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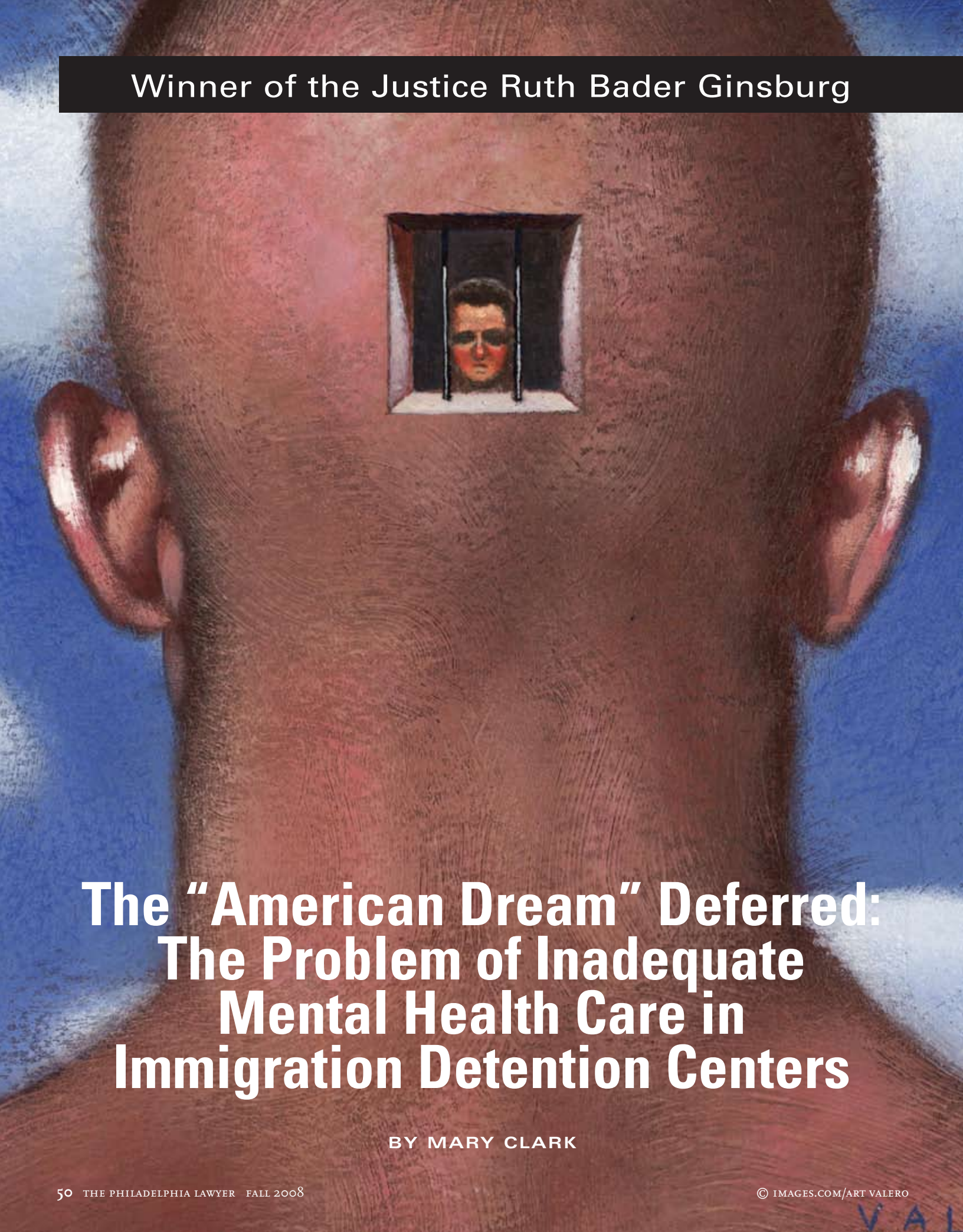

The "American Dream" Deferred: The Problem of Inadequate Mental Health Care in Immigration Detention Centers

BY MARY CLARK

On any given day, about twenty-seven thousand (27,000) aliens are held in immigration detention facilities and jails throughout the United States. They are civil detainees awaiting a decision on whether they will be removed from this country. Approximately one fourth of immigrant detainees have mental health issues, whether due to a pre-existing illness or caused by the stress of living in confinement. In a study of detainees seeking asylum, a group which makes up almost twenty-five percent of the total detainee population, significant depression symptoms were found in eighty-six percent of detainees, anxiety was found in seventy-seven percent, and post-traumatic stress disorder in fifty percent.

