

June 14, 2011

Charles Edwards
Acting Inspector General

Carlton Mann
Assistant Inspector General for Inspections

Dear Mr. Edwards and Mr. Mann,

The undersigned organizations write in appreciation for the Office of Inspector General's work on the recently-released *Management of Mental Health Cases in Immigration Detention* report (OIG-11-62), and to share responses to the report in furtherance of our fruitful working relationship.

Management of Mental Health Cases in Immigration Detention aptly spotlights significant barriers to the provision of efficient and effective mental health care in immigration detention. We concur that broad systemic deficits in coordination and information sharing, and in matching of resource deployment to detainees' needs, are problematic across detention centers used by ICE. Global data on projected and actual usage of health care resources, which is not presently compiled, is a fundamental necessity in detention management and planning, as you have recognized.¹ In order for ICE to resolve any of your recommendations, it is critical that the agency gather and analyze information about mental health histories and needs of detainees as a first step. Although a universal electronic health records ("eHR") system will enable this analysis, the project cannot await implementation of eHRs at every detention location. We support your recommendation that IHSC Field Medical Coordinators ("FMCs") must be tasked with monitoring and tracking mental health care within their districts. We would suggest that you urge ICE to assign FMCs to collect periodic statistical reports from contracting partners who directly provide care to ICE detainees in IGSA and CDF facilities. Pending full implementation of electronic health records, FMCs should also be tasked with ensuring that people continue to receive psychiatric medications during and after transfers between detention facilities: interruptions in treatment at such times are common, in our experience.

Only after ICE understands the scope of need through improved oversight and data collection, can it make informed, rational plans to allocate its resources accordingly. Our experiences as advocates for people in detention confirm that at present, individuals with acute needs continue to be sent to facilities that are understaffed and cannot adequately care for them. For example, Texas Appleseed has encountered a detainee with known mental health care needs who was sent to a facility that did not even have a full-time physician on staff, let alone provide psychiatric services. The result was that the individual was held in segregation and could not attend immigration court proceedings because of significant mental health deterioration. The Florida Immigrant Advocacy Center worked with another

¹ The National Commission on Correctional Health Care, for example, states, "For monitoring, budgeting, and planning purposes, health administrators need a wealth of statistical information on health care activities and utilization patterns." (B. JAYE ANNO, PH.D., CCHP-A, CORRECTIONAL HEALTH CARE: GUIDELINES FOR THE MANAGEMENT OF AN ADEQUATE DELIVERY SYSTEM 315 (Dec. 2001)) Accreditation by the American Correctional Association requires, at minimum, production of quarterly statistical reports that document "use of health care services by category; referrals to specialists; prescriptions written; laboratory and x-ray tests completed; infirmary admissions, if applicable; on-site or off-site hospital admissions; serious injuries or illnesses; deaths; and off-site transports." (PERFORMANCE-BASED STANDARDS FOR ADULT LOCAL DETENTION FACILITIES, 4TH ED. 126 (June 2004))

victim of ill-planned detention placement: Luis, who has schizophrenia and was enrolled in a day treatment facility when ICE arrested him. ICE detained Luis at Glades County Detention Center in Florida, where the appropriate medication regime was unavailable. He was without necessary medication for three months, during which time he was unable to participate in his court proceedings or understand what was happening. The court was forced to cancel multiple hearings as a result, which further prolonged Luis' detention. We endorse your recommendations around aligning mental health care infrastructure with defined needs; reinvigorating staff recruiting efforts, taking into account the pool of potential employees in various localities; and identifying detainees' mental health care needs as soon as possible upon their entry into custody so as to enable appropriate decision-making and assignments.

We are very appreciative of the attention your work has brought to these critical issues. In addition, we would like to offer the following observations and urge you to continue to work with ICE to ensure public accountability for these critical reforms:

1. In the short term, ICE must detain fewer individuals with mental health care needs.

The vacancies you have documented at IHSC-staffed detention facilities are so numerous as to make it clear that minimally adequate care cannot be provided for the number of detainees with mental disabilities expected in those facilities. Pending progress on hiring and retention of mental health professionals, DHS simply cannot send individuals to locations where it knows they will not receive requisite care. To continue to do so would be to leave ever-increasing numbers of immigrants effectively defenseless in a system they cannot comprehend.

