

Justice for Immigration's Hidden Population

Protecting the Rights of Persons with Mental Disabilities
in the Immigration Court and Detention System



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Texas Appleseed Mission

Texas Appleseed's mission is to promote justice for all Texans by using the volunteer skills of lawyers and other professionals to find practical solutions to broad-based problems. This report builds on *Assembly Line Injustice: Blueprint to Reform America's Immigration Courts*, published in 2009 by Appleseed and Chicago Appleseed. Specifically, this study examines how the nation's immigration court and detention systems fail to address and accommodate the basic needs of people with mental disabilities—and how this failure compromises humane treatment and just adjudication of immigration cases for this vulnerable population. This report would not have been possible without our close collaboration with pro bono law firm Akin Gump Strauss Hauer & Feld LLP.

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in the Immigration Court and Detention System

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INTRODUCTION

1

The U.S. immigration system is deeply flawed and over-burdened. From inconsistent enforcement to insufficient resources to mistreatment of immigrants, these deficiencies are extensively documented by governmental and non-governmental agencies alike. Immigration courts decide over 230,000 cases annually, and more than 33,000 immigrants are detained daily. In some Texas jurisdictions, immigration judges are handling twice as many cases as they were four years ago.

What is not so widely reported is what is happening to a hidden population of immigrants who are particularly vulnerable in this troubled system: individuals with mental disabilities, ranging from trauma as a result of persecution to depression caused by detention, from intellectual deficits to profound mental illness. Given their unique needs, immigrants with mental disabilities present significant challenges. Unfortunately, our immigration system fails—and further marginalizes—this vulnerable population. Immigrants with mental disabilities are unnecessarily detained in a system ill-equipped to care for them, sometimes arbitrarily transferred away from their communities, often denied basic due process in a complex immigration court system, and all too frequently released from detention or removed from the United States with little concern for their safety and well-being.

Texas Appleseed and the law firm of Akin Gump Strauss Hauer & Feld LLP have worked for the past year to identify and document the scope of the problems facing immigrants with mental disabilities. Our study focuses on Texas, a state with a disproportionately large population of immigrants and immigration detention centers. The problems we uncovered, however, are not unique to Texas. As we spoke with national experts, it soon became clear that individuals with mental disabilities face systemic problems in immigration courts and detention centers across the country.

Methodology

The genesis of this report was a series of complaints by immigration attorneys in Texas that a growing population of immigrants with mental disabilities was being denied fair

hearings in immigration court. At the same time, the national Appleseed organization was completing its research for *Assembly Line Injustice* (published in June 2009), which detailed substantial problems in the immigration court system.¹ Texas Appleseed decided to investigate the specific problems facing immigrants with mental disabilities, and asked Akin Gump to join as pro bono counsel.

Together, Texas Appleseed and Akin Gump started the investigation by reviewing the literature and news reports on individuals with mental disabilities in the immigration system. We then interviewed, by phone and in person, more than 40 attorneys and mental health professionals who work with immigrants with mental disabilities. In addition, we spoke with nearly all of the nation's leading advocates for immigrants with mental disabilities.

We also interviewed immigration judges and observed immigration court hearings. We soon learned that while immigrants with mental disabilities fare poorly in immigration court, their legal challenges are compounded by poor treatment in detention. In the detention system, immigrants with mental disabilities are often denied appropriate care that could enable them to participate more fully in their immigration court proceedings. To conduct further research, we visited two detention centers in Texas, where we met and spoke with immigration enforcement officials and medical professionals. We also interviewed several immigrants suffering from mental disabilities in these detention centers. Inspired by this project, several Akin Gump attorneys decided to represent detained immigrants with mental disabilities in immigration court; their first-hand experiences inform several recommendations in this report.

Our examination also included a review of government documents, which we obtained through the Freedom of Information Act (FOIA). These documents include immigration court statistics, reviews of detention facilities, and available information regarding detainees with mental disabilities. The data confirm that the vast majority of immigrants in Texas are unrepresented in immigration court, as is the case nationally. These documents also provide insights into the state of mental health care at multiple Texas detention facilities and demonstrate the lack of adequate system-wide policies or data regarding detainees with mental disabilities.

Finally, several leading lawyers for immigrants with mental disabilities contributed to this study by helping us identify relevant issues and by reviewing our conclusions and recommendations. The report was drafted by Texas Appleseed staff and teams of Akin Gump attorneys in Dallas, Houston, Los Angeles, New York, San Antonio and Washington, D.C. As part of our drafting, we shared our conclusions orally with Immigration Judges Dana Marks and Denise Slavin, President and Vice President, respectively, of the National Association of Immigration Judges; and with the Department of Homeland Security (DHS) Office of Inspector General and with Immigration and Customs Enforcement (ICE).

Core Principles

Our analysis and recommendations are based on five core principles integral to ensuring just treatment and due process for immigrants with mental disabilities:

Frequently Used Terms

Mental Disability: For purposes of this report, the term “mental disability” includes both the full range of mental illnesses, from depression and post-traumatic stress disorder to schizophrenia and other major mental disorders, as well as intellectual disabilities (mental retardation). We have not attempted to distinguish between levels or categories of mental disability, except where a mental illness requires diagnosis and treatment, and to the extent that a disability renders an immigrant incompetent to understand an immigration court proceeding.

Immigrant: The term “immigrant” has a specific, narrow meaning in the law (the broader legal term is “alien”). For purposes of this report, however, we use the word “immigrant” as it is commonly used to refer to all non-citizens. In certain contexts, this report also refers to immigrants as “detainees” or “respondents,” the latter term typically used to describe immigrants in immigration court.

Immigration Agencies: These acronyms are widely used in this report to refer to the federal agencies with roles and responsibilities in the immigration court and detention system.

DHS – U.S. Department of Homeland Security

ICE – Immigration and Customs Enforcement

DIHS – Division of Immigration Health Services

DOJ – U.S. Department of Justice

EOIR – Executive Office for Immigration Review

BIA – Board of Immigration Appeals

- **Identification:** Individuals with mental disabilities cannot be accommodated unless and until their disability is diagnosed or otherwise identified. This identification should happen at the earliest point possible in the detention system or in the immigration court process. Furthermore, immigrants’ mental health should be monitored in detention, as studies have shown that detention often exacerbates or causes a deterioration of mental health.
- **Accommodation:** Once identified, the system must accommodate immigrants with mental disabilities. If detention is necessary, detained immigrants with mental disabilities must be provided appropriate, good quality health care services, including timely diagnosis and treatment. Immigrants with mental disabilities must also be guaranteed due process: a fair opportunity to advocate for appropriate release and for their substantive immigration rights.
- **Transparency:** Immigrants, their lawyers and non-governmental organizations must be allowed to monitor the treatment of individuals with mental disabilities. The veil of secrecy that shrouds the immigration detention and removal system perpetuates inadequate treatment. The Department of Homeland Security (DHS) must monitor treatment and include independent groups in its reviews to ensure that

this monitoring is adequate. Reviews and system-wide statistics, with protections for immigrants' privacy, should be accessible to the public.

- **Accountability:** Even the minimal standards that should help immigrants with mental disabilities are often not enforced. Every actor in the system—from detention officials to medical professionals to immigration judges—must be held accountable for the care and treatment of this vulnerable population.
- **Efficiency:** Providing better treatment of immigrants with mental disabilities can result in cost-savings and greater efficiencies in the immigration court and detention system. DHS can exercise discretion, already permitted under federal law, to allow immigrants to remain in their communities if they are already receiving mental health treatment, particularly in mental health institutions. If immigrants with mental disabilities must be detained, providing basic mental health treatment and medications in detention can avoid costly out-patient care and minimize catastrophic decompensation (degradation or deterioration of mental health for individuals who had previously managed mental illness). A court system more ably equipped to adjudicate cases for immigrants with mental disabilities should operate more efficiently, decreasing the time immigrants spend in proceedings and in detention.

Using these five principles as guidance, Texas Appleseed has developed core recommendations to improve how the U.S. immigration system treats this vulnerable population of immigrants with mental disabilities. Each is analyzed and discussed in more detail in the body of this report.

Core Policy Recommendations

Immigrants with mental disabilities should be recognized as a vulnerable population deserving special protections.

As an overarching principle, throughout the immigration system persons with mental disabilities should be recognized as a particularly vulnerable population and accorded due protections that account for a diminished capacity to protect, advocate and, in some cases, care for themselves. The U.S. immigration system has long acknowledged that certain vulnerable populations, such as unaccompanied minors and victims of trafficking, deserve and are thus afforded protections such as release to appropriate caregivers, placement in least restrictive settings, assistance in immigration court, and appropriate social services. Unfortunately, U.S. immigration law stigmatizes individuals with mental disabilities, excluding from admission to the U.S. individuals with a “mental disorder and behavior associated with the disorder that...has posed a threat to the property, safety or welfare of the respondent or others,”² even if their current behavior poses no threat. Acknowledgment of this population and its unique needs is an important first step toward the sensitive treatment required of any just system. Creating a more just immigration system must include repealing laws like the above standard.

Place immigrants with mental disabilities in a least restrictive setting.

Immigrants with mental disabilities, who are taken into ICE custody, should be placed in the least restrictive setting appropriate to the individual. In most cases, this will mean allowing the immigrant to remain in the community where he can continue with mental

health treatment. Detention often exacerbates mental illness,³ separates immigrants with mental disabilities from therapeutic services and family, frequently leads to misdiagnosis, and interrupts continuity of care. Immigration and Customs Enforcement (ICE) policy recognizes that, absent detention mandated by law, ICE personnel should use “judicious discretion in identifying and responding to meritorious health-related cases” where detention would be “problematic,” in part because of the expense of detention and the cost of health care.⁴ Unfortunately, our research documents that this discretion is rarely exercised, and immigrants with mental disabilities are routinely subjected to detention that is neither in the best interest of the immigrant’s mental health or the government’s fiscal health. Absent mandatory detention or other overriding concerns, such as national security, immigrants with mental disabilities should be allowed to remain in environments where they can receive appropriate care and support while proceeding through the immigration court system. Alternatively, if detention is necessary, immigrants with mental disabilities should be detained in the least restrictive setting, for example a non-penal residential setting in close proximity to the detainee’s community connections.

Provide appropriate diagnosis and care in detention.

Not only does detention exacerbate mental illness for many immigrants, but the ICE detention system suffers from chronically inadequate medical staffing, inappropriate diagnoses, and substandard mental health care. ICE has the responsibility to ensure that immigrants in its custody are provided with medical treatment that meets professional standards of care. ICE must ensure that all facilities in which it detains immigrants—not just those that it operates—have sufficient mental health staffing, and that the staff provides proper diagnosis, appropriate administration of medication, and proficient therapeutic treatment. ICE appears to recognize that substantial improvements are needed. Dr. Dora Schiro, the former Director of the Office of Detention Policy and Planning, acknowledged in an October 2009 review of the ICE detention system, that “a new set of standards, assessments and classification tools [is needed] to inform care, custody, restrictions, privileges, programs, and delivery of services consistent with risk level and medical care needs of the population.”⁵

Establish a competent medical records system.

The ICE detention system does a poor job of developing and tracking medical records, which creates problems at many levels. Inadequate record-keeping leads to misdiagnosis and inappropriate treatment, increasing the inefficiency of the health care delivery system in detention. Immigrants and their attorneys are often unable to access medical records, denying them the opportunity to advocate for release when appropriate, better care if detention is necessary, and fair process in immigration court. ICE needs to establish an electronic medical records system that not only allows its medical staff to access information necessary to treat immigrants in ICE custody, but also provides timely access for immigrants and their advocates. DHS’ \$7 million FY 2011 budget request to design and develop an electronic health records system is an important step forward.

