention and intervention, ICE's 2011 PBNDS expects facilities to minimize risk by providing comprehensive personnel training, screening procedures, a clear and fast referral system, close supervision in special housing, and treatment (U.S. Department of Homeland Security, 2018). All facility personnel should undergo comprehensive training at orientation and then annually to ensure minimal risk. Timely training is vital because staffers spend a considerable amount of time with detainees, and they are often the first to witness self-harming behavior. While several requirements need to be met during the intake process of a detainee, ICE does require a mental health screening within 12 h of admission by a qualified health care professional or trained correctional officer. These screenings should be appropriately documented with the information gathered during observations and interviews with the detainee. According to protocol, staffers need to refer any detainee that has been identified as a suicide risk to a mental health provider within 24 h after identification. The mental health provider needs to evaluate and determine the level of suicide risk, the appropriate level of supervision needed, and whether the detainee needs to be transferred to an in-patient mental health facility.

Detainees treated in the facility require close supervision and continuous monitoring to minimize the opportunities for self-harm. This monitoring should occur every 15 min or more frequently if the evaluation of the detainee exhibits a higher risk. Detainees are required to be placed in special isolation in rooms designed for evaluation and monitoring, including suicide resistant furniture. PBNDS 2011 further states, "All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, welfare checks at least every 8 h conducted by medical personnel, and daily mental health treatment by a qualified clinician (U.S. Department of Homeland Security, 2018)." Detainees should only be discharged from suicide observation by an appropriately trained and qualified medical staff member and reassessed within 72 h of release. ICE uniformly expects all contracted facilities to notify them through the chain of command of any suicide attempt or any suicide resulting in death within 24 h of its occurrence. Furthermore,

ICE expects notification if any suicide prevention and intervention cannot be executed properly.

Although the DHS and ICE have set guidelines for safer operations in facilities under their jurisdiction, immigration detention centers often fail to adopt these guidelines as policy because the management of these centers is systemically deficient and neglectful. Organizational failure has become normalized in immigration detention centers in their day-to-day operations. Under a normalized organizational failure model, detention facilities neglect suicide prevention and intervention training, creating a high risk of detainee death. Having personnel, including medical staff, with little to no training in suicide prevention and intervention is alarming, as vulnerable detainees already have limited advocates in detention. Due to the lack of training, facilities may underreport the number of detainees who need mental health services. Moreover, mental health services in immigration detention fail to account for the emotionally and socially stressful process of deportation. This is an issue in the 116 immigration detention facilities across the United States analyzed in our study. Detention deficiencies have become the norm in the immigration removal process, in defiance of the DHS standards of facility operation.

3. Data and methods

During the years 2003–2015, 150 immigrant detainees died under the custody of ICE, and about 13% of those deaths were detainees who committed suicide. Utilizing data obtained through a Freedom of Information Request (FOIR), we analyzed qualitative data from 116 of the largest ICE detention facilities using ATLAS.ti, a data analysis software that allowed us to create an initial code scheme that uncovered patterns across varying facilities. The initial coding scheme, created by the lead author in 2016, consisted of 55 detention deficiencies that ranged from detainee classification systems to medical care. These coding schemes were then linked to our various data to create an organizational map of ICE operations. Previous work focused on this data, examines death and the medical care deficiencies that create dangerous environments for detainees (Hernandez et al., 2018). The "suicide" code is the focus of this study and is examined through the framework of how ICE objectifies, rationalizes, and normalizes the social suffering of vulnerable Latinx immigrants (Moore, 2014; Bonilla-Silva, 1997; Chase, 1995). Data for this project was coded by the lead author and a report was created to only feature suicide related material. This report included contracts, audit inspection reports, and death reports of those who committed suicide while in the custody of ICE. Each member of the research team read and analyzed this entire suicide report. The analysis report was then merged and made into a master project on ATLAS.ti.