In our estimation, ICE likely does not have sufficient capacity system-wide to care for the volume of people with mental health care needs it currently takes into custody. Estimates conservatively put the proportion of detainees with mental disability at 15%,² or more than 57,000 based on the Office of Immigration Statistics' report that 383,524 immigrants were detained in FY2009.³ It is not feasible that such a significant volume of need could be met by shifting detainees between locations, where all evidence suggests staffing and other capacity shortages are chronic throughout the detention system.

It is not just one or two IHSC-staffed facilities that are problematic: 11 of 18 had mental health staff vacancy rates of 50% or greater, and 9 of 18 did not have a clinical director. Overall, 41% of positions at these facilities stood empty. Among the driving factors cited were competition, non-competitive salaries, and isolated detention locations. These same factors affect non-IHSC-staffed detention facilities and have produced similar, or worse, deficiencies there. Some larger non-IHSC contract facilities, with average daily populations in the 500 to 1000 range, have no full-time physician on staff, and no allocation for full-time mental health staffing. Private detention services contractors cut costs in order to make competitive bids in significant part by incurring lower labor costs⁴; thus, contract facilities not staffed by IHSC are neither hiring nor paying more prolifically than IHSC itself.

² *Id.* at 17.

³ DEPT. OF HOMELAND SECURITY OFFICE OF IMMIGRATION STATISTICS, IMMIGRATION ENFORCEMENT ACTIONS: 2009 3 (August 2010).

⁴ *E.g.*, James Austin, Ph.D., Garry Coventry, Ph.D., *Emerging Issues on Privatized Prisons* (Bureau of Justice Assistance, February 2001), at iii.

Moreover, isolated and undesirable locations are the rule in ICE detention. 67 facilities with average daily populations of more than 100 immigrants are located an average of 60 miles from the nearest major city. Among these 67 facilities, 32 are not staffed by IHSC and are located 40 or more miles from the nearest major city; at these locations alone, not taking into account hundreds of facilities with smaller ICE populations, a staggering 10,510 detainees are housed each day, on average, in centers that are highly likely experiencing the same serious hiring difficulties confronting IHSC.⁵

Until the detention system is restructured so that ICE uses only facilities that can and do meet mental health staffing needs, the agency has no responsible choice but to detain fewer people with mental disabilities and health care needs. The answer is not to transfer detainees with mental disabilities to remote detention centers that are more appropriately staffed; such transfers can deny noncitizens access to their family members, medical care providers and attorneys, exacerbating the difficulties they face in detention and in immigration court. Although IHSC's newly-piloted mental health classification system is a positive step, it will not help to divert individuals from unnecessary detention, based on our understanding that classification will take place after people have already been taken into custody and booked into a long-term detention facility. Release from detention is more administratively complicated to effect than a discretionary decision not to detain in the first place, so efficiency demands that mental health needs be identified before a formal detention decision is made.

We urge you to work with ICE to ensure not only progress on filling staffing vacancies, but also that full advantage is taken of opportunities to identify and decline to detain people with mental disabilities who do not need to be detained, or for whom detention would have negative medical consequences. ICE can make significant strides by instituting a clear policy of not taking into custody any immigrant who is actively undergoing mental health treatment, court-ordered or otherwise. ICE benefits because detention costs will decline if ICE does not need to pay for additional or emergency mental health care, or for extended detention stays where court proceedings are delayed due to the poor mental health of a respondent. In addition, ICE need not worry about its ability to locate at the appropriate time such individuals who are already under the supervision of other authorities.

We also strongly advocate your involvement in ensuring full implementation of ICE's Civil Enforcement Priorities memo, which affirms that, "Absent extraordinary circumstances or the requirements of mandatory detention, Field Office Directors should not expend detention resources on aliens who are known to be suffering from serious...mental illness, or who are disabled."⁶ We agree with your assessment that expeditious identification for the purpose of fulfilling this directive will be aided by expanded collection of medical records from prior care providers. We hope that you will consider further encouraging ICE to involve FMCs or other trained medical personnel in completing the Risk Assessment Tool

⁵ Data about isolated detention centers is drawn from and calculated based on Appendix 6 to the National Immigrant Justice Center's *Isolated in Detention* (September 2010).

⁶ John Morton, Assistant Secretary, ICE, *Memorandum: Civil Immigration Enforcement: Priorities for the Apprehension, Detention, and Removal of Aliens* (Policy No. 10072.1, FEA No. 601-14) (June 30, 2010). This policy directive was re-issued in March 2011 with one modification, a disclaimer of liability for any alleged breach.

such that it becomes an effective mechanism for identifying people with mental disabilities as quickly as possible after they first come into contact with ICE. The Risk Assessment Tool can and should be designed to recommend referral to an alternatives to detention program for people with mental health issues.