The Department of Homeland Security (DHS), which oversees the detention centers, acknowledges that there is widespread depression among immigrant detainees. One official explained that immigrants come to this country "with dreams of freedom and end up being detained. There's anxiety that comes with that." Guidelines for detainee medical care, which were adopted by the U.S. Immigration and Customs Enforcement (ICE) in 2001, include standards for the treatment of detainees with mental health issues. The standards, however, have serious defects and are not uniformly complied with at the over 300 detention facilities across the country. This is in part due to the fact that, unlike rules for the treatment of criminal inmates in federal and state prisons, the ICE standards are not legally enforceable.

There is a heightened need for quality mental health care in immigration detention centers that stems from the high rate of mental illness among detainees, the danger posed by improperly-cared for detainees, the complete dependency of detainees on detention center staff for medical treatment, and the fact that detainees with mental health issues are often unable to represent themselves in legal proceedings. This comment provides an overview of the problems that the ICE standards pose in the treatment of mentally ill detainees. In addition, it discusses the legal framework for addressing these problems and explains why change is most likely to occur as a result of increased awareness. Finally, this comment proposes solutions to the problem, including improving and codifying the ICE standards; and creating alternatives to detention.

I. BACKGROUND

Under the Immigration and Nationality Act (INA), an alien may be detained for various reasons. First, every alien who arrives in the United States seeking asylum is subject to mandatory detention while their asylum case is being decided, even if an immigration officer determines at the time of the initial interview that the alien has a strong case. Second, an alien already in the United States who appears to be deportable may be detained pending a decision on whether or not he/she will be removed from the country. Detention for these potentially removable aliens is not always mandatory, and the Attorney General may release such aliens on bond or on conditional parole. Detention *is* mandatory, however, for all potentially removable aliens who are involved in terrorist activities or have committed certain crimes. Finally, every alien against whom a final order of removal has been ordered must be detained until the removal order has been executed, for a period not to exceed ninety days.

Since 2001, the number of immigrant detainees in this country has tripled, due to more restrictive immigration controls, tougher enforcement laws, and increased mandatory detention provisions. Currently, about 300,000 aliens are detained each year by ICE. These detainees are housed in 330 facilities across the country, including eight of facilities owned and operated by ICE, twenty-eight private facilities under contract with ICE, and about 300 state and local jails that have intergovernmental service agreements with ICE. The average detainee is held in custody for thirty-five days, but aliens who eventually receive asylum status are held for an average of ten months. Some aliens are detained for years.

It costs the United States government over two billion dollars each year to detain these aliens. The government offers various rationales to justify this costly detention program. First, the government seeks to prevent aliens who are in removal proceedings from absconding. Thirty percent of aliens in removal proceedings who are not detained fail to appear for their removal hearings and the government has recently increased the categories of aliens who may

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be detained in the hope of decreasing the rate of abscontion. The government also detains certain aliens in the name of public safety. This is the rationale behind detaining aliens with criminal convictions and those suspected of being involved in terrorist activities. Finally, aliens are detained in order to deter future immigration violations and restore credibility to the enforcement system. This rationale applies to arriving aliens in particular, who, given the prospect of lengthy detention, may be discouraged from entering the United States in the first place.

II. THE NEED FOR MENTAL HEALTH CARE IN IMMIGRATION DETENTION CENTERS

One fourth of immigrant detainees suffer from mental illness. These detainees are extremely vulnerable, often unable to represent themselves in legal proceedings. When improperly cared for, they pose a danger to themselves and others. For these reasons, and because they are completely dependent on detention center staff for their medical treatment, it is vital that standards for mental health care in immigration detention centers be of high quality and consistently applied.