Data for this analysis consisted of inspection reports from 2008 to 2014, 47 detainee death reports from 2003 to 2017, and 108 intergovernmental contracts. This analytical process is referred to as inductive category development and is valuable when existing research on the subject matter is limited or scarce (Kondracki and Wellman, 2002; Mayring, 2000). Thematic codes and memos on suicide prevention and intervention provided context to our various forms of data (i.e., audit inspection reports, contracts, and death reports) and allowed us to examine how detainee mental health policies are truly enacted in immigration detention. Due to the considerable size and assortment of data, we also focused on *how* these policies jeopardize the lives of detainees based on the textual evidence.

Further, Wendy Leo Moore's (2014) *structurally contextualized critical discourse* method was most useful to bridge the gap between the limitations of inspection reports and conventional context analysis. While Moore (2014) examined Supreme Court cases, this process of analysis allowed for the identification of legal frames in immigration detention contracts, inspection reports, and death reports that employed an explanation and justification for poor treatment, lack of accountability, and poor mental health outcomes. A critical evaluation of suicide prevention and intervention practices and policies is interconnected to our arguments about the racialized practices of immigrant detention. Informed by both sociological theory and critical discourse analysis methods, this analytical process accounts for what is ultimately excluded and deemed irrelevant while also helping to build context to how detention centers explain and justify negligence in suicide prevention and intervention. Lastly, Moore's *structurally contextualized critical discourse* method assists in the critical evaluations of how these inspection reports "relate to and connects with the racialized practices, institutional arrangements, and structures that maintain white supremacy" and inequality (Moore, 2014).

4. Findings

4.1. Deficient staff training as a risk to suicide prevention and intervention

JeanCarlo Jimenez, a 27-year-old Panamanian citizen, committed suicide on May 15, 2017, after enduring 19 days in solitary confinement (Urevich, 2018). ICE's detention standards dictate that detainees should not be held in solitary confinement for more than 14 days, despite numerous human rights and scientific organizations defining its practice as torture (Appelbaum, 2015; Cloud et al., 2015). Further, detention personnel must screen and evaluate detainees for mental health issues promptly. Jimenez died in the Stewart Detention Facility in Lumpkin, Georgia, a facility with a history of deficient staff training in suicide intervention and prevention. The underlying conditions that lead to Jimenez's death can be positioned within the context of ICE's organizational failure, which allows the supervision of detainees, particularly those in suicide watch, by unqualified staffers (Mellahi and Wilkinson, 2004; Meyer and Rowan, 1977). Although these facilities are supposed to meet standards that would prevent this type of incidents, there is no sanction whatsoever, not even after a detainee takes their life.

A year after JeanCarlo Jimenez committed suicide, Efrain de la Rosa committed suicide in solitary confinement at Stewart Detention Center in Lumpkin, Georgia (Enforcement and Removal Operations, 2018). Similar to Jimenez, de la Rosa spent 21 days in confinement before committing suicide. Facility personnel failed to follow suicide intervention and prevention standards even though de la Rosa had two documented mental health conditions, schizophrenia and bipolar disorder. There were no financial sanctions applied to the facility by the DHS. This failure to prevent suicide stems from insufficient staff training in suicide prevention and intervention, a characteristic of these facilities' daily operations. The Stewart Detention Center fails to train its workforce on suicide prevention and intervention 50% of the time. The inadequate staff training is yet another example of the organizational failure which normalizes the notion that the well-being of detainees is not a priority and results in unequal health outcomes for Latinx detainees.

In our sample, 56% of facilities failed to train their personnel in suicide prevention and intervention properly. Table 1 identifies the four facilities with the worst failure rates in our sample. The staff in our analysis consisted of facility officers, sometimes referred to as

Table 1
Percentage of staff without suicide prevention and intervention training.

	Failure to train staff on suicide prevention and intervention	Training failure rate after 1st deficiency was first identified by inspection process
All Facilities	56%	20%
Stewart Detention Center	50%	50%
El Centro Service Processing Center	6%	29%
Immigration Centers of America-Farmville	96%	96%
Eloy Detention Center	100%	100%

correctional officers, booking officers, and medical staff, which included nurses and physicians. Additionally, 20% of these facilities neglected to train their workforce after initial inspection reports highlighted the training deficiencies. For example, an audit report for El Centro Service Processing Center on the southern border of California evidenced a pattern of management not attending their annual training on suicide prevention and intervention in 2008. In 2009, ICE found that four additional supervisors at El Centro did not complete training, and in 2011, a contract psychiatrist did not complete annual training requirements. El Centro Service Processing Center is just one example of a faulty detention management system that does not prioritize detainee mental health. This particular facility creates a dangerous environment since crucial players in management lack the knowledge to help detainees undergoing severe mental health crises. This feature of organizational failure allows for suicide to be an acceptable outcome of detention, despite ICE's own detention standards stating otherwise.