2. ICE must avoid the conflict of interest inherent in any representation of detainees by DHS or detention contractor employees.

Applicable regulations currently provide for the possibility of a “custodian” to appear in court on behalf of a detainee. Your report indicates that those who play this role include ICE Field Office Directors and Assistant Field Office Directors, other Enforcement and Removal Operations officers, and wardens or correctional officers from detention facilities that contract with ICE. Each of these individuals has natural, necessary interests (e.g., rapid removal of immigrants and ongoing detention for the duration of proceedings) in direct conflict with those of immigrant detainees, and so it stands to reason that attorneys with whom you spoke uniformly “expressed misgivings about the practice.” Immigration regulations also prohibit “conduct that is prejudicial to the administration of justice or undermines the integrity of the adjudicative process,” 8 C.F.R. § 1003.102(n), of which representation by a custodian is a prime example.

Permitting such an obvious conflict of interest to occur at such a critical place in the process severely damages the credibility of Immigration Court proceedings, and places ICE custodians in an untenable position. We urge you to join us in calling upon the Office of the Principal Legal Advisor to not merely publish further guidance on the practice, but to yield to common sense and principles of basic fairness in court by prohibiting appointment of an ICE or detention contractor employee to represent any person in immigration court.

3. Involuntary isolation of people with mental disabilities is unconstitutional and impermissible.

Your concern regarding conditions of segregated housing for detainees with mental disabilities is well-placed, and we are very appreciative of the investigation you have conducted which revealed use of special housing units to isolate individuals needing acute mental care. We are pleased to know that detention health care providers agree with us that segregation is particularly counterproductive and damaging when applied to people with mental disabilities. This assessment understates the case against the solitary confinement of people with mental disabilities, however: courts have found the practice to be an unconstitutional imposition of cruel and unusual punishment.⁷

In any population, regardless of mental health history, solitary confinement has been repeatedly and conclusively found to cause:

- Difficulty recognizing reality and distinguishing between external and internal stimulæ; hallucinations and altered perception;
- Loss of ability to control one’s own behavior, and lack of understanding of what is acceptable; long-term impulse-control disorder;

⁷ *E.g., Harden-Bey v. Rutter*, 524 F.3d 789 (6th Cir. 2008); *Scarver v. Litscher*, 434 F.3d 972 (7th Cir. 2006); *Shoats v. Horn*, 213 F.3d 140 (3rd Cir. 2000); *Jones El v. Berge*, 164 F. Supp.2d 1096 (W.D. Wis. 2001); *Ruiz v. Johnson*, 37 F. Supp.2d 855 (S.D. Tex. 1999); *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995).

- Abnormal malleability, sensitivity, and vulnerability to the influence of those who control the environment; unwanted and extreme feelings of paranoia and aggression;
- Depression, apathy and lethargy; disproportionate tendencies toward suicidal behavior;
- Decline in memory and ability to concentrate; and
- Heightened rates of psychosis and self-mutilation.⁸

There is broad expert consensus that the individuals most susceptible to these consequences are those with pre-existing mental illness, brain damage or mental retardation, chronic depression, borderline personality disorder, and impulse-ridden personalities.⁹

Rather than designate a time limit for holding people with mental disabilities in segregation units, we request that you urge ICE to prohibit their involuntary isolation altogether, except for extremely short periods of no more than 2-4 hours as necessary for stabilization and preparation for transfer to an in-patient facility.

4. Indefinite transfers to in-patient hospitals or mental health facilities raise additional due process concerns, and require additional safeguards.

We are appreciative of the attention you have drawn to policy and procedures surrounding transfers of detainees to in-patient care facilities. Our experiences confirm your observation that failure to assign authority over this process to particular officers is problematic, and has led to unnecessary transfers that seem not to be based on any standardized factors. Human Rights Watch, for example, noted that an LPR interviewed while confined in one such facility said she did not know why she had been transferred there, since she did not need medical or psychiatric care.¹⁰

While we agree that decision-making authority over transfers to and from in-patient facilities must be clarified, we believe the problems in this area are larger in scope. We urge you to work with ICE to ensure inclusion of additional critical directives in a hospital transfer policy. First, consistency and transparency demand that ICE articulate criteria, based on the degree of supervision, medication or other intervention needed to maintain detainees' safety, to trigger consideration of transfer to a treatment facility.