A. High Rate of Mental Illness Among Detainees

The rate of mental illness in immigration detention centers is so high that DHS itself has acknowledged that a problem exists. At one detention center, detainees are so severely depressed that suicide attempts are commonplace, occurring almost monthly. There are two explanations for the high rate of mental illness. First, many detained asylum-seekers have survived torture or severe trauma in their home countries and are at particular risk of becoming retraumatized due to the detention. As one doctor explained, "[f]or someone who's been tortured and locked up in a cell as a political prisoner in their native countries, the experience of being locked up here again can trigger panic attacks, flashbacks."

Second, detention centers are psychologically stressful on detainees. While more than half of the detainees in a study of asylum-seekers by Physicians for Human Rights and the NYU/Bellevue Center for Survivors of Torture (hereinafter the NYU/Bellevue Study) reported having mental health problems when they arrived at the detention center, seventy percent stated that their mental health had "worsened substantially while in detention." Immigration lawyers, detention center staff, and doctors have also reported that the emotional health of immigration detainees deteriorates over time. One lawyer witnessed many detainees who arrived as fully-functioning adults, yet "seemed depressed and anxious" after six months in detention, and "were difficult to converse with and expressed fears . . . that they were going crazy" after just a year.

One reason for the psychological stress on detainees is the prison-like conditions of the detention facilities. Most immigration detainees are held in state and local prisons. For detainees held in immigration detention centers, the environment is barely distinguishable from a prison. Most facilities use correctional models of surveillance and security, such as inmate "counts" to monitor detainees' whereabouts, strip searches, 24-hour surveillance lighting, and surveillance cameras in the housing units. A study of nineteen facilities across the country found that almost all detainees are restricted in their movement, and handcuffs and leg shackles are frequently used when detainees leave the detention facilities. At one facility, detainees are not even allowed outside on a daily basis; while at others, the outside areas can barely be considered "outside," as they consist of a "small concrete slab that is well fenced in with razor wire." These prison-like conditions both depress and humiliate detainees, many of whom have broken no law in the United States.

Another reason detainees suffer such high levels of mental stress is the poor treatment they receive from detention center staff. In the NYU/Bellevue Study, fifty-four percent of detainees reportedly experienced verbal abuse by the staff and nine percent experienced physical abuse, including getting hit in the chest and kicked by detention center guards. Guards reportedly yelled at, bullied, and humiliated the detainees, telling them to go back to their home countries if they did not like the way they were being treated and threatening to place detainees in solitary confinement, known as "segregation."

Finally, detainees often suffer stress because they have no idea when they will be allowed to leave the detention center and what their future will hold. One detention center official noted that inmates in federal prisons were less depressed than immigration detainees because "they at least knew when they were getting out and had something definite to look forward to." While the average immigrant detainee is held a total of thirty-five days, many stay more than ninety days, and some have been held for as long as three years.

Adding to the frustration and feeling of hopelessness, detainees are often not informed in advance of their upcoming hearings and may be transferred to other facilities without notice, often in the middle of the night. These actions make it extremely difficult for detainees to obtain legal counsel. To make matters worse, detention centers are often placed in isolated locations to ensure that detainees do not receive access to information and legal support. Such practices seem targeted to break the will of detainees and convince them that it would be easier to return to their home country than continue to fight their cases. Unfortunately, many detainees with strong legal cases decide not to appeal because they cannot endure these detention practices. For others, the practices merely drive them into deeper depression.