Improve the chances for fair outcomes in immigration court.

Many immigrants face a daunting challenge in immigration court: the government is represented by counsel while most immigrants have no lawyer. The challenge is

magnified for those immigrants with mental disabilities that diminish their capacity to participate in the proceedings. Immigration courts currently have no mechanisms for determining whether a respondent has a mental disability. Regulations provide minimal guidance for competency hearings, leaving immigration judges, DHS trial attorneys and immigrants scrambling to invent ways to accommodate mental disabilities in the courtroom. Immigrants with mental disabilities that impair their capacity to receive a fair hearing need to be represented by legal counsel, and in some cases may also need a guardian. Immigration judges need better direction, through regulations and training, to help them more accurately recognize and provide a fair hearing for individuals with mental disabilities. DHS trial attorneys need training and guidance on whether and how to pursue immigration charges against a respondent with mental disabilities.

Ensure the safe release or removal of immigrants with mental disabilities.

DHS currently does not ensure that immigrants with mental disabilities are safe upon release from detention or removal from the United States. During our examination, we heard stories of immigrants left at bus stops thousands of miles away from where they were initially apprehended after being released from detention, with no concern for their well-being. In one instance, a young man was deported to Mexico with no provision for treatment of his profound mental illness; more than a year later, his parents have not been able to locate him. DHS needs to develop and follow protocols that ensure that immigrants with mental illness, once released from detention, are provided with adequate care. Further, DHS must ensure that it complies with the United States’ obligations under the 1951 Refugee Convention, to the extent that individuals merit protection from persecution in their home countries on account of their mental disability.

This report organizes Texas Appleseed’s findings into four broad areas where access to justice for immigrants with mental disabilities must be addressed:

Section 1: Improving Mental Health Diagnosis and Treatment in the Civil Immigration Detention System

Section 2: Removing Barriers to Accessing Immigrants’ Medical Records

Section 3: Ensuring Fair Treatment of Immigrants with Mental Disabilities in Immigration Court

Section 4: Ensuring Safe Release or Repatriation of Detainees with Mental Disabilities

In each of these Sections, Texas Appleseed offers both specific Policy Recommendations as well as Implementation Strategies.

We recognize that immigrants with mental disabilities can present unique challenges in every context, from diagnosis and treatment to legal representation. Moreover, many of the difficulties this population encounters are the result of broader problems in the immigration system, issues that have proven resistant to easy fixes. Nonetheless, the United States immigration system can and must do better for this vulnerable “hidden population” to ensure that they do not continue to fall through the cracks.

Policy Recommendations—A Summary

Improving Mental Health Diagnosis and Treatment in the Civil Immigration Detention System

1. Immigrants with mental disabilities should be detained only when required by law, for national security concerns, or for risks to health and safety.
2. Detained immigrants with mental disabilities should be placed in settings appropriate to their needs.

Immigration and Customs Enforcement (ICE) should:

3. Establish improved and consistent procedures for screening and diagnosis in detention.
4. Improve mental health care in detention facilities.
5. Train guards and other detention center personnel to identify and interact appropriately with detainees with mental disabilities.
6. Adopt enforceable detention standards with a meaningful oversight process.

Also:

7. An independent office should be established within the Department of Homeland Security (DHS) or the Department of Health and Human Services responsible for health care for all those in DHS custody.

Removing Barriers to Accessing Immigrants' Medical Records

The Division of Immigration Health Services (DIHS) should:

8. Develop an electronic medical records management system.
9. Ensure immediate transfer of an immigrant detainee's medical records during facility transfer.
10. Allow detainees and their attorney's timely access to medical records.

Ensuring Fair Treatment of Immigrants with Mental Disabilities in Immigration Court

The U.S. Department of Justice should:

11. Establish consistent procedures for recognizing respondents who may have mental disabilities.
12. Establish standards for proceeding once a court recognizes a mental disability.
13. Establish procedures for meaningful collection of data regarding respondents with mental disabilities in the immigration system.

Ensuring Safe Release or Repatriation of Detainees with Mental Disabilities

Immigration and Customs Enforcement (ICE) should:

14. Adopt clear procedures governing safe domestic release of detainees.
15. Ensure safe repatriation of immigrants with mental disabilities.

BACKGROUND

The U.S. Immigration System

Immigrants encounter the U.S. immigration system in multiple ways, including through applications for benefits, such as permanent residency or work permits; at apprehension, detention, and deportation; or in immigration court proceedings. A basic understanding of this system—particularly detention and the immigration courts—is required to appreciate the issues faced by immigrants with mental disabilities.

Apprehension, Detention and Release

To enforce U.S. civil immigration law, DHS apprehends immigrants through several mechanisms, including border patrol, workplace raids, agreements with local officials, and coordination with state and federal prisons. Not all immigration enforcement involves detention, but over the past decade detention has become a primary focus of enforcement, particularly for those either arrested or otherwise identified by federal or local law enforcement officials.⁶ Immigration detention is civil administrative confinement, intended not for punishment but to ensure attendance at immigration court proceedings and, when ordered, removal from the United States.⁷

The trend toward civil detention accelerated in 1996, when Congress passed legislation mandating detention for many categories of immigration violations.⁸ In 1994, the daily population of immigrants in detention was 5,532;⁹ as of September 2009, the daily population in detention under the authority of ICE had grown to 31,075.¹⁰ In total, ICE detained between 380,000 and 442,000 immigrants in fiscal year (FY) 2009.¹¹ For some immigrants, detention is a lengthy ordeal: in 2009, approximately 19,000 immigrants were detained for more than four months, and 2,100 were detained for more than a year.¹²

Unless there is a change in immigration detention policy, every estimate indicates that the immigration detention population will continue to expand at great expense to the government. This increased reliance on detention is not cheap: cost estimates to detain an immigrant for one day range from an average of \$97 to \$141;¹³ in total, detention will cost ICE approximately \$1.77 billion in FY 2010.¹⁴

The detained immigrant population includes asylum seekers, persons who have entered the United States without authorization, U.S. permanent residents who may be subject to deportation for having committed criminal acts (the vast majority of which are non-violent and many of which are relatively minor), and others who simply have no documented right to remain in the U.S.¹⁵ Immigrants in detention range in age and include women, men and entire families.

Detainees are held in “facilities largely designed for penal, not civil, detention,” ICE recently acknowledged.¹⁶ Not surprisingly, immigrants in the civil detention system are often treated like criminals: they are typically required to wear prison uniforms, housed in cells or “pods,” allowed only limited contact with the outside world, and monitored constantly.

The more than 33,000 immigrants that ICE detains daily are held in as many as 350 facilities across the U.S.¹⁷ About half the detainee population is housed in 21 immigration-only facilities, seven of which are owned by ICE and operated by private corporations (known as Service Processing Centers, or SPCs), seven of which are owned and operated by private contractors (referred to as Contract Detention Facilities), and seven of which are county jails used solely for immigrants pursuant to Inter-Governmental Service Agreements (IGSAs).¹⁸ Five of these 21 immigration-only facilities are located in Texas.¹⁹ In total, Texas houses at least one quarter of the immigration detainees in the United States, many of whom were transferred to Texas from other parts of the country (primarily California, the Mid-Atlantic and the Northeast) where detention space is limited.²⁰

“In this bizarre labyrinth of contracts and sub contracts, what’s lost is accountability, transparency, responsibility. It is very difficult to know who is responsible and oversight gets lost.”

—Tom Barry, Center for International Policy, Dec. 10, 2009²¹

The other half of the immigration detention population is held in approximately 240 state and local jails pursuant to IGSAs.²² This portion of the detention population is concentrated in fewer than 50 jails that average 100 or more immigration detainees daily.²³ The civil immigration detention population is often co-mingled with the criminal population housed at these jails.

Health Care in Detention

The conditions of detention for immigrants are governed by detention standards adopted by the Immigration and Naturalization Service (INS) and ICE. In 2008, ICE created 41 Performance Based National Detention Standards (PBNDS) based on American Correctional Association standards for pre-trial felons. The PBNDS were supposed to go into full effect on January 1, 2010, replacing the National Detention Standards that had been in effect since 2001, though the review of detention by ICE has put full implementation into question.²⁴ The PBNDS cover seven general topics (Safety,

Security, Order, Care, Activities, Justice, Administration and Management). Included within “Care” are two standards that have particular application to individuals with mental disabilities: “Medical Care” and “Suicide Prevention and Intervention,” both of which are discussed in more detail in Section 1.

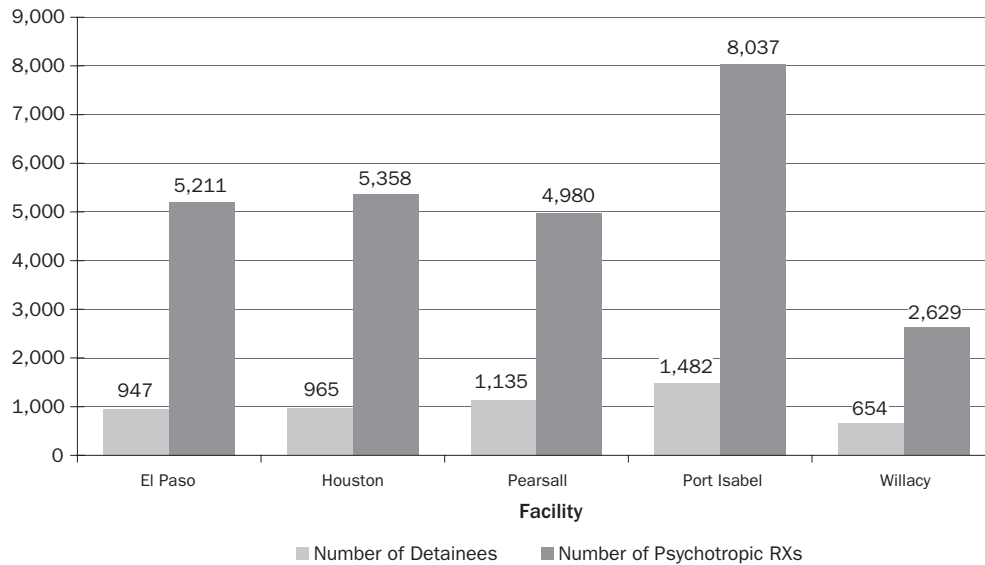
Like the National Detention Standards that came before them, the PBNDS are not binding on DHS; in 2009, DHS rejected a long-pending petition for rulemaking to codify the standards, which would have made them judicially enforceable against DHS.²⁵ Particularly with respect to health care, detention standards are not being met.²⁶ An October 6, 2009 review of the ICE detention system (published by Dr. Dora Schriro, who drafted the review while serving as Director of the ICE Office of Detention Policy and Planning) found substantial deficiencies in the delivery of health care to detainees and recommended that ICE “establish a well-managed medical care system” that would create “clear standards of care for detainees and monitor conditions systematically.”²⁷ These deficiencies include substandard medical and mental health treatment for detainees, which in several well-publicized cases has led to detainee deaths.²⁸ In total, more than 100 detainees have died in ICE custody since 2003.²⁹

The responsibility for detainee health care varies depending on the type of facility. As the Government Accountability Office found in 2009, “ICE’s organizational structure for providing health care to detainees is not uniform across facilities.”³⁰ In the 21 immigration-only facilities, health care is provided by the ICE Division of Immigration Health Services (DIHS),³¹ which is staffed by Public Health Service commissioned corps officers from the Department of Health and Human Services (HHS) and by other contracted medical professionals.³² (Another agency, also called DIHS, was located within HHS until 2007 and provided health care to detainees through interagency agreements. The transition has led to some confusion within DHS. Both DHS documents and DHS employees we interviewed were unclear about which agency has responsibility for the current-day DIHS.)³³