⁸ For discussion of the psychological and psychiatric consequences of solitary confinement, including these hallmarks, *see, e.g.*, Bruce A. Arrigo & Jennifer Leslie Bullock, The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change, 52 Int'l Journal of Offender Therapy and Comparative Criminology 622 (2008); Stuart Grassian, Psychiatric Effects of Solitary Confinement, 22 Washington University Journal of Law and Policy 327 (2006); Craig Haney, Reforming punishment: Psychological limitations to the pains of imprisonment, American Psychological Association (2006); Michael Jackson, The psychological effects of administrative segregation, 43 Canadian Journal of Criminology 109 (2001); Stuart Grassian, Redacted Testimony, Madrid v. Gomez, 889 F.Supp. 1146 (N.D. Cal. 1995), online at http://www.prisoncommission.org/statements/grassian_stuart_long.pdf; Craig Haney, Infamous punishment: The psychological consequences of isolation, 8 National Prison Project Journal 3 (1993); Stuart Grassian & Nancy Friedman, Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement, 8 Int'l Journal of Law & Psychiatry 49 (1986); Stuart Grassian, Psychopathological Effects of Solitary Confinement, 140 American Journal of Psychiatry 1450 (1983).

⁹ *See, e.g., Madrid*, 889 F. Supp. at 1235-36.

¹⁰ HUMAN RIGHTS WATCH/ACLU, DEPORTATION BY DEFAULT: MENTAL DISABILITY, UNFAIR HEARINGS, AND INDEFINITE DETENTION IN THE U.S. IMMIGRATION SYSTEM 75 (July 2010).

Second, safeguards – including a hearing process – must be put into place to guarantee that transfers do not violate due process rights. Lacking specified time limitations or a clear process for refusing treatment¹¹, transfers of detainees to in-patient treatment facilities can amount to involuntary civil commitments, which in turn may be ordered only when subjects are given an opportunity to present evidence regarding the necessity of commitment, and only for as long as necessary to satisfy a legitimate purpose. *See, e.g.*, 18 U.S.C. § 4245 (transfer of a federal prisoner to an in-patient care facility over the prisoner’s objection may occur only after a hearing, and only until the facility director determines and informs the court that treatment at the facility is no longer needed). These procedural safeguards exist in recognition of the fact that civil commitment involves a severe loss of liberty. *E.g.*, *Addington v. Texas*, 441 U.S. 418, 425-26 (1979). Moreover, the federal law recognizes that people with mental disabilities cannot be unnecessarily detained in a treatment facility if their mental health condition does not warrant in-patient treatment – instead, individuals must be housed in the least restrictive setting appropriate to their needs. *Olmstead v. L. C. by Zimring*, 527 U.S. 581, 597 (1999).

Temporary transfer to a specialized facility may indeed be in the best interest of some immigration detainees with acute mental health care needs, but these individuals have the constitutional and statutory right to have their own views on their best interests heard and considered in the process. We urge you to work with ICE to not only implement a standardized system for tracking and placement of detainees in in-patient facilities, but to also create a hearing process for determining the objective necessity of institutionalization where it is disputed.

Thank you, again, for your thoughtful investigation and analysis of ICE’s treatment of people with mental disabilities. We are anxious to follow future progress on your recommendations, and would like to respectfully request periodic updates from you on the status of ICE’s responsive actions. We will follow up with your office around this request.

With best regards,

Organizations

American Civil Liberties Union
American Immigration Council
Bellevue/NYU Program for Survivors of Torture
Capital Area Immigrants’ Rights Coalition
Center for Justice and Accountability
Center for Survivors of Torture at Asian Americans for Community Involvement
Detention Watch Network
Florida Immigrant Advocacy Center
Immigration Equality
Institute for Redress and Recovery
Lutheran Immigration and Refugee Service
Maria Baldini-Potermin & Associates, PC
Massachusetts Immigrant and Refugee Advocacy Coalition
Monmouth County (NJ) Coalition for Immigrant Rights

¹¹ *Id.* at 75-76.

National Center for Transgender Equality
National Immigrant Justice Center
National Immigration Forum
National Latina Institute for Reproductive Health
North Carolina Immigrant Rights Project
Pennsylvania Immigration Resource Center
Physicians for Human Rights
Program for Torture Victims
Rights Working Group
Survivors International
Survivors of Torture, International
Texas Appleseed
Women's Refugee Commission

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cc: John Morton, Director, Immigration and Customs Enforcement
Margo Schlanger, Officer for Civil Rights and Civil Liberties
Kelly Ryan, Acting Deputy Assistant Secretary, Office of Policy