B. Danger Posed by Improperly Cared for Detainees with Mental Illness

Quality mental health care is particularly important in detention facilities, because failure to properly care for a mentally ill detainee can pose a danger to the detainee himself as well as to other detainees. A lawsuit by the American Civil Liberties Union (ACLU) described the case of Bill Roy Kurt Marion, a Canadian detainee who was known to be suffering from depression. Other detainees notified officials that Marion had large red marks on his neck and that he may have been trying to commit suicide, yet officials did nothing. A few days later, Marion hanged himself with a bed sheet. The ACLU lawsuit also described detainees who had been kept awake at night by mentally ill detainees who banged on the doors and walls of their cells all night and the Miami Herald has described incidents in which improperly-cared-for mentally ill detainees "terrorized or assaulted other patients, officers, and medical staff" at the Krome Detention Center in Florida.

C. Dependency of Detainees

It is also important that immigration detention centers provide quality mental health care because detainees are completely dependent on these centers for their medical needs. Detainees are only able to receive medical treatment at the detention facility itself or at a pre-approved clinic, under the supervision of detention center staff. ICE Detention Standards, however, do not provide measures for appealing medical decisions.

Detainees with severe health conditions may be able to obtain medical parole in order to attend to their medical needs on their own, outside of the detention center; but this privilege is only granted in rare instances. In addition, when parole is granted, it is only

with the approval of detention center staff, who are involved in the process of making recommendations.

D. Inability of Mentally Ill Detainees to Legally Represent Themselves

Finally, quality mental health care in detention centers is vital because immigration detainees with serious mental health problems may be unable to articulate their cases to a judge or asylum officer. Such detainees may nevertheless be forced to represent themselves, because immigration detainees are not entitled to government-funded counsel. Alternatively, such detainees may be forced to spend years in immigration custody with no end in sight. If a detainee is ordered removed, the detainee's country of origin may refuse to accept the detainee based on his/her mental illness, causing the detainee to potentially spend years in immigration custody. Where it is possible to improve the mental health of a detainee, a judge may delay proceedings indefinitely in order to give the detention center staff time to restore the detainee to competence. Whatever happens, lack of adequate mental health care could seriously and unfairly hurt a detainee's chances of obtaining legal status in this country.

III. PROBLEMS WITH THE ICE STANDARDS FOR DETAINEE MEDICAL CARE

ICE has established Detention Standards for Medical Care and Suicide Prevention and Intervention, which include standards for the treatment of detainees with mental health issues. These standards apply to all detention facilities used by ICE. They require all detainees to receive an initial medical and mental health screening within fourteen days of arrival. All facilities are required to employ a medical staff large enough to perform basic exams and treatment and must have a plan for the delivery of 24-hour emergency health care. In addition, they must have a mechanism that allows detainees to seek health care services outside of the facility, where necessary. Facilities must respond to these "sick call" requests in a "timely manner." In addition, in order to provide off-site health care, detention center officials must obtain prior approval from the Division of Immigration Health Services (DIHS), a component of the U.S. Department of Health and Human Services (HHS).

ICE has also established standards for the treatment of potentially suicidal detainees that require that all staff be trained in suicide prevention and intervention, including the identification of risk factors and the psychological profile of a suicidal detainee. Potentially suicidal detainees may be allowed to remain in the general population if they present no imminent danger to life or property, but the medical staff has the authority to "segregate" the detainee. Segregated detainees must be closely supervised and may be placed in a "special isolation room" to minimize opportunities for self-harm.

The ICE standards themselves are not perfect. For one thing, they do not define what constitutes a "timely manner" in which to respond to sick calls, leaving facilities to establish policies which allow staff to wait up to seventy two hours to respond to detainee requests for outside medical care. In addition, the standards do not specify when, if ever, DIHS must respond to non-emergency medical requests. DIHS conducts reviews from Washington, D.C. and often approves of requests for medical care after excessive delays or simply denies requests without explanation. This is particularly problematic for detainees seeking mental health care, because such care is not considered an "emergency" by DIHS, and DIHS has emphasized that "[c]are for . . . pre-existing illnesses that are serious but not life threatening" is not required. In addition, DIHS has stated that care for "accidental or traumatic injuries incurred while in the custody and acute illnesses is not required but simply reviewed for appropriate care."