Additionally, mental health services are not prioritized in facilities similar to El Centro Service Processing. Latinx immigrants, before their deportation, are found to have poor access to healthcare, and anti-immigrant policies can accelerate mental health problems and overall well-being. Mental health problems can only deteriorate with detention as a direct consequence of these policies. Once in detention, many Latinx immigrants are removed from their family and support network, a significant contributor to social integration and overall well-being (Ayón et al., 2010). Even if all detention staff members followed the appropriate protocols, detention and the prospect of imminent deportation create conditions for poor mental health for unauthorized Latinx immigrants because the racialized framing of the U.S. immigration system continually exposes them to stressors and other risk factors.

The daily operation of immigrant detention facilities depends on appropriate employee training. Staff members, even if they are not medical personnel, should have comprehensive training in suicide prevention and intervention in order to determine if detainees are at risk of suicide. The pattern of deficiencies exhibited in our sample demonstrate that suicide prevention and intervention is not carefully considered by immigration detention personnel, thus leading us to conclude that the lives of detainees are in jeopardy under their custody. This was indeed the case for the Virginia's Immigration Centers of America-Farmville facility because, in 2011, only 1 out of 28 employees were adequately trained in suicide prevention. The inspection revealed that the only staff member that had completed the training was the psychiatrist, and the rest of the employees offered no explanation for failing to complete the trainings. They were completely unfamiliar with suicide prevention and intervention guidelines. This leads us to argue that little concern is focused on suicide prevention and intervention. Even when some training is available during employee orientation, some facilities fail to include suicide prevention and intervention in the discussion. One of these facilities, the Eloy Detention Center in Arizona, exhibited a history of undertraining employees in both 2009 and 2010. In 2010, their new employee orientation did not cover suicide prevention training, even though the facility was well aware that detention guidelines require it. Since 2003, five detainees have committed suicide at the Eloy Detention Center, the latest being the suicide of Jose de Jesus Deniz-Sahagun occurring on May 20, 2015. According to his Detainee Death Report, the 31-year-old man from Mexico exhibited hysterical behavior and was visibly emotional on May 17; he had jumped twice from a concrete bench in a Border Patrol holding room as an act of self-harm. Deniz-Sahagun was taken to the emergency room after attempting to break his neck because "he feared his life was in [en]danger [ed] by both Mexican coyotes and [the United States Border Patrol] (U.S. Department of Homeland Security, 2015)." Although he was treated for his head injury, there was no behavioral or psychiatric documentation from the ER upon his return to the Eloy facility. The registered nurse that completed the intake failed to document in his medical record the conversation she had with about Border Patrol agents about Deniz-Sahagun's mental state.

During the initial screening, medical personnel failed to assess Deniz-Sahagun within 24 h and to house him in a secure environment where he would be continuously observed. One of their administrative errors was to determine Deniz-Sahagun's condition to be routine rather than urgent. His condition grew worse as he became more agitated and fearful of his life because of his cellmate and detention officers. After a serious of psychotic episodes, Deniz-Sahagun was determined to be suffering from a delusional disorder, often caused by disturbing events, and placed on suicide watch by a facility doctor. The doctor prescribed psychotropic medications, but health services administrators at the Eloy Detention Center failed to administer them and did not take further measures to prevent his suicide on May 20, 2015. A 9-cm toothbrush handle was found in his stomach, and his cause of death was documented as asphyxia due to choking as a manner of suicide. His death remains painful and preventable. The actions at the Eloy Detention facility demonstrate that a personnel's inability to assess suicide risk accurately can lead to an untimely death. Although staff members at the Eloy Detention facility were documented to lack suicide prevention and intervention training, no employee was fired, and the facility was not sanctioned financially. The lack of accountability by ICE and the DHS allows organizational failure to thrive and it has become norm rather than exception. For example, a congressional oversight committee investigation in 2020 found that a worker at Eloy falsified observation logs to conceal the fact that personnel did not properly monitor a severely ill detainee in solitary confinement, and he died as a result (Gonzalez, 2020). Although this was not a suicide case, this speaks volumes about the overall organization failure of the detention system, demonstrated in its inability to safeguard immigrants' wellbeing while covering up these events with a bureaucratic paper trail that varies in accuracy.