DIHS coordinates and authorizes off-site medical care for the 50 percent of all immigration detainees who are housed in state and local jails, but does not have any responsibility for their day-to-day care. These detainees are screened, diagnosed and treated by whatever medical system is used in these state and local jails.³⁴

Health care is particularly important for immigrants in detention, as screenings at detention centers showed that 34 percent of detainees suffer from chronic conditions, including hypertension, diabetes and/or mental health issues.³⁵ Responses to our FOIA requests indicate that ICE keeps scant system-wide data regarding immigration detainees with mental disabilities. One estimate is that at least 15 percent of immigration detainees have a mental disorder.³⁶ The Director of DIHS noted in the spring of 2009 that “demands on DIHS to provide mental health care services for detainees continue to grow with the size of the detainee population.”³⁷ In FY 2008, ICE recorded a total of 29,423 mental health interventions for detainees in DIHS care, 13 percent of the total number of DIHS intake screenings for the same year.³⁸

Number of Psychotropic Prescriptions Issued in Texas DIHS-Staffed Facilities (January 1, 2005 — June 1, 2009)



DIHS apparently keeps few, if any, meaningful statistics concerning immigrants with mental disabilities in detention. Through the Freedom of Information Act, we asked DIHS for all records relating to the number of persons in detention receiving mental health care annually since January 1, 2006, as well as specific requests relating to drugs prescribed. The only data DIHS provided was an aggregated total number of psychotropic drug prescriptions in facilities where DIHS provides health care services, for the period of January 1, 2005 through June 1, 2009. During this period, 14,859 immigrants in detention nationwide received an average of more than five prescriptions for psychotropic drugs.³⁹

The Immigration Court System

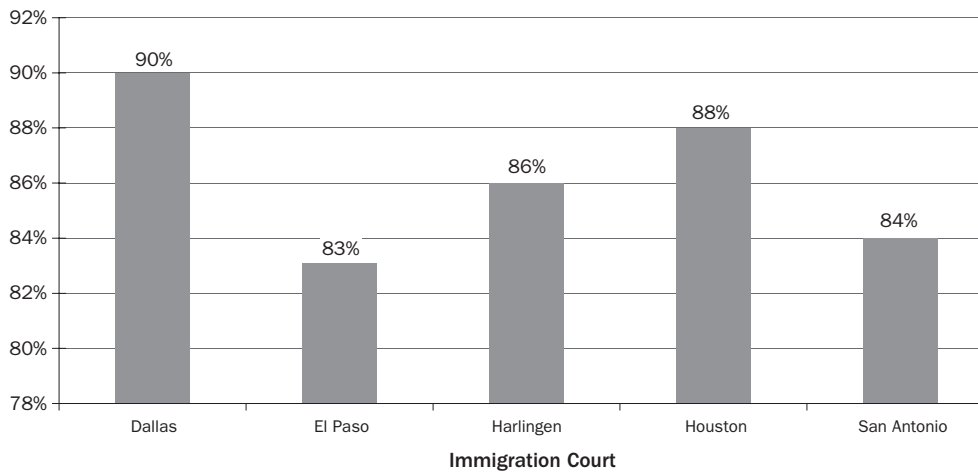
The U.S. immigration court system, administered by the Executive Office for Immigration Review (EOIR), an agency within the U.S. Department of Justice, adjudicates civil immigration violations, primarily through proceedings to “remove” (i.e., deport) immigrants.⁴⁰ Most immigrants in detention are placed in removal proceedings in immigration court. The immigration court system is comprised of approximately 230 immigration judges in more than 55 immigration courts across the United States,⁴¹ as well as the Board of Immigration Appeals (BIA) in Falls Church, Virginia, which hears appeals from all immigration courts.

In these proceedings, DHS trial attorneys represent ICE, whose mission is to “protect the security of the American people and homeland by vigilantly enforcing our nation’s immigration and customs laws.”⁴² With this focus on security and enforcement, it is no surprise that DHS trial attorneys see their mission as deportation rather than determining whether the immigrant has a right to remain in the United States.⁴³ Immigrants typically face these experienced DHS trial attorneys without legal representation of their own.

Unrepresented in Texas Immigration Courts

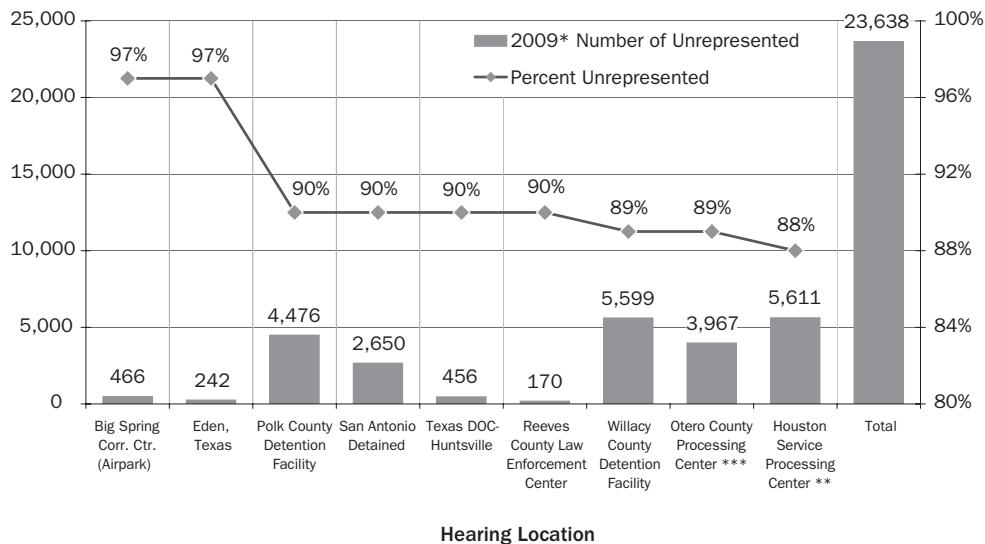
Texas immigration courts generally follow national trends. Across all immigration courts in Texas, 86 percent of detained immigrants are unrepresented by legal counsel. The Dallas court has the most unrepresented detained cases, at 90 percent, followed by Houston, at 88 percent.

2009 Percentage of Detained Cases without Counsel



Certain detention facilities have particularly high numbers of detainees unrepresented in immigration court proceedings. Below are the facilities with the highest numbers of unrepresented detained cases in Texas. They are mostly in rural communities, with the Houston and San Antonio facilities being notable exceptions.

Texas Detention Facilities with Highest Percentage of Unrepresented



* EOIR provided data through May 31, 2009. Data was proportionally adjusted to reflect the entire calendar year.

** EOIR data lists this facility as a Service Processing Center. ICE records indicate that this facility is a Contract Detention Facility.

*** Located in New Mexico, just over the Texas-New Mexico border. All detainees' immigration court proceedings are heard in El Paso.

While immigrants are permitted to have a lawyer or accredited representative represent them in immigration court, they are not appointed government-funded counsel if they cannot afford their own. Due to their inability to obtain paid or pro bono counsel, 60 percent of all immigrants in the immigration court system went without legal counsel in 2008—and 84 percent of all detained immigrants had no attorney.⁴⁴

The U.S. immigration court system is notoriously overwhelmed, with 290,233 proceedings completed in FY 2009. The 2009 Appleseed report *Assembly Line Injustice* estimated that each immigration judge must decide four cases per business day to keep up with this workload. Our interviews confirmed that the immigration courts have insufficient resources. Over the past three years in South Texas, while detention capacity increased from 850 to 4,200 beds, the number of immigration judges held constant at three. Another advocate told us that Houston-area immigration judges served fewer than 800 detainees in 2006; the same number of judges now is responsible for at least double that caseload.

SECTION 1:

Improving Mental Health Diagnosis and Treatment in the Civil Immigration Detention System

“In the past five years, ICE has experienced considerable growth in immigration detention. This growth has presented significant challenges to a system that was not fundamentally designed to address ICE’s specific detention needs.”

– U.S. Immigration and Customs Enforcement (ICE) Assistant Secretary
John Morton, August 6, 2009⁴⁵

Immigration Customs and Enforcement (ICE) recognizes that its detention system does not meet the needs of the agency or of immigration detainees. ICE’s acknowledgement of the need to expand alternatives to detention is a welcome attitude shift, particularly with respect to vulnerable populations.⁴⁶ Recognizing deficiencies is only a starting point, however. More work is needed to meet the needs of immigrants with mental disabilities, who often require medical and mental health care, individualized housing, and other specialized attention.

ICE should permit apprehended immigrants with mental disabilities to reside in the least restrictive setting appropriate to their individual needs and circumstances. For most immigrants with mental disabilities, this means leaving them in their communities to receive appropriate care and family support. In cases where ICE must detain an immigrant, the least restrictive setting may be a residential or other non-penal facility where the immigrant will be provided adequate care, while still having access to a community support system. This guiding principle also requires that ICE use specific detention measures, such as restraints and segregation, only when necessary and in consultation with mental health professionals.

In the current system, immigrants are forced into detention facilities that are incapable of providing for their most basic needs. The aggressive move to detain immigrants, hostile detention environments, lack of proper diagnosis and treatment protocols, and understaffing or staffing with inadequately trained or unqualified facility staff—combined

with ineffective enforcement of existing standards—all contribute to insufficient care for immigrants with mental disabilities. Poor treatment of these immigrants violates their Constitutional rights. Detained individuals with disabilities have “substantive rights under the Due Process Clause of the Fourteenth Amendment,” including rights to “safe conditions of confinement” and “freedom from bodily restraints.”⁴⁷ This admonition is particularly true for those detained on noncriminal charges. Another federal court has held that such detention “may be a cruel necessity of our immigration policy; but if it must be done, the greatest care must be observed in not treating the innocent like a dangerous criminal.”⁴⁸

POLICY RECOMMENDATION 1:

Immigrants with mental disabilities should be detained only when required by law, for national security concerns, or for risks to health and safety.

ICE’s routine apprehension of immigrants with mental disabilities has resulted in a large and vulnerable population of detainees who are not receiving adequate care and treatment. This situation is a direct consequence of ICE’s failure to exercise its existing discretionary decision-making powers to allow immigrants with mental disabilities to remain in the community, where they can continue to receive treatment and family support while their immigration status is adjudicated. Mental disabilities should trigger discretionary release to a less restrictive setting. Immigration officers are charged with the duty to exercise discretion when making custody determinations. The apprehending officer must determine whether or not it is appropriate to detain an individual who exhibits extreme mental illness; detention is only appropriate in very limited and rare circumstances.⁴⁹ The same considerations apply when ICE is determining whether to release an immigrant from detention.

ICE Policy

In situations where staff must respond to a pickup request or detainer placed against an...alien with a severe medical or psychiatric condition, the Field Office Director (FOD) should weigh the appropriateness of taking that person into federal custody absent a mandatory detention requirement, exceptional concern such as national security, or articulable danger to the community that cannot be addressed by the referring agency. A favorable exercise of discretion should be considered on a case-by-case basis whenever a medical or psychiatric evaluation, diagnosis, treatment plan, or other documentation provided by the referring agency indicates the existence of extreme disease or an impairment that makes detention problematic and/or removal highly unlikely.

—*Memorandum of U.S. ICE Director John P. Torres, Discretion in Cases of Extreme or Severe Medical Concern (December 11, 2006)*

Notwithstanding this clear discretionary authority, ICE officers continue to apprehend and detain immigrants with mental disabilities who would be better served by remaining in their communities. Immigrants with mental disabilities are often subjected to mistreatment while detained at facilities that lack the resources to provide adequate treatment and basic care. Often detention facility staff do not have the proper training to manage immigrants with mental illness and intellectual disabilities. Furthermore, the detention of immigrants with mental disabilities has placed a heavy fiscal burden on the immigration system.