Another problem with the standards is that they do not directly address medical prescriptions or mental health counseling. The NYU/Bellevue Study found that many asylum-seekers wanted counseling for their mental health problems, but only thirteen percent received such services. In addition, most detainees were unaware that medication was available. While most detainees in the study who requested medications received them, only forty-two percent of detainees who wanted medications knew that they could request them. Due to cost and/or availability, many detention facilities also change detainees' prescription medications—sometimes to a generic form and sometimes to a different medication altogether. In one troubling example, a bipolar detainee had his antidepressant medication switched to a completely different medication, even though he had never been evaluated by a psychiatrist. Another detainee who had a gender identity disorder was taken off his hormone therapy medication and suffered severe symptoms of withdrawal and depression as a result. The detainee had never been seen by a mental health specialist, despite requesting counseling on numerous occasions.

Finally, the ICE Detention Standards for Suicide Prevention and Intervention are particularly problematic because isolation is not considered an appropriate response to suicidality, as it is likely to exacerbate depression. What is more, the standards do not define what may constitute an "isolation room," leading some facilities to house potentially suicidal detainees in fully padded "rubber rooms," with uncovered holes in the center of the rooms to be used as toilets. One detainee described being put in isolation like this:

> [T]hey strapped me to a bed in a room with someone to watch me. The bed was close to the wall and I tried to bang my head against the wall. They put something to protect my head. I was strapped to the bed for two days—only when I would have to go to the bathroom, then I would be released. It was not for two days until a doctor came and spoke to me.

Detainees in the NYU/Bellevue study felt that isolation was a disincentive for informing detention center staff about suicidal thoughts and as a result, only seventeen percent of detainees with suicidal thoughts actually spoke to staff members about them.

While the ICE standards are far from perfect, the development of uniform standards is nevertheless a step in the right direction. The biggest problem with the ICE Standards, however, is that the facilities do not consistently comply with them. While ICE has maintained that "when a facility fails to meet the intent of the [standards], the relationship with the deficient facility is terminated," the reality is that the standards are not uniformly enforced and the facilities have not been punished. An audit by the DHS Office of the Inspector General (OIG) found that at least eight percent of detainees never received the required initial medical screening. Another study reported that when detainees *are* screened, it is often by an admitting officer, rather than a nurse or doctor. In addition, according to the OIG Audit, fifty percent of detainees who requested outside medical care never received a response. The audit also found that facilities only complied with suicide prevention standards twenty percent of the time.

The tragic consequence of poor mental health care is that it can result in death. Over sixty-six detainees have died while in custody in just the last four years. While only thirteen of these deaths were suicides, it is impossible to estimate just how many deaths were caused at least in part by mental illness. Physical and psychological health, after all, are often interdependent, and doctors have noted that detainees' "pain, headaches, and gastrointestinal problems may be somatic manifestations of . . . psychological distress." In addition, "the stress of incarceration as well as limited mental health services may be compounding these [physical] problems." Given that American taxpayers pay over seventy-two million dollars a year for detainee medical health care, sixty-six detainee deaths in four years is unacceptable.

IV. THE IDEAL SOLUTION

Under international standards, the detention of "extremely vulnerable" groups such as those with special medical or psychological needs is considered inherently undesirable. The United Nations High Commissioner for Refugees (UNHCR) has released guidelines, which state that "active consideration of possible alternatives should precede any order to detain ... persons with a mental or physical disability." In an ideal world, Congress would amend the INA to comply with international standards, providing for special detention procedures for detainees with mental health issues. The amendment would provide that under the Attorney General's discretion, and on an individualized basis, mentally ill detainees could receive parole through either a supervised release program or an alternative to detention, allowing them to receive medical treatment outside of a detention facility as they await a judge's decision regarding whether or not they will be removed from the United States. The Attorney General would have the authority to deny parole to any alien who it could demonstrate was likely to abscond or pose a threat to public safety. This process would not be similar to the case-by-case adjudication of detention cases that occurred before 1996.