Similar to the Eloy Detention Center, the Clinton County Correctional Facility in Pennsylvania had a detainee suicide in 2011. According to the inspection report, "the detainee was in ICE custody for 9 day at the time of his death and was not on suicide watch when the death occurred. Officers who conducted mental health screenings at the time did not have specialized training to conduct mental health or suicide screening …". The oversight of essential training that protects vulnerable detainees from self-harm and frames it as legally acceptable is central to the racial project of immigration enforcement. The existing management structure of the detention system fails to enact reflective adjustments based on previous deficiencies. Despite the detainee's suicide in 2011, an audit report from 2012 emphasized that the staff was still not adequately trained in suicide prevention and intervention. Neither Eloy Detention Center nor Clinton County Correctional Facility were financially sanctioned by ICE due to their continued deficiencies, thus normalizing organizational failure. Continuous shortcomings are accepted as suitable for Latinx immigrants in deportation proceedings due to their racialized status.

Most immigration detention facilities fail to train their employees on proper suicide prevention and intervention altogether, while some facilities train their staff inadequately. For example, the Worcester County Jail in Maryland reported a lack of training in suicide intervention during an in-progress suicide attempt. The 2011 inspection report reads, "As it could mean the difference between life and death, it is critical that staff know the actions they are to take if they observe a detainee attempting to take his or her own life." All these omissions in suicide prevention and intervention highlight how dangerous immigration detention centers are for Latinx immigrants. Staff members, whether medical or officers, should know what actions to take during an in-progress suicide attempt because this knowledge can save a detainee's life. The normalization of negligence dehumanizes detainees to the point where death is an acceptable outcome of detention under ICE's organizational failure model.

Although we focus on suicide policy, our analysis demonstrates how detention personnel lacking fundamental training can become a hazard for facility operations and suggests that the reporting of how many detainees undergo mental health evaluations and/or attempt suicide might

be inaccurate and most likely undercounted. The failure of the immigration detention system in providing necessary training to its employees evidences a low level of care for those in their custody. Employees are taught not to care, not even enough to keep detainees alive, thus they are also complicit in allowing suicide to become an acceptable outcome of detention. Inspection reports find these training deficiencies year after year, but there are no improvements nor accountability. This lack of humanity strengthens our argument about the racialized nature of the deportation process. In the next section, we discuss the discrepancies and mistakes in suicidal re-evaluation in detention facilities.

4.2. Disorientation in suicide re-evaluation

As previously discussed, adequate suicide prevention and intervention requires that employees are trained at their initial hire date and annually as stipulated by ICE and the DHS own guidelines. However, organizational failure allows an atmosphere of confusion to prevail when it comes to the re-evaluation of detainees under suicide watch. A significant issue evidenced in our analysis was the lack of re-evaluation by trained and qualified staff. Table 2 identifies the three facilities with the highest percentage of failure to re-evaluate suicidal individuals. In these facilities, detainees were released to the general population without an ensuing examination by medical personnel after spending time under suicide watch This negligence suggests the re-evaluation process is not a stable feature of suicide prevention in detention; this is mainly an issue in the facilities identified in Table 2.

The Stewart Detention Center, the same facility where both Jean-Carlo Jimenez and Efrain de la Rosa committed suicide, holds a record of not re-evaluating detainees by appropriately trained medical staff. In 2011, a review of the Stewart Detention Center's records found that detainees on suicide watch were not properly re-evaluated when they were placed in solitary confinement. The lack of re-evaluation fails to recognize the urgency of providing life-saving care to detainees undergoing emotional disturbances, especially those under solitary confinement. This continuous malpractice allowed Efrain de la Rosa to die in 2018. ICE's organizational failure creates conditions that may enable subpar mental healthcare in immigration detention, and that may contribute to a person's death during the deportation process.