“(I)t costs seven times as much to incarcerate someone with mental illness than a healthy individual.”⁵⁰

–United States Senator Russell Feingold (D-Wis.), September 15, 2009

Immigrants with mental disabilities, like many other immigrants, are often apprehended through the criminal justice system, workplace raids, and border patrol. However, ICE apprehends immigrants with mental disabilities at mental health institutions or hospitals. We also learned of cases where ICE apprehended immigrants who had been ordered civilly committed before the immigrant was able to receive appropriate care as per the civil commitment order. This practice is prohibited by the Code of Federal Regulations and should be immediately terminated.

ICE Policy

An immigrant “confined because of physical or mental disability in an institution or hospital shall not be accepted into physical custody by [DHS] until an order of removal has been entered and [DHS] is ready to remove” the immigrant.

–8 C.F.R. § 1236.2(b) (2009)

Immigrants detained by ICE have the opportunity to ask for release. Many immigrants can request that ICE release them on bond, and have the ability to seek review of the bond determination by the immigration court. For other immigrants, including those who are detained upon arrival at the border or subject to statutory mandatory detention on certain criminal or terrorist grounds, ICE is the only agency with authority to authorize release via “parole.” In those cases, judges have no authority to review the parole decision.⁵¹ ICE can also place immigrants in the Alternatives to Detention program.

Bond, parole and the Alternatives to Detention Program can be used to ensure that the community connections, support structures, and treatment opportunities for an immigrant with mental disabilities are not severed. ICE considers several factors in determining bond, including community and family ties.⁵² While parole is subject to more stringent standards, parole applications may be granted for “urgent humanitarian reasons” or a “significant public benefit” as long as the detainee does not present a security or a flight risk.⁵³

Case Study

Just before Thanksgiving, a 50-year-old legal permanent resident was transferred to the Willacy County Detention Facility in Texas. The immigrant, who had lived in the United States since 1974, was declared incompetent by a New York criminal court and was ordered to serve 90 days in a mental institution. Before the order was implemented, ICE apprehended the individual. Even though the ICE officer was given a copy of the court order, the officer transferred the immigrant from New York to Texas. His attorney commented, “They transferred him to Texas, because they can... If he was declared incompetent [by the criminal court], then he will be incompetent in immigration court as well. He will end up like these other cases at Willacy who stay there for two years.”

His sister said the transfer to Texas occurred so quickly that his family had no idea where or why he had been taken. “Nobody knew what was happening until he called a friend who told my mother that he was in Texas. Even the legal aid attorney [his criminal defense attorney] didn’t know he was in Texas. It was a shock to us,” she said. “He has been there a month and hasn’t taken any medication. They need proof that he, in fact, has a mental illness and that there is a mental facility to accept him. They asked for proof that he is mentally ill. He has a lot of proof. I hope that the documentation gets to them before January [his scheduled court hearing]... If they deport him, it will be the end of his life and the end of my mother’s life. My mother says he will die out there in the streets.”

Bond and parole determinations for immigrants with intellectual disabilities (mental retardation), mental illness, and mental incompetence should follow ICE policies referenced in this section.⁵⁴ In addition, ICE parole regulations allow the parole of detainees “who have serious medical conditions” for whom “continued detention would not be appropriate,” as well as detainees “whose continued detention is not in the public interest.”⁵⁵ As discussed below, however, release should be decided in a manner that ensures the safety and well-being of the immigrant.

Case Study

The apprehension of a permanent resident from New York and his transfer to a Texas detention center illustrates the problems that can occur when immigrants with mental disabilities are not paroled by ICE for the duration of their legal proceedings in immigration court. This immigrant, who suffered from severe schizophrenia, was an ideal candidate for parole: he was not a flight risk, he was living with his mother, he had no history of violence, and he was stable due to years of treatment by a team of psychologists and social workers. In addition, he was clearly eligible for relief from the immigration charges brought against him.

While in detention, his numerous parole requests were denied, and his mental state deteriorated rapidly. As a result, he refused to fight his case or communicate with

(continued on next page)

Case Study (continued):

his attorneys. He was able to win his case only after a guardian was appointed in state court to represent him—a lengthy procedure during which he remained in detention. Had he been granted parole and released to his mother, he would have been able to continue receiving treatment and maintain his fragile mental stability, allowing him to continue working with his immigration attorneys. Instead, his mental deterioration led to unnecessary delay and costs to the government, not to mention complication of his mental illness.

Unfortunately, this case study does not represent an isolated circumstance. Detainees’ mental health often deteriorates dramatically in detention. ICE has considerable authority to release detainees on parole, bond or into the Alternatives to Detention Program. This discretion is rarely exercised, and release requests are routinely and arbitrarily denied, without due regard for the merits of the underlying case. Compounding this problem, ICE often has the incentive, as the immigration prosecutor advocating for removal, to use detention as a prosecutorial advantage. In other words, ICE is both judge and jailor when adjudicating parole requests. Some detainees may agree to deportation simply to be relieved of the trauma of immigration detention.

While ICE has failed to appropriately exercise its discretion in the apprehension and release of immigrants with mental disabilities, it has also inappropriately used that discretion to “dump” detainees. For example, in order to avoid the costs associated with the treatment and care of immigrants with major medical conditions, including conditions acquired due to negligent care in detention, ICE has explored deportation of these immigrants, or release of these immigrants into the hands of family members incapable of accommodating their health care needs.⁵⁶

“Eventually, faced with paying \$10,000 a month for nursing home care [due to a head injury that occurred while in detention], officials settled on a third course: ‘humanitarian release’ to cousins in New York who had protested that they had no way to care for him.”

—Nina Bernstein, “Officials Hid Truth of Immigrant Deaths in Jail,” *New York Times*, January 9, 2010.

Though “dumping” of immigrants with major medical conditions is an unacceptable practice, unnecessary detention of immigrants with mental disabilities serves neither the government’s nor the immigrant’s interests. Accordingly, ICE should exercise its existing discretionary authority and not apprehend or detain immigrants with mental disabilities who would be better served by remaining in their communities. As part of the current detention reform effort, ICE is developing a risk assessment protocol for immigration officers to use in making detention determinations. Taking the following Implementation Strategies into account would make this protocol more responsive to immigrants with mental disabilities.

Implementation Strategies:

ICE should:

- Detain immigrants with known or documented mental disabilities only when necessary, such as when they are a threat to national security or a real danger to themselves or others. If a detainee has strong familial or personal ties to the community, and detention is not otherwise indicated, detention should not be considered.
- Leave an immigrant with mental disabilities in the care of a hospital, private institution, or appropriate caregiver. If flight risk is a concern, ICE can require status reporting from the hospital, private institution, or appropriate caregiver and notification of any change in status or residence.
- If a criminal court has found an immigrant incompetent and ordered treatment, ICE should wait until treatment is complete before considering detention.
- Release detained immigrants with mental disabilities as soon as practicable unless continued detention is necessary. ICE can require status reporting from the hospital, private institution, or appropriate caregiver, and notification of any change in status or residence. If release is not possible, ICE should automatically screen individuals for placement into its Alternatives to Detention Program.⁵⁷

In addition:

- Detainees should be given the opportunity for independent review of ICE custody determinations. Currently, immigration judges have the authority to grant bond for some detainees. This authority should be expanded to include review of all ICE release determinations at the request of the immigrant.

POLICY RECOMMENDATION 2:

Detained immigrants with mental disabilities should be placed in settings appropriate to their needs.

“All but a few of the facilities that ICE uses to detain aliens were built as jails and prisons.”

—Dr. Dora Schriro, Immigration Detention Overview and Recommendations,
October 6, 2009

As explained above, detention is medically traumatic and dangerous for this population. The prison-like conditions in ICE facilities only increase the symptoms exhibited by detainees with mental disabilities, who account for at least 15 percent of immigration detainees.⁵⁸ For immigrants who must be detained, placement in the least restrictive setting appropriate to their individual circumstances includes providing a range of non-penal residential environments, treating them fairly while in detention, and minimizing transfers away from their communities.

The system of prisons and jails used by ICE, as well as the correctional facility standards used to govern conditions in these facilities, all contribute to the worsening of immigrants’ mental health conditions. Immigrants in detention spend the majority of their time in cells or pods, often dressed in prison uniforms, while access to religious services, visitation, recreation and legal materials is minimal.⁵⁹ A study conducted by a team of medical professionals found that levels of anxiety, depression and post-traumatic stress disorder worsened the longer individuals were held in detention.⁶⁰ Although many detainees in this study had suffered pre-immigration trauma and reported suffering from symptoms prior to detention in the U.S., the majority of detainees reported that their symptoms grew much worse while in detention.

“People are nervous about treating people (in detention) like human beings. They treat them as detainees or criminals, so there is no empathy or sympathy.”

–Detention Facility Mental Health Practitioner

In penal settings, immigration detention center staff are frequently not qualified to deal with detainees with mental disabilities. As a result, these detainees are placed in restraints or segregation. Our interviews indicated that many detainees are treated as if their mental disabilities are simply a behavioral problem.

ICE Policy

Medical Isolation: The clinical medical authority may place a detainee in medical isolation who is at high risk for violent behavior because of a mental health condition. On a daily basis, the clinical medical authority must reassess the need for continued medical isolation for the health and safety of the detainee.



Restraints: Restraints for medical or mental health purposes may be authorized only after the facility’s clinical medical authority determines that less restrictive measures are not appropriate. The facility shall have written procedures that specify the conditions under which restraints may be applied; the types of restraints to be used; the proper use, application and monitoring of restraints; requirements for documentation, including efforts to use less restrictive alternatives; and after-incident review.

–Operations Manual ICE Performance Based National Detention Standards (PBNDS), Part 4.22.V.K.5 and 6

“When they are crazy and cannot be managed they go to ‘seg’ [segregation] when there is not room in the short stay unit.”

–Detention Facility Nurse

Despite having these policies on the books, and even though the vast majority of detainees pose no threat, immigrants with mental disabilities are often treated like criminals. According to ICE policy, detainees are transported in handcuffs and/or leg shackles, which are often left on when a detainee travels outside of a facility for medical treatment. Further, detainees are frequently segregated into special housing units or isolation when they are on suicide watch, when they have exhibited symptoms of mental illness, or when they are considered to be at risk for violent behavior. Detainees who are placed in segregation or isolation frequently are restricted or denied access to basic services, such as washroom facilities, toilet tissue, toothbrushes, recreation, religious services, telephones or the legal library. Detainees in segregation or isolation often have difficulties meeting with legal counsel, accessing pro bono services, attending legal rights presentations, and meeting with detention officers.

“When they put you in ‘el pozo’ [‘the hole,’ or solitary confinement] you only have a little space. You have a toilet and a little place where you can sleep. And there is a little place where they put the food, but they throw it without caring. If you don’t take it rapidly, they throw it, whether it is hot or cold. They don’t care. They throw it as if you were an animal. It makes you lose control mentally. That is why I did not come out so well, mentally. I would lose my mind—I would lose my mind severely. I even wanted to commit suicide.”

—Former detainee at the South Texas Detention Center who was held in solitary confinement for more than half of his nine months in detention.

Immigrants with mental disabilities are also ill-served by ICE’s practice of transferring detainees to facilities around the United States in order to save money or to take advantage of excess bed space, without regard to detainees’ mental health needs or community ties.

ICE Policy

The detainee shall not be informed of the transfer until immediately prior to leaving the facility, at which time he or she shall be notified that he or she is being moved to a new facility within the United States and not being removed.