From 1997 to 2000, the U.S. government funded a successful supervised release project for detainees that could be used as a model for the proposed amendment. Participants in the program, called the Appearance Assistance Program, were released from detention centers, but were required to report regularly in person and by phone to the supervising organization. Participants were informed of the consequences of failing to show up for their hearings and of violating immigration laws. The program was both successful and cost-effective—supervising an immigrant through the program cost about twelve dollars a day, whereas incarcerating one costs sixty-one dollars a day. The government has since established pilot programs in twelve cities and has reported that over ninety percent of participants show up for their court dates.

Another alternative to detention that could be used as a model for the proposed amendment is the use of electronic monitoring devices to track the whereabouts of non-citizens placed in removal proceedings. ICE utilized electronic monitoring devices in a trial program in Florida, but the program was criticized for tracking more than just those non-citizens who would had been detained. As long as ICE does not use the devices to track immigrants who would not otherwise be detained, the program could be extremely useful in allowing mentally ill detainees to be released from detention.

V. REALISTIC REMEDIES

Given the current political climate, Congress is unlikely to change detention procedures in the near future, and even less likely to amend the INA for the benefit of mentally ill detainees. Any meaningful change in this area will most likely occur at a slow pace, through increased public awareness and improvements to the ICE Detention Standards for Medical Care.

I. Public Awareness

Last year, the ACLU brought a lawsuit against one detention facility—the San Diego Correctional Facility—for deficient medical care. In its complaint, the ACLU described the detention facility's failure to adequately treat over fifteen detainees with medical, dental, mental health, and vision problems. The ACLU argued that the poor medical care provided by the detention facility amounted to punishment in violation of the Fifth Amendment to the Constitution. The ACLU argued that the Fifth Amendment, which applies to all "persons" within the United States, including aliens who are unlawfully present in the country, prohibits "any person acting under color of federal law from subjecting any person in the custody of the United States to punitive conditions of confinement without due process of law." It further argued that under Jones v. Blanas, immigration detainees are entitled to a higher standard of protection than criminal detainees. Thus, according to the ACLU, to establish a Fifth Amendment violation, an immigrant detainee merely needs to demonstrate the indifference of medical staff to a condition where "failure to treat . . . [the] condition could result in further significant injury or the unnecessary and wanton infliction of pain." The ACLU argued that the detainees in this lawsuit had therefore established Fifth Amendment violations.

The case has not yet been decided. While the ACLU makes a strong argument, it is unlikely that the lawsuit will change this country's immigration laws. Congress has exclusive power to createate immigration law, including the power to detain aliens, and the Supreme

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Court has consistently shown deference to Congress' immigration decisions. Even where the Court has strongly disagreed with Congress, it has held that "any policy toward aliens is . . . so exclusively entrusted to the political branches of government as to be largely immune from judicial inquiry or interference." Congress' immigration power is subject to some constitutional limitations, however, and a number of recent cases have held that the indefinite detention of immigrants would raise constitutional concerns. Nevertheless, the Court has continuously reaffirmed Congress' power to detain immigrants generally and has implied that as long as aliens are not indefinitely detained or forced into hard labor without a hearing, they may be detained in whatever manner Congress deems appropriate.

The Supreme Court has not heard any cases specifically regarding the mental health treatment of immigrant detainees. Prior to the San Diego case, however, the ACLU brought two lawsuits regarding immigrant detention centers. The first, Reno v. Flores, challenged INS regulations involving the detention, processing, and release of detained immigrant juveniles. The second case, Bunikyte v. Chertoff, challenged the detention conditions for children at the Don T. Hutto family detention facility in Taylor, Texas. Both cases ended in settlements. The *Flores* settlement "sets out [a] nationwide policy for the detention, release, and treatment of minors in the custody of [ICE]." It was intended as a "stopgap measure," but fifteen years later, "neither DHS nor Congress has yet promulgated binding rules regarding standards for the detention of minors." The plaintiffs in the *Bunikyte* lawsuit argued that conditions at the Hutto facility specifically violated the terms of the *Flores* settlement. *Bunikyte* also ended in a settlement, in which ICE agreed to modify certain detention conditions in the Hutto facility. Among other things, ICE was required to allow children over twelve years old to move freely about the facility, end the disciplinary policy of threatening to separate children from their parents, install privacy curtains around toilets, supply more toys and age-appropriate books to the children, and end the practice of requiring children to wear prison uniforms.