About 13% of the immigration detention facilities in our analysis had issues with re-evaluation practices. Medical staff in these facilities often reported confusion as to who was authorized to release detainees from suicide watch. According to the PBNDS, physicians are the only employees allowed to release detainees from suicide watch. Registered nurses are not allowed to release detainees from suicide watch, especially if they have not undergone specialized training. For example, in 2014, a review of detainee medical records found that the Denver Contract Detention Facility in Colorado failed to re-evaluate suicide watches 67% of the time after initial screening. Additionally, 50% of those cases were not re-evaluated after the second day. One case failed to be re-evaluated for 13 days. The inspection found that the Denver Contract Detention Facility often allows suicide watch to be discontinued by unqualified personnel. The healthcare supervisor could not provide documentation verifying consultation with either the psychiatrists or psychologists before releasing detainees to general population. These practices in daily operation demonstrate that detainees with pressing mental health needs do not receive the proper care or adequate treatment. Despite not following protocols, the Denver Contract Detention Facility was not sanctioned by ICE.

Table 2
Percentage of facilities that failed to Re-Evaluate detainees on suicide watch.

All facilities	13%
Stewart Detention Center	75%
Denver Contract Detention Facility	67%
LaSalle Detention Facility	50%
Sherburne County Jail	66%

The LaSalle Detention Facility in Louisiana also exhibits these same dangerous practices. In 2012, an inspection report found that a psychiatrist completed only 50% of suicide watch terminations. The facility's nurse practitioner inappropriately removed detainees off of suicide watch, even though they lack the authority to return detainees to the general population. According to a 2016 special report from the Southern Poverty Law Center, the LaSalle Detention Facility has a history of delaying and denying physical and mental health care. Their indifference has been noted because, during a 2016 interview with a detainee at LaSalle, it was reported that "one detainee tried to hang himself in the dorm. The code was called, but no administrators came (Southern Poverty Law Center, 2016)." The report continued to state:

The psychological care at LaSalle is ineffective, according to detainees. "Psych is bad. They just give you meds," said Catalina, who has been detained for over eight months. "A blue and brown pill, they didn't tell me what was in it. When I took it, I almost passed out? They don't tell you the consequences of medication. There is no therapy–just meds" (Southern Poverty Law Center, 2016, p. 33).

The passage above suggests that detention is part of a structure in which negligence and abuse towards vulnerable detainees have become normative. While LaSalle Detention Facility claims to operate effectively, employee training remains unsuitable, and re-evaluation is poorly handled. Additionally, there are no efforts on the part of ICE or the DHS to correct LaSalle Detention Facility's malpractice.

The Sherburne County Jail in Minnesota has similar deficiencies as the ones described above. Since Sherburne County Jail holds a contract with ICE, they are permitted to hold detainees subject to deportation, despite these detainees holding no criminal record. County jails are required to have classification systems that separate inmates from detainees to ensure the wellbeing of those under ICE custody. A 2011 inspection report found that Sherburne County Jail does not have a system that distinguishes suicide attempts between inmates and detainees. A nurse's recollection of a suicide watch in February 2011 was the only record available for evaluation, and the Office of Detention Oversight found that in that facility, the registered nurses discontinued suicide watches without the authorization of the clinical director. Sherburne County Jail stated having contradictory policies in place which confused medical staff about who could authorize the removal of suicide watches.

The disorientation regarding re-evaluation and suicide watch protocol are further indication of organizational failure. The inconsistencies in suicide prevention and intervention standards create toxic and dangerous environments for detainees with mental health needs. Detainees who are removed from suicide watch prematurely may become a risk to themselves. Additionally, detainees afflicted with severe mental health conditions lack advocacy to get the help they need during their time in detention. While the inspection process may document significant deficiencies in the suicide prevention and intervention process, there is a considerable lack of accountability, allowing poor practices to continue endangering detainees' lives. The normalization of organizational failure in detention facilities affirms the dehumanization of detainees and deems them unworthy of proper care and better conditions. Thus, deportation proceedings, formally classified as administrative process, serve as punitive mechanism, justified by the racialization of Latinx immigrants.