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Upon transfer to another facility or release, the medical provider shall ensure...at least 7 days’...supply of medication shall accompany the detainee.

—PBNDS, Part 7.41.V.B.3 and Part 4.22.V.S

Under the general transfer policy, ICE has almost unlimited power to detain immigrants in any facility and to move them to other facilities for the convenience of the government, without weighing the impact on the detainee and without advance notice. For example, ICE often transfers detainees thousands of miles to facilities in Texas and Louisiana for reasons of expense and space. This transfer policy, which is based on correctional

standards that prioritize security, only compounds difficulties for immigrants with mental disabilities. Immigrants are kept in the dark about an impending transfer and have little or no opportunity to contact family members, counsel or other sources of support in the community prior to transfer.

“At least notify the attorney and the relatives of where he has been taken. If you are going to detain him, (keep him) at least within the state that he lives, so that his family can go and see him.”

– Family member of detainee transferred from New York to Texas

The implementation of standards to protect vulnerable populations, such as disabled persons, is not a novel idea. The Americans with Disabilities Act (ADA) was enacted to ensure that disabled persons were not denied access to employment opportunities or public accommodations by requiring that facilities provide “reasonable accommodations.”⁶¹ Similarly, the Civil Rights of Institutionalized Persons Act (CRIPA) allows the Department of Justice to sue state or local jails “subjecting persons residing in or confined to an institution..., to egregious or flagrant conditions.”⁶²

ICE’s detention restructuring, announced in 2009, acknowledges the need for less restrictive settings for immigration detainees, including “converted hotels, nursing homes and other residential facilities for non-criminal, non-violent populations.”⁶³ In addition, ICE recognizes that detainees should not be categorized as criminals and treated like a criminal population.

Implementation Strategies:

In this spirit, to ensure that immigrants with mental disabilities are treated fairly in the detention system, ICE should:

- Amend the ICE one-year benchmark to “revise immigration detention standards to reflect the conditions appropriate for various immigration detainee populations” to require that immigrants with mental disabilities who must be detained be placed in the least restrictive setting appropriate to their individual needs and circumstances.⁶⁴
- Amend ICE policies to require that only a mental health professional may authorize the use of restraints or isolation for a detainee suffering from a mental disability that renders the detainee at severe risk of exhibiting violent behavior towards others. ICE should discipline personnel who inappropriately order use of restraints or isolation.
- Transfer detainees with mental disabilities only when necessary or to provide better mental health care—and only after it has been established by a comprehensive evaluation that the transfer will not negatively affect the detainee’s condition or treatment. Detainees should be given at least 14 days of any prescribed medication upon transfer to ensure they have medication until their required physical examination. In addition, detainees should be given advance notice of any transfer and provided the time and ability to challenge the decision.

POLICY RECOMMENDATION 3:

ICE should establish improved and consistent procedures for screening and diagnosis in detention.

“The current mental health intake assessment is quite brief and does not lend itself to early identification and intervention.”

–Dr. Dora Schriro, Immigration Detention Overview and Recommendations,
October 6, 2009

Our interviews and facility visits confirmed Dr. Schriro’s assessment of the inadequacy of mental health screening in detention centers. One Texas immigration attorney told us that detainees’ “illnesses were checked at the door. The cases...reflect the systematic medical maltreatment that detainees face across the country, as the government rushes people in and out to save a buck by skipping treatment.” The problem stems from both insufficient mental health screening standards and inadequate staffing. The Performance Based National Detention Standards (PBNDS) provide relatively detailed guidance for general health screenings of new detainees. These health screenings are designed to be performed within 12 hours of a detainee’s arrival and are to include a comprehensive inquiry into past and current mental health symptoms. If the initial screening reveals mental health issues, the standards require a detainee to be referred for a comprehensive evaluation by a mental health provider within 14 days of the referral.

ICE Policy

Initial medical, dental and mental health screening of immigrants assigned to a detention facility shall be done within 12 hours of arrival by a health care provider or a detention officer specially trained to perform this function.



Intake screening for mental health problems will include:

- Referral as needed for evaluation, diagnosis, treatment and monitoring of mental illness;
- Crisis intervention and management of acute mental health episodes;
- Transfer to licensed mental health facilities of detainees whose mental health needs exceed the capabilities of the facility; and
- Suicide prevention program.

–PBNDS, Part 4.22 V.I.1 and K.1

These standards require that screening include an inquiry into a detainee’s past history of serious illness; current illness; current and past medication; past surgical procedures; use of alcohol and drugs; observation of behavior, including state of consciousness, mental status, appearance or conduct; and history of suicide attempts or current suicidal/

homicidal ideation or intent. Screening also must “include observation and interview items related to the detainee’s potential suicide risk and possible mental disabilities, including mental illness.”⁶⁵

If mental illness is discovered at the intake screening, from medical documentation or subsequent observations by detention staff or medical personnel, ICE policy requires that the administrative health authority immediately refer the detainee to a mental health provider for a mental health evaluation. Any detainee referred for mental health treatment shall receive a comprehensive evaluation by a licensed mental health provider as clinically necessary, but no later than 14 days after the referral. The mental health evaluation must include: the reason for referral; any history of mental health treatment or evaluation; suicide attempts; current suicidal/homicidal ideation or intent; current use of medication; and prior history of physical, sexual or emotional abuse and recommendations for appropriate treatment.⁶⁶

These standards are not adequate, but even if they were, they are not routinely followed. Not only do facilities often fail to conduct initial screenings within 12 hours (or even within several days), but they also fail to provide necessary mental health evaluations within the 14-day requirement. The high frequency of transfers exacerbates the situation as many people may not be in one facility long enough to meet the 14-day threshold for an in-depth physical or mental health examination. The Health Services Administrator at the Laredo Processing Center noted that “ICE moves detainees so often there are many instances where a detainee has been in ICE custody in excess of 14 days, but never in one detention center long enough to have a [physical examination].”⁶⁷

Even when screenings are performed, they fail to identify mental health conditions, including profound illness. Both immigration attorneys and detention center medical providers report that screenings are often not true psychological evaluations and detainees with mental illness are given inappropriate or insufficient medicine, diagnoses and treatment. This frequently results in the worsening of the mental health of the detainee. Furthermore, although the PBNDS require that all medical care activities be translated for non-English speaking detainees, we heard of several instances of examinations conducted in English for detainees who were not capable of understanding and communicating effectively in English.

Case Study

Through our field research, Texas Appleseed learned that two immigrants admitted to the South Texas Detention Center in Pearsall, Texas, were never treated for their manic depression and schizophrenia. One detainee, a legal permanent resident, had been diagnosed with bipolar disorder, post-traumatic stress disorder, and severe depression prior to her detention. Her mental health issues were not diagnosed when she was first detained by ICE in August 2006, and during her 18-month detention her mental illness continued to go undiagnosed and untreated. Guards at the South Texas Detention Center ridiculed her by telling her she was not truly sick, that she was faking her illness, that she had no rights in the United States, and that she would be deported to Mexico.

“It’s a complete disregard for people with mental disabilities... [t]hey’re doing nothing or very little for detainees.”

–Texas Immigration Attorney

Similar screening problems were reported in the Willacy County Detention Center. Health care practitioners who worked at Willacy—the largest immigrant detention facility in the nation—report that the intake screening system is not staffed sufficiently to manage health care issues. It routinely takes at least four to five days at Willacy for a detainee to undergo an initial screening. If a detainee comes into the system on medication for mental illness, there is no way to continue that medication unless the detainee has documentation of the prescription. The lack of adequate screening at Willacy is of particular concern since one mental health practitioner estimates that 35 to 40 percent of the population at Willacy suffers from some form of mental illness.

Some intake screening forms used in detention centers demonstrate the lack of professional mental health evaluation. For example, the Willacy DIHS intake form dated May 2008 directs the screening staff to ask the detainee whether “[you] might lose your mind or go crazy” and “[are] afraid you might hurt or kill yourself or others.” Even when phrased in a manner that respects the dignity of detainees with mental illness, the mental health questions on intake forms are perfunctory and lack the sophistication necessary to detect mental illness. A standard DIHS form (revised in December 2007) addresses suicide, potential violent behavior, psychosis and sexual abuse in only eight direct questions, based on the erroneous assumption that the detainee will adequately self-report mental health issues. The forms also appear to expect that the screenings will be conducted by a person unfamiliar with mental health symptoms and diagnosis. For instance, the form used at Willacy in May 2008 asks the person conducting the screening to observe whether the detainee is “acting crazy or strange.”

Screening and diagnosis is also hampered by the failure to transfer medical records with detainees. A lack of medical records often results in misdiagnosis and mistreatment, at unnecessary expense to the government and unnecessary suffering for the detainee. This challenge is discussed in greater detail in the next Section. Intellectual disabilities appear to be ignored altogether in the current screening protocol. The PBNDS require that a mental health evaluation include an “estimate of current intellectual function,” but fail to specify when this “estimate” is to be conducted. Failing to screen for intellectual disabilities at intake poses risks both for detention center staff and detainees. One former detention center medical professional told us that “no one was doing IQ tests to see what was going on” before she was hired at the facility. “They were negligent in that area because they should have been doing them. One man came in his 30s who was functioning as a six-year-old and [there was] a 40-year-old functioning like an 11-year-old, so we had acting-out behavior. The other medical staff could not understand why they would act the way they did, so people got misdiagnosed. Only when the IQ tests showed how the detainees were functioning, were we able to explain to the other staff how to treat them. You can judge a person wrong if you don’t understand how the person is functioning.”

Improved detention center screening and diagnosis will result in better care and lower detention costs.

Implementation Strategies:

ICE should:

- Create a comprehensive and prompt protocol for intake and screening for mental disabilities. The screening should include more appropriate questions for evaluating mental health issues and guidelines for observing and assessing a detainee’s mental status, including any intellectual disabilities. The screening interview should be conducted in the detainee’s native language if the detainee is not proficient in English and should use culturally-appropriate questions and terminology.
- Develop enforcement mechanisms to ensure compliance with the 12-hour screening requirement, including financial penalties for contract facilities.
- Ensure that any detainee requiring a mental health evaluation receive it as soon as practicable, with consideration for immediate mental health care needs. The current standard that a complete physical examination be conducted within 14 days of detention at one facility leaves too many people who have urgent mental health needs without timely and appropriate treatment.
- Require that all facilities housing immigrant detainees use a standard mental health intake form developed in consultation with experts on mental health diagnosis.
- Ensure that the intake interview at an immigration detention facility is conducted by qualified personnel.
- Implement procedures to continuously monitor the mental health status of detainees. Not only should improved intake and screening procedures be implemented, but ICE should create programs to continuously monitor for symptoms of mental illness. This is particularly important given that detention can exacerbate symptoms of existing mental illness or trigger depression or anxiety.
- Maintain a sufficient number of personnel at each detention center with expertise to diagnose mental disabilities.

POLICY RECOMMENDATION 4:

ICE should improve mental health care in detention facilities.

Even when the screening process successfully detects a mental disability, detention centers are not adequately staffed to treat the disability. This lack of qualified staff results in poor treatment and improper medication. These problems exacerbate symptoms of mental illness, compromise the safety of detainees and detention staff, and prevent the effective legal representation of detainees.

In 2008, ICE adopted specific standards for mental health care in detention for the first time.

ICE Policy

Each facility shall have an in-house or contractual mental health program, approved by the appropriate medical authority, that provides: [i]ntake screening for mental health problems [to include]: [r]eferral as needed for evaluation, diagnosis, treatment, and monitoring of mental illness; [c]risis intervention and management of acute mental health episodes; [t]ransfer to licensed mental health facilities of detainees whose mental health needs exceed the capabilities of the facility; and [s]uicide prevention program.