Settlements like these, which are made with individual detention facilities and/or regarding specific populations, will only bring about change to a single facility or population group. Neither the *Flores* nor the *Bunikyte* settlement has led to a change in immigration law or general detention practices. The hope, however, is that lawsuits like these will bring the larger problem of poor quality immigration detention facilities into the national spotlight.

The strategy appears to be working. As a result of the ACLU's work, Congress has begun to show concern over inadequate immigrant detainee medical care. In a hearing before the Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law last year, entitled "Detention and Removal: Immigration Detainee Medical Care," members of the ACLU and other non-profits, as well as doctors, detainees, and family members of deceased detainees, testified regarding the poor medical treatment provided by immigration detention facilities. An ICE official and the Medical Director of Immigration Health Services also testified. As a result of the hearing, Subcommittee Chairwoman Zoe Lofgren noted that it appeared that ICE's detainee medical standards provide for inadequate treatment of individuals and are being implemented in an inappropriate manner. She claimed that the hearing was "one of the most important hearings that I have had an opportunity to participate in" and added that she hoped it would be "the first step in making necessary changes" to improve detainee medical care. The Subcommittee has yet to make any recommendations.

II. Improvement and Codification of ICE Detention Standards

One of the first steps in improving detainee medical care will be to improve and codify the ICE Detention Standards for Medical Care and Suicide Prevention and Intervention. The standards must be binding on all facilities and should include the following provisions, designed to improve mental health care in detention centers. First, mental health care must be made an integral part of medical care. To that end, the standards should require detention facilities to have at least one mental health professional on staff and provide individual and group counseling services. Second, the standards should require facilities to regularly screen detainees for significant psychological symptoms. Such screening must be done by mental health professionals as opposed to general detention center staff. Third, the standards should clearly define what a "timely response" to non-emergency sick call requests should be and should not allow response times to be longer than forty-eight hours. Fourth, they should require facilities to provide for means of increasing awareness of available medical care, including prescription medication. Fifth, the standards should encourage facilities to only use isolation as a last resort for potentially suicidal detainees. Sixth, the standards should require that only persons with a background in psychiatry make medication decisions and that such decisions be made only after in-person consultations with detainees. Finally, they should define the time frame within which DIHS must respond to detainee requests for outside medical care.

In addition, DIHS should work with the detention facilities to ensure faster and more consistent turn-around time for sick call requests. This may require the hiring of additional DIHS staff members as well as the creation of formal DIHS standards of review. DIHS should also include severe mental health problems in its definition of "emergency care," to ensure that detainees with serious mental illnesses receive on-site medical care.

VI. CONCLUSION

Immigration detention centers have a responsibility to provide safe and humane treatment to detainees in their custody. Given that one fourth of all detainees suffer from some mental health issue, and are dependent on these facilities to fulfill their healthcare needs, it is crucial that these facilities provide quality mental health care. The consequences of not providing such care could be grave. Inadequate mental health care puts all detainees in physical danger and could unfairly damage mentally ill detainees' chances of obtaining legal status in the United States.

This comment has argued that current ICE standards for mental health care have serious defects and are not being implemented in an appropriate or uniform manner. As a result, in just the last four years, thirteen detainees have committed suicide and over sixty-six have died while in custody. This comment has argued that while amending immigration law to avoid detaining mentally ill non-citizens would be the ideal solution, it may not be politically possible in the near future. Realistically, increasing public awareness of the problem must be the first step, and non-profit organizations like the ACLU have already begun publicity efforts with testimony before Congress and lawsuits aimed at individual detention facilities. Next, Congress must make improving and codifying the ICE Detention Standards for Medical Care and Suicide Prevention and Intervention a priority. Given that over 300,000 aliens are held in custody each year, the need for effective and enforceable standards is more critical than ever. ■

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