5. Conclusion

The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 reclassified and broadened the types of crimes that resulted in deportation. The ensuing system of mass detention and deportation has greatly afflicted Latinx immigrants. While the conditions of detention facilities were poor during the Obama administration, the Trump administration's unfavorable stance on immigration and unyielding

support for ICE has allowed its practices to expand and worsen as exemplified by their family separation policy. This has also solidified the status of the immigration apparatus as a racial project due to its constant assaults on immigrants' human rights. The organizational failure in the structure of detention and removal has become normalized and will continue jeopardizing immigrants' wellbeing. The fact that there have been no negative consequences towards a system that imprisons children in nefarious conditions offers little to no hope in the implementation of more humane policies. The immigration apparatus has now a strong record of inflicting pain and suffering on Latinx immigrants (Moore, 2014; Bonilla-Silva, 1997; Chase, 1995) to the point of putting them at risk for self-harm and suicide.

The 2017 death of JeanCarlo Jimenez demonstrates how a 27-year-old committing suicide is not an anomaly in detention but rather an ordinary outcome of a failing organization that operates based on racialized principles. The Stewart Detention Facility failed to provide him with life-saving mental health services due to their consistently poor practices in workforce training. This facility remains functional and not liable for their neglectful practices. This Georgia detention facility is not one isolated example of organizational failure. In the contrary, it is only one example of the organizational failure of ICE's detention and deportation apparatus; a failure they seem unwilling to address and correct since its inception.

Employees with limited suicide prevention and intervention training cannot correctly assess the mental health needs of detainees nor provide them with adequate treatment. Additionally, facilities that have limited to no training in suicide prevention and intervention often unreliably report suicide watches, which means that suicidal detainees are often unseen and untreated. This means that suicide and mental health risks will continue to be underreported because employees do not have the training to identify and assess these cases. As in the case of Jimenez, employees' misuse of solitary confinement as a substitute for in-patient mental health treatment increases the risk for self-harm and suicide. Solitary confinement practices, particularly its use within immigration detention, should also be evaluated in this critical lens.

The organizational failure of ICE's detention facilities evidenced in our analysis is rooted in a racial project. Poor practices are now expected and normalized in detention facilities' daily operations, justified on detainees' racialized status, which deems them as unworthy of more humane practices. We are not implying that detention facilities would function "better" if all employees were trained adequately, but it is important to critically discuss how the Office of Detention Oversight documents these practices without any financial repercussions to the offending facilities. We examined ICE's very own written communications to evidence their neglect in successfully implementing suicide prevention and intervention protocols. Based on this evidence, we argue that immigration detention facility oversight is mere "myth and ceremony" (Meyer and Rowan, 1977) more preoccupied in creating this semblance of functionality than addressing the structural causes of poor health outcomes within these settings. A recent and striking example is the mishandling of the COVID-19 pandemic in detention facilities. A report by Physicians for Human Rights (PHR) and Harvard Medical School suggests facilities did not implement safety protocols and detainees did not have proper access to testing, medical care, or even basic items like soap to wash their hands. Detainees who complained were retaliated against by placing them in solitary confinement (PHR, 2021). Hence, we argue ICE's organizational failure is beyond repair, as illustrated by its continuous deficiencies and inability to care properly for those under their custody (Papst, 2008; NIJC, 2016; DHS, 2019a, b). A complete restructure of the immigration apparatus is urgently necessary to end all impediments to immigrants' wellbeing and perhaps, abandon the detention practice altogether. .