—PBNDS, *Part 4, Section 22.V.K.1*

ICE struggles to meet these standards, particularly because of a failure to hire a sufficient number of qualified mental health professionals. As of September 2009, for instance, ICE reported that there were only three psychiatrists and no psychologists employed at the five largest Texas detention facilities, including no psychiatrist at the South Texas Detention Center. Together, these facilities have an average daily population of more than 5,000 immigrants. Not surprisingly, detainees often report a delay in obtaining necessary care. One attorney we interviewed said that her clients often suffer from delays in care: “It can take three to seven requests to actually see a doctor at Willacy.”

Case Studies

According to an August 2007 review by the Detention and Removal Operations San Antonio Field Office, personnel at the South Texas Detention Complex left a physically disabled woman with mental illness naked on the floor in solitary confinement, bleeding from her menstrual cycle. She was left in this state for several days with no sanitary napkins, according to the report. A physician’s assistant at the facility noted that “the facility is not equipped to provide the proper mental treatment for the detainee.”⁶⁸

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A Texas detention facility nurse describes why better staffing is essential. “Tragically, we had a person out of control while there wasn’t a psychiatrist [here]. He was becoming increasingly agitated, and was only given Ativan—a short acting anti-anxiety medication because the physician on duty did not feel comfortable with anti-psychotics. He only got one shot, was still suffering and never got anything else. A few days after that, he assaulted an officer and hurt him quite badly. The detainee was taken to the jail across the street and the officer pressed charges. I don’t know what happened to him after that. He was just going to be deported without treatment. He was banging on the door asking to let him go home, and he was hallucinating. They could not provide additional medications because no doctor was available... 4. The plan was to keep him calm. At the very least, if he had been able to get attention several times a day and reassurance, he might have been ok.”

Detention facilities often fail to provide proper medications to detainees with mental illness, resulting in both over- and under-medication. In instances where medications are provided they are sometimes different than what the detainee was previously prescribed, or there is a complete failure to dispense necessary medications. The PBNDS authorize physicians to involuntarily prescribe psychotropic medications to detainees with mental illness, if in compliance with applicable laws. One attorney we interviewed described a client who was improperly medicated at the Port Isabel Detention Center in Los Fresnos, Texas. When she went to meet with him one afternoon, he had dried white foam around his mouth and slurred speech and could not stay awake. The next time the attorney visited her client, she asked him about this—he told her that he generally took his meds and slept until about 3 p.m. every day.

Case Study

Andre Osborne was detained by ICE in New York in 2008 for removal from the U.S. based on a 15-year-old drug charge. After being transferred to the Willacy Detention Center in Texas, he was diagnosed with severe depression and was put on new drugs even though he had been previously diagnosed in his community. Osborne said he “was very depressed because I was dealing with an issue of a disabled wife at home. I was in mandatory detention with no possibility of receiving a bond. ...I took the medicines into the dorm...washed up, brushed my teeth,...came to my bunk, opened a magazine and started to read like I do every night and that was the last thing I remember until I woke up the next day at 4:30 p.m.” While unconscious from the medications, he fell out of a top bunk and severely injured his face. He was taken by ambulance to a local hospital.

He slept through the entire 19-hour episode. After he awoke, he asked the facility counselor what had happened. “When she gave me the time between the actual medical emergency call,...and the time when I came back to the facility...I am asking myself only one question: ‘How could I not know all of this?’ And she said, ‘Osborne, you were overmedicated. You were heavily sedated, and that’s why you don’t remember anything.’”

He refused further medication and was released to his wife in late 2009 after nearly two years in detention.⁶⁹

When a detention center cannot provide appropriate mental health care, ICE standards require that detainees be transferred “to licensed mental health facilities.” In theory, transfer to specialized facilities should increase the quality of mental health care for detainees, but in practice it can result in detainees being involuntarily committed without the knowledge of their families and counsel. Viewing immigrants as criminals, rather than low-risk civil detainees, can result in unnecessary costs. For instance, staff at one state hospital in Texas that ICE uses for mental health care told us that whenever a detainee becomes a patient at the facility, ICE sends two guards to sit in a van outside the hospital in an effort to ensure that the detainee does not escape. The hospital staff consider this practice absurd: not only is the hospital a locked facility, but most

detainees who are sent to the hospital for treatment are so ill that they lack the capacity to plan an escape. The hospital staff also noted that the guards often had never met the detainee—making it virtually impossible for them to recognize the immigrant.

Less is known about the Columbia Regional Care Center in Columbia, South Carolina, a correctional health care facility used by ICE. Columbia Care serves inmates with serious mental health or other medical issues who are transferred there from county and state correctional facilities, ICE and the U.S. Marshals Service. ICE detainees appear to be the only civil detainees sent to Columbia Care. Our interviews with immigration attorneys indicate that ICE has no clear standards for transferring detainees to Columbia Care or for returning detainees to immigration detention, where their immigration court proceedings can be restarted. One attorney we interviewed noted that ICE shipped one of his clients to this facility because the ICE detention center did not have the capacity to deal with her mental health care: “She is not so severely mentally ill, so it indicates they have little capacity to deal with the issue.”

Case Study

An immigration attorney described a case in which a client with schizophrenia was transferred to Columbia Care once the judge adjourned his immigration hearing and ordered DHS to obtain a competency assessment. The immigrant’s family was not told about the transfer to Columbia Care. His mother went to visit him after his court hearing and was told he was no longer in detention. The immigration officials refused to give her any information. “[His] mother feared that [her son] had been disappeared. After more than six months of not knowing where her son was, [his] mother finally received a call...[he] told his mother that he had been taken to a prison hospital in South Carolina and had not been allowed to use the phone or contact anyone.” Two and a half years passed before he was brought back to San Diego and had his immigration case re-opened.

Implementation Strategies:

To provide adequate mental health care to detained immigrants, ICE should:

- Hire sufficient numbers of psychiatrists, psychologists, social workers and other qualified medical staff to meet the mental health care needs of both long- and short-term detainees. Facilities should have at least one full-time mental health specialist qualified to supervise the treatment of mental illness.
- Adopt its proposed medical (and mental health) system for detainees.
- Develop treatment protocols that draw from other successful programs, particularly in the non-penal context and that include well-documented procedures to monitor mental health treatment and avoid over-medication or inappropriate medication. For example, the United Nations Refugee Agency has implemented Guidelines on Mental Health and Psychosocial Support in Emergency Settings, a useful reference in drafting improved standards for the treatment of detainees with mental illness.⁷⁰

- Develop specific standards for the transfer of detainees to mental health facilities. These standards must ensure that the facility provides treatment appropriate to the needs of the detainee in the least restrictive setting. ICE must notify lawyers and family members in advance of such transfers. Further, ICE should ensure periodic reevaluation of the transfer, particularly in cases where the detainee’s immigration case has been stayed because of the transfer.

POLICY RECOMMENDATION 5:

ICE should train guards and other detention center personnel to identify and interact appropriately with detainees with mental disabilities.

Our investigation documented many instances of mistreatment of individuals with mental disabilities in immigration detention—indicating an immediate need to improve training of detention facility staff. Basic training standards exist, but are not adequate to ensure humane and effective treatment of detainees with mental disabilities.

“When mentally ill detainees act out, guards punish these patients because they see these acts as questioning the guards’ authority rather than as a symptom of their illness.”

—California Immigration Attorney

ICE Policy

O. Emergency Medical Services and First Aid:...Detention and health care personnel will be trained annually to respond to health-related situations within four (4) minutes...The training (for detention and health care personnel) shall be provided by a responsible medical authority in cooperation with the facility administrator and shall include...recognizing signs and symptoms of mental illness and suicide risk.



All staff responsible for supervising detainees will be trained, initially during orientation and at least annually, on effective methods of suicide prevention and intervention with detainees.

—PBNDS, Part 4, Section 22.V.0 and Part 4, Section 24.II.1

These standards focus solely on emergency situations and thus do not train staff to interact appropriately with individuals with mental disabilities in more routine situations. Training should focus on de-escalation techniques and cultural perceptions of mental illness.⁷¹ The end goal of training should be to prevent emergency situations through early identification of mental disabilities and appropriate interaction to diffuse difficult

situations. Furthermore, our investigation determined that training standards are not uniformly implemented and are not rigorously enforced. ICE does not, for example, penalize facilities or private contractors for noncompliance, creating little incentive for facilities to improve their training practices.

“Of the 10 training records reviewed within the past year, only one had documented suicide prevention training. This is a violation of the El Paso SPCs local policy...the compliance officer reported there is a pattern of management cancelling the required annual training.”

–Detention Field Inspection Group Quality Assurance Review,
El Paso Service Processing Center, March 2008

The standards’ focus on training for emergency situations often means that detention center personnel are ill-equipped to interact with detainees with mental disabilities. A medical practitioner at a Texas immigration detention facility observed, “Guards have called detainees ‘crazy’ because of their medication.” Guards also can be insensitive to patient privacy issues: “[They] announce the detainee’s name and the fact that they need to go to mental health [therapy].” Focus groups with immigration detention personnel documented that many guards had a poor understanding of mental illness and often equated it with violent behaviors and intellectual disabilities. In some cases, guards expressed fears that mental illness was contagious.⁷²

In recent years, many governmental agencies have improved their staff response to incidents involving people with mental disabilities. Police departments and detention facilities have seen the value of providing specialized training to officers carefully selected to interact with persons with mental disabilities. This extra training has resulted in improved outcomes in interactions with people with mental disabilities.⁷³ These units use their skills to avoid injury, diffuse conflicts and ensure appropriate mental health treatment, and they avoid engaging in unproductive punitive responses. Meaningful training of guards and medical personnel can also reduce the use of isolation in the Special Management Unit.⁷⁴

Some mental health training systems specific to immigration detention have been developed in recent years. A multi-year pilot mental health training program was developed in conjunction with the predecessor agency of ICE, the Immigration and Naturalization Service (INS).⁷⁵ In 2005, the DHS Office for Civil Rights and Civil Liberties developed a short program to train detention facility staff on unique needs of traumatized asylum seekers who came to the United States seeking protection. However, based on multiple interviews with attorneys who work with immigration detainees and health care providers in immigration detention, it appears these trainings were never effectively implemented.

Implementing effective mental health training, as part of an improved mental health care strategy, has produced tangible results in the criminal justice setting, decreasing suicides and improving mental health outcomes at facilities. It should reap the same benefits in the immigration detention setting.

Appropriate mental health training can reduce the costs associated with the detention of immigrants with mental disabilities. It can equip personnel with the skills needed to identify minor problems resulting from unmet mental health care needs before they turn into expensive medical emergencies. Appropriate training is an essential part of creating better overall detention conditions, which improve operational efficiency and could prevent lawsuits arising from injury or death suffered by detainees with mental disabilities.

Implementation Strategies:

ICE should develop and mandate trainings that teach detention center personnel to:

- Understand definitions of mental illness, mental health diagnoses and the impact of mental illness on individuals. Trainings should pay specific attention to the effects of trauma and torture, post-traumatic stress disorder, depression and other mental health issues frequently experienced by immigration detainees.
- Identify when an individual appears to be in need of mental health care, either emergent or chronic.
- Be familiar with information regarding mental health resources available at the detention facility as well as facility protocol for housing assignments and provision of care for detainees with an identified mental illness. Trainings should include presentations by the mental health staff serving the detention facility.
- Understand different cultural perceptions and responses to mental illness.
- Follow privacy protections for all medical concerns, including mental illness.
- Develop skills necessary to identify, stabilize and de-escalate situations that stem from a mental disability.