Workforce practices in immigrant detention facilities reflect ICE's ideology and are the "rational means to the attainment of desirable ends" (Meyer and Rowan, 1977, p. 345). The ends being more than preventing unauthorized immigration; they also aim to intimidate immigrants and those racialized as such, through their ever-growing surveillance mechanisms (Provine and Doty, 2011) and inflict suffering in their communities (Moore, 2014; Bonilla-Silva, 1997; Chase, 1995). Their failure to address deficiencies in detention facilities could be one of those means, as detention officers' inability to recognize suicidal behavior contributes to further mental health deterioration. The overall neglect to provide adequate training on suicide prevention and intervention during hiring and annually thereafter, suggests that detainee well-being is not the priority of detention facilities. The top priority is to punish, to push detainees to the edge, to poor mental health, suicidality, or self-deportation (Golash-Boza, 2015). The lack of training also leads to disorientation in suicide watch protocols, often leading to unqualified personnel releasing detainees on suicide watch to the general population without a re-evaluation of their conditions. Mental health care services are treated as optional rather than required. We call for a deeper analysis of these practices, particularly in immigration detention facilities that detain younger adults and children.

The lack of accountability further jeopardizes the lives of detainees. While inspection reports may indicate these deficiencies there is no corrective course, no sanctions or incentives to improve. Year after year, inspections conclude these facilities operate poorly yet they apply no retribution normalizing the substandard state of detention centers. Audits and inspections provide a façade of functionality but have done little to address the overall organizational failure. As the evidence suggests, there are no punitive consequences to facilities who report suicides of detainees, even when evidence of malpractice exists. This is why we call for the complete restructure or elimination of this potentially dangerous portion of the deportation process.

ICE's lack of corrective action and sanction, as shown in its own internal reports and audits, supports the notion that their organizational failure is part of the racial project of the immigration apparatus. The framing of their organizational failure as racial project lends credence to how the dehumanization of detainees has become normalized in deportation procedures. . Although deportation is an administrative process, we highlighted how immigration detention facilities fail to provide proper detainee care by allowing poor daily operations to persist, despite protocols in place to ensure otherwise. While the focus of this paper centered on suicide prevention and intervention policies in immigration detention, this examination can assist further research on how and why continuous deficiencies continue to be overlooked in the inspection process. The hazardous conditions in immigrant detention, often the last space detainees inhabit before complete removal, illustrate the effects of unchecked organizational failure and the punitive nature of this racial project (Provine and Doty, 2011). Immigrants, particularly those undergoing extreme emotional distress in detention, continue to be under the custody of poorly trained staff that treats them as criminals and sees deportation as punishment. The failure to prevent detainee suicides reflects the broader ideology of ICE as organization, one that normalizes pain and suffering and serves as instrument of white supremacy (Moore, 2014).

Our main contribution to the literature on immigrant health is presenting evidence of the negligent conditions of detention facilities, the inattention to their mental health needs, which in the worst cases, leads to suicide. We used data from ICE's internal reports painstakingly obtained through a Freedom of Information Request. We acknowledge that this data might significantly underreport suicide and self-harm cases. Immigrants in detention are a high-risk population for poor physical and mental health due to facilities neglectful conditions, and yet we have very little information about their health outcomes. We hope that future research will follow suit and aim to study this particularly vulnerable group. Based on the conditions of detention, we can only speculate that many other health conditions proliferate, and thus, there is a need for further investigation. Moreover, we use organizational failure as a framework to discuss the many deficiencies in detention facilities and their consequences. We also argued that ICE's organizational failure and lack of corrective action and penalties are justified on the racialized

identity of Latinx immigrants. Hence, framing the broader immigration apparatus as a racial project that negatively affects the lives of immigrants, both in their communities and in the context of detention. For those who are swept under the system of detention and removal, the racial project becomes more salient, more visible. The organizational failure is not a coincidence but a fixed feature of a racial project that aims to punish unauthorized immigrants and threatens Latinx communities. Besides further examination of health outcomes in detention, there is a need to expand the body of literature regarding the effects of immigrant enforcement in communities to elucidate how this racial project is enacted in subtler ways.

Author contribution

Beatriz Aldana Marquez, Texas State University—writing-original draft, formal analysis, investigation, Guadalupe Marquez-Velarde, Utah State University—writing-review & editing, resources; John M. Eason, University of Wisconsin, Madison—conceptualization; Linda Aldana, SUNY Albany, investigation.

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