Standards must specify the minimum number of hours for mental health training. Otherwise, content is likely to be addressed only superficially and the system will not reap the benefits of an established mental health training regime. The new standards for initial training should be 40 hours or more for specialists and between eight and 16 hours for all staff, with additional annual training for both groups.⁷⁶ Those with specialized training could staff a housing unit designed specifically for individuals with serious mental illness or could provide support for the entire facility.

POLICY RECOMMENDATION 6:

ICE should adopt enforceable detention standards with a meaningful enforcement and oversight process.

“We need a system that is open, transparent and accountable.”⁷⁷

—John Morton, DHS Assistant Secretary for Immigration &
Customs Enforcement, August 2009

The announcement of “a major overhaul of the agency’s immigration detention system,”⁷⁸ and the subsequent release of the October, 2009 immigration detention assessment report by Dr. Schriro are important steps to improve the immigration detention system, but the “idea of reform” is not new to the immigration detention system. In the past decade, INS adopted detention standards in 2000, followed by another detention reform process announced by DHS in 2007. Each reform initiative has been followed by findings of abuses and inadequate standards of medical care in the detention system. This latest DHS reform process will be meaningful only if there is effective enforcement and oversight.

The current reform process outlined a few accountability measures:

- ICE created the Office of Detention Policy and Planning (ODPP), with staff in field locations, to oversee immigration detention reform and accountability within the system.
- The Detention Field Inspection Group was given a new name, the Office of Detention Oversight (ODO), and moved to the new ODPP.
- ICE announced that it will place more than 50 staff members at major detention facilities, to ensure oversight and compliance with detention standards.⁷⁹

Nonetheless, ICE and DHS stopped short of creating a system of accountability that would allow remedies for violation of its own standards. In July 2009, shortly before the August 6th detention reform announcement, DHS, under court order to respond, rejected a request to create judicially-enforceable detention standards through agency regulations. In its notice denying the petition, DHS stated that regulations are unnecessary because it has monitoring and evaluation processes and the agency “is committed to better management of detention facilities.”⁸⁰

The record of past reform efforts indicates that a commitment to “better management of detention facilities” is no substitute for enforceable regulations. The health and mental health care standards developed as part of the 2007 reform effort, for example, failed to hold detention facilities accountable for deficient care. Inspection without serious enforcement is insufficient. In 2007, ICE created the Detention Field Inspection Group (DFIG) with responsibility for investigating claims of mistreatment at immigration detention facilities. At the same time DHS hired the Nakamoto Group, a private consultant, to place permanent staff in the 40 largest immigration facilities to ensure compliance with detention standards. DHS hired another consultant, Creative Corrections, to conduct certain facility compliance reviews.

The funds spent by DHS on these consultants did nothing to improve accountability in the system. Rather, reviews of Texas detention facilities from 2007 to 2009 highlight problems and inconsistencies with the detention oversight process. For instance, a February 2008 Creative Corrections annual review of the Rolling Plains Detention Center in Haskell, Texas found acceptable conditions across the board at the facility. Two weeks later, a detainee died at the facility, prompting a DFIG review. That second review, dated March 18, 2008, found the medical clinic understaffed “in quantity and quality,” and the majority of medical care provided by Licensed Vocational Nurses with minimal supervision.⁸¹

In April 2008 Creative Corrections deemed the South Texas Detention Center in Pearsall, Texas to have “acceptable” medical care and gave the facility an overall rating of “good”—despite the fact that its own review found that 10 of the 55 medical care positions were not filled, creating “difficulty meeting the 14-day standard for physical examinations.”⁸² A month later, a DFIG investigation of a complaint of sexual assaults by facility guards found that, “poor medical care was the most problematic issue facing the facility.”⁸³

The Willacy County Detention Center in Raymondville, Texas, often referred to as the “tent city,” was erected and opened within 45 days in 2006. It has had a mixed history of compliance reviews. The facility has never been accredited by the American Correctional Association (ACA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the National Commission on Correctional Health Care (NCCCHC). Two separate ICE reviews of Willacy, both dated March 2007, found markedly different results. One found the facility acceptable, with “minor issues” that were “corrected immediately.”⁸⁴ The second listed multiple deficiencies at the facility, including poor sanitation, significant understaffing in health care facilities, and problems with guard training and qualifications.⁸⁵

A 2008 Creative Corrections review found the Willacy facility deficient based on safety and security issues, not based on detention conditions. During that same time period Willacy was the subject of numerous accounts of insufficient and inedible food, guard misconduct, and inadequate health and mental health care.⁸⁶

“These facilities are designed to break down a person, so that eventually they say, ‘You know what, Government, I give up. Deport me.’”⁸⁷

—Texas Immigration Attorney

In the spring of 2009, Creative Corrections gave Willacy a rating of “good,”⁸⁸ and an on-site Nakamoto Group consultant examined the facility daily for standards compliance. Despite this evaluation and monitoring, in that same year, Dr. Dora Schriro, then DHS Special Advisor on ICE and Detention Removal, was required to intervene twice in Willacy’s operations. In the spring of 2009, after her visit, all Level 3 detainees (indicating a higher level criminal history) were removed from the facility; activities were initiated for people at the facility, including wellness classes for men and English classes for women; and new tighter criminal background standards were implemented for guards. The facility also initiated efforts to hire a psychiatrist, as no mental health professional had served the 3,000-capacity facility for many months. A few months later, Dr. Schriro and her team conducted a second visit due to an undisclosed crisis. Local reports alluded to allegations that a women detained at the facility had been sexually assaulted by a guard.

Since the implementation of the 2007 detention reforms, at least six major studies by nonprofit organizations and a large number of media stories have documented severe deficiencies in the immigration detention system, including major health care and

mental health care shortfalls.⁸⁹ In response to reports and articles, Congress allocated \$2 million in 2009 to hire a consultant to assess medical and mental health care in the immigration detention system.

Transparency and Data: Necessary Components of Meaningful Reform

Texas Appleseed faced challenges accessing immigration detention facilities to conduct research for this study. An initial request to tour the Port Isabel Detention Facility was not finally approved until the day before the proposed tour date. The tour approval letter specified that “one-on-one interviews [with detainees] will not be allowed at this time.” The accompanying request to tour the Willacy County Detention Facility was denied. Many months later, a tour of the Willacy facility was approved with only a few days notice. A tour request submitted to the T. Don Hutto Detention Facility was denied. Our experience, coupled with that of other organizations and new evidence documenting a network of previously undisclosed detention locations, highlights a lack of transparency in the system.⁹⁰

The dearth of medical and mental health data is another shortcoming in the existing immigration detention evaluation and compliance system. A 2009 Texas Appleseed FOIA request to DIHS revealed that, “DIHS does not have numbers for individuals in ICE custody...or the percentage of people diagnosed with mental illness or mental retardation since January 1, 2006.” This system-wide lack of data means that ICE does not have the necessary tools to assess the scope of medical needs within the existing system and to ensure that detainee medical needs are being met.

The DHS decision to deny the petition for a rulemaking for standards enforcement also cites regular visits by the United Nations High Commission for Refugees (UNHCR) and the American Bar Association (ABA) as another indication that existing procedures are adequate. Though the ABA and UNHCR visits are helpful, their reports are often confidential and they are not able to truly evaluate complex issues, such as the quality of health and mental health care at detention facilities.⁹¹

The deficiencies in enforcement and oversight of immigration detention are compounded by the many contractors and sub-contractors in the ICE detention system, which has created a system rife with inefficiencies.⁹² A clear system of accountability and meaningful oversight will not only improve the standards of care in detention, but also create better value for the system, holding private contractors and ICE employees alike to appropriate standards. Enforcing standards related to medical care and training will avoid unnecessary emergencies and redundant expenditures.

Based on the track record of the ICE detention system and the unsatisfactory results of recent reform efforts, a multi-tier system of accountability is necessary, including mechanisms to enforce standards. The system should include continued Congressional oversight, legal oversight by expanding the Civil Rights for Institutionalized Persons Act to explicitly include immigration detention, and administrative oversight that includes serious accountability for DHS and ICE at the national, regional and facility level.

Implementation Strategies:

The U.S. Congress should:

- Require annual updates from ICE documenting progress in implementation of detention reforms.
- Continue to hold hearings in relevant committees to ensure that immigration detention complies with U.S. law and international commitments.
- Expand the Civil Rights for Institutionalized Persons Act to allow the Department of Justice to enforce standards at all immigration detention facilities, including federally-run service processing centers, contract detention facilities, and facilities run through Inter-Governmental Service Agreements (IGSAs).

ICE should:

- Maintain appropriate records and statistics about immigrants in detention, including medical and mental health-related data, to allow for meaningful assessments of the system.
- Develop, implement and enforce revised detention standards that ensure immigration detainees with mental disabilities are held in the least restrictive environment, and have access to appropriate assessments and long-term mental health care if held in detention.
- Mandate annual compliance reviews of all detention facilities, including all Intergovernmental Service Agreement (IGSA) facilities, sub-field office facilities, staging facilities, and Border Patrol facilities. Non-compliance must be accompanied by adequate sanctions, including termination of contracts for detention centers run by private companies.
- Include experts from within ICE as well as representatives of local and national non-governmental organizations (NGOs) working with immigration detainees, independent medical and mental health experts, and appropriate consultants in annual compliance review teams.
- Make public all immigration system statistics and reviews, and NGOs studying immigration detention should be given improved access to facilities for tours and to speak with detainees.
- Include compliance standards in IGSA contracts, with provisions that IGSAs should be terminated or financially penalized for noncompliance.
- Ensure the independence of the Office of Detention Policy and Planning (ODPP) and the Office of Detention Oversight (ODO) in conducting facility reviews.

POLICY RECOMMENDATION 7:

An independent office should be established within the Department of Homeland Security (DHS) or the Department of Health and Human Services responsible for health care for all those in DHS custody.

The Public Health Service (PHS) has provided health care in the immigration system since the late 19th century. The mission of the PHS is “to protect, promote, and advance the health and safety of our Nation.”⁹³ Somewhere along the line, the mission for PHS staff working in ICE detention facilities shifted from one to “protect...health and safety” to a standard of care described by one immigration attorney as “deportable health.” The October 6, 2009 detention reform proposals make some progress in establishing an appropriate system to oversee medical care, but DHS must take the extra step to reform the mission of DIHS and create an independent health care agency that is not an arm of law enforcement.

Case Study

According to an attorney working in South Texas, “One of the DIHS social workers at the Port Isabel Detention Center provided a detainee with a simple letter outlining his medical condition. The detainee then submitted the letter to the immigration court, and the social worker was suspended from employment for three months and almost terminated. Prior to her termination, the social worker would call [me] when detainees needed assistance. After her suspension, we never spoke to her.”

ICE Policy

Core Principle: ICE will provide sound medical care.

—U.S. Department of Homeland Security, “Fact Sheet,”
October 6, 2009

The Division of Immigration Health Services (DIHS), which is staffed by the Public Health Service (PHS), coordinates and provides health care to people in immigration detention. The DIHS mission—to “protect America by providing health care and public health services in support of immigration law enforcement”—is not patient-focused, but rather is directed at supporting law enforcement.⁹⁴ The standard of care guided by this mission has hurt immigration detainees, particularly those with mental disabilities or other complicated medical needs. The emphasis on care to enable deportation, with no regard for long-term health and mental health impacts, leads to problems such as over-medication, under-medication and the use of solitary confinement as a replacement for treatment in cases where untreated mental illness leads to behavioral challenges.

“[Non-emergency] medical conditions which the physician believes, if left untreated ... would cause deterioration of the detainee’s health or uncontrolled suffering affecting his/her deportation status will be assessed and evaluated for care.”

– “DIHS Medical Dental Detainee Covered Services Package,”
Immigration Health Services, 2005 (*emphasis added*)

The Schriro Report highlights some positive changes in the administration of health care: a medical care systems administrator for the Office of Detention Policy and Planning; a new Medical Director position in ICE; and a medical care advisory group. In her recommendations for medical care, Dr. Schriro also suggests that “ICE may benefit from forming an office designated to assume accountability and authority for the integrated delivery of medical service system-wide.”⁹⁵

These changes represent important steps forward for an institution plagued with systemic health care and mental health care deficiencies, but they do not address the basic conflict of interest that exists between a mission to provide access to meaningful medical care to immigrants in civil detention and the law enforcement and deportation mission of ICE. Effective change in the system requires not only adding new oversight offices and assessments, but also creating a new culture and establishing accountability based on providing high quality health care.

“The PHS officers who work at ICE facilities follow the medical policies and procedures established by ICE. PHS does not issue its own policies to its officers regarding medical treatment of people at detention facilities.”

– Response to 2009 Texas Appleseed FOIA request
to the Public Health Service of HHS

The current detention reform process at ICE offers an opportunity to clarify the mission of DIHS and provide the office with explicit and appropriate independence to make health care decisions based on a standard of protecting health rather than one of protecting national security.

Implementation Strategies:

The Division of Immigration Health Services (DIHS) or any new office created to oversee health care in immigration detention should:

- Clarify its mission to provide quality medical and mental health care that is in the best interest of the individual patient in ICE custody regardless of the status of immigration proceedings.
- Be independent of ICE’s law enforcement mission and the mission of the Office of Detention and Removal Operations to “ensure departure of removable aliens.”

- Report to an office in DHS or HHS focused on ensuring positive health care outcomes for immigration detention.
- Be accountable both for health care provided in ICE-run facilities and in IGSA facilities, even if it is not directly providing care in those facilities.
- Establish an office focused on continuity of care issues, to ensure that individuals with known diagnoses, either from within or outside of detention, are continually provided with appropriate care if they must be transferred to different facilities.
- Be transparent, by collecting and making public statistics that enable effective assessments to ensure an appropriate standard of care.

SECTION 2:

Removing Barriers to Accessing Immigrants' Medical Records

"[T]here is no policy on the maintenance, retention, and centralized storage of medical records; instead, a new medical record is opened each time a detainee is transferred to another detention facility. After the detainee is transferred from the facility the file remains onsite. While a medical summary should accompany detainees upon their transfer, it does not routinely occur."

– Dr. Dora Schriro, Director of the ICE Office of Detention Policy and Planning⁹⁶

Immigration and Customs Enforcement (ICE) admits that the system used by the Division of Immigration Health Services (DIHS) to manage and maintain detainees' medical and mental health records is substantially deficient. As a consequence, and as our interviews uncovered, detainees are routinely denied access to necessary medical treatments and medications because their records are not transferred with them.⁹⁷ These inadequacies create inefficiencies in the detention process, as facilities are unduly burdened by duplicative health screening, misdiagnoses and inconsistent care. Furthermore, even when records exist and can be found, immigrants and their lawyers have difficulty accessing those records, which would enable them to advocate for better treatment in detention and fair process and perhaps substantive relief in immigration court.

POLICY RECOMMENDATION 8:

The Division of Immigration Health Services (DIHS) should develop an electronic medical records management system.

The DIHS process for managing and maintaining the medical and mental health records of immigrant detainees is archaic. DIHS continues to maintain medical and mental health records of immigrant detainees in paper form,⁹⁸ lagging other agencies that have

implemented integrated electronic document systems. For example, North Dakota's electronic document system allows the Department of Transportation, Department of Veterans Affairs, Department of Commerce, and the Insurance Department to access common records.⁹⁹

An electronic medical records management system can create substantial increases in efficiency by reducing costs associated with paper-based systems. Start-up costs associated with an electronic document system will be recouped by reducing processing queue time, minimizing duplicative activities, decreasing data keying requirements, creating data entry outsourcing opportunities, reducing storage and retrieval expenses, improving access to records and information, automating business processes, and improving responsiveness to the needs of the facility and detainee.¹⁰⁰

A previous attempt by DIHS to implement an electronic medical records system failed because it was cumbersome for the end users. This failure resulted in the continued use of an archaic records system, ineffective health management for immigration detainees, and reduced operational efficiency.¹⁰¹ One finding in Dr. Schriro's October 2009 report, confirmed by our interviews, is that DIHS's current approach to managing medical records results in detainees being transferred between facilities, only to arrive at a new placement without any medical or mental health records.¹⁰² As a result, the receiving facility must absorb the cost of a records search and, if they are not found, must diagnose or re-diagnose the detainee for known medical and mental health problems. Additionally, the detainee's health may suffer from failure to receive appropriate and timely treatment or medication upon transfer, or from a staff member's reliance on incorrect self-reporting during the initial screening.

"Sometimes, [we would repeat tests and duplicate services already provided] but most of our staff were good at calling and insisting on getting the records. But sometimes other facilities would say that they have the records but can't find them[.]"

—Detention Center Mental Health Professional

These problems can be rectified by creating a new electronic medical records management system. ICE officials have stated that they want to move towards electronic records, and ICE has requested funding in the FY 2011 budget sent to Congress to "begin the design and development" of an electronic medical records system.

Implementation Strategies:

The Division of Immigration Health Services should:

- Establish a uniform, effective, efficient, and user friendly electronic medical and mental health records system to ensure that the records are obtained by receiving facilities in a timely and appropriate manner.
- Ensure that any electronic medical records management system is developed with appropriate patient privacy safeguards.

- Require and enforce timely updating of all medical records.
- Mandate that all detention centers have access to the same set of updated medical records for each detainee.
- Coordinate transfer of records with state and federal criminal facilities, relevant state agencies that oversee care for individuals with mental disabilities, and mental health care providers to obtain a detainee's history of mental illness and treatment.

POLICY RECOMMENDATION 9:

The Division of Immigration Health Services (DIHS) should ensure immediate transfer of an immigrant detainee's medical records during facility transfer.

Existing processes for transferring detainees between ICE facilities must be modified to meet ICE's own Performance Based National Detention Standards (PBNDS). According to the applicable standards, medical records should be transferred with a detainee.

ICE Policy

A summary of the detainee's medical care (transfer summary) shall be marked "CONFIDENTIAL MEDICAL RECORDS" and shall accompany the detainee who is being transferred. This includes detainees who are being transferred into or out of ICE custody. Full copies of the medical records or parts thereof must be made immediately available upon the request of the receiving facility's administrative health authority or clinical medical authority. Other requirements for the transfer of records are contained in the Detention Standard on Transfers of Detainees.

—PBNDS, *Part 4, Section 22.V.U.4.c*

Though transferred detainees are supposed to arrive at the new facility with a paper summary of their medical file, all indications are that ICE's current practice falls far short of meeting the PBNDS standard. Failure to transfer files is hardly an isolated problem. In 2008, 100,284 detainees were transferred once, 98,871 detainees were transferred twice, and 34,252 detainees were transferred three or more times between facilities,¹⁰³ transfers that are conducted at the sole discretion of ICE.¹⁰⁴ Of the 353,111 detainees in ICE detention facilities in FY 2008, 24 percent were subjected to two or more transfers.¹⁰⁵

Despite this significant and seemingly routine process, an audit by the DHS Inspector General revealed alarming deficiencies in the detainee transfer system. At the five facilities audited, many members of the ICE staff were unaware of crucial procedures for handling detainee transfers.¹⁰⁶ For example, the Detainee Transfer Notification form, which outlines basic information about the detainee, was improperly completed for 143 out of the 144 detainee transfers audited—a less than 1 percent success rate.¹⁰⁷ As a result, detainees often experience a lapse in or discontinuation of treatment and medication, or they receive improper treatment and medication.¹⁰⁸

Continuity of care is a challenge for detainees who are transferred into or between facilities without proper records. A 2008 *Washington Post* article highlighted the plight of a detainee with mental illness who was not given critical treatment when he was detained at an ICE facility in Texas. Although the detainee's prior physician made specific treatment recommendations, the facility never incorporated the physician's recommendations into the detainee's medical file. As a result of this failure to transfer medical records, the detainee did not receive the recommended and necessary care.¹⁰⁹

Case Study

One attorney we interviewed described a client who was transferred to Texas from New Jersey, where he had been detained for several months. His medication and related records did not move with him (although a medical summary was sent), so her client underwent a second full evaluation after he arrived in Texas. More than a week passed before he received any medication, and it was different from what he had been prescribed in the New Jersey detention facility. The attorney said, "The new medication made him slower, and he heard voices. A month and a half later, and after three separate requests, my client was given his proper medication."

These failures to document medical problems are exacerbated by the transfer process. Detainees may receive effective healthcare at one facility, only to have it discontinued upon transfer to a different facility. For example, one detainee was refused necessary medical care either because medical staff expected that the detainee would be transferred again or removed from the United States before the records were received.¹¹⁰ Unfortunately, it does not appear that legal representation resolves these issues. Attorneys told us that attempts to have their client's medical records transferred along with the detainee have been futile, depriving their clients of necessary medical treatment.

Failure to transfer medical and mental health records with the detainee occurs at multiple stages of the process. Often, a transferring facility's medical staff are not notified about a detainee transfer. As a result, the medical staff are never given an opportunity to send medical records and appropriate medication to the receiving facility. Detainees who are admitted or transferred to a facility show up empty-handed, requiring the facility's staff to spend time tracking down the detainee's records.

*An ICE review of a Houston immigrant detainee's suicide revealed that "[a] major area of concern was lack of medical records...Following the death, the detainee's health records from his previous institution [a Bureau of Prisons facility] revealed the detainee had been diagnosed and treated for Schizophrenia and had at least one documented suicide attempt...Such information would have been valuable to the mental health provider and medical staff at Houston."*¹¹¹

—2008 OIG Report on ICE Policies Related To Detainee Deaths
and the Oversight of Immigration Detention Facilities

Lack of continuity of care negatively impacts all detainees, but the consequences are most poignant for detainees suffering from mental illnesses who are denied previously-prescribed medication and treatment at a receiving facility. Texas Appleseed heard reports of detainees suffering from paranoia and hallucinations, and becoming hostile to others and themselves to the point of suicidal ideations. This creates safety concerns for the detainee and staff, in addition to the obvious health issues.

“When people are moved in the system, their medical records do not travel with them. In GEO (a detention facility in downtown San Antonio run by GEO Group Inc.), [my client] was getting his medications, but when he moved to Pearsall, he did not get medications (for his mental illness). Records don’t seem to move with people even locally, from Karnes City to GEO to Pearsall.”

—Texas Immigration Attorney

Implementation Strategies:

In order to ensure the immediate transfer of all detainee medical records, ICE and DIHS should:

- Expand current standards to require that all medical records be transferred to a receiving facility before or along with the detainee. The revised standard should include periodic auditing and reporting of compliance statistics.
- Adopt specific instructions detailing the information to be included in the medical records. Including adequate information would allow receiving facilities to prepare for detainees, to provide consistent healthcare, and to reduce the health and safety issues that can result from delays in medical record transfer.

POLICY RECOMMENDATION 10:

The Division of Immigration Health Services should allow detainees and their attorneys timely access to medical records.

Another obstacle to effective medical treatment is the failure of DIHS or designated local healthcare providers to allow access to medical records to detainees and their counsel. Currently, DIHS policy requires a detainee or detainee’s counsel to file a FOIA request, usually to both the Department of Homeland Security (DHS) and the Department of Justice (DOJ), which often takes three to four months to be answered. (As documented in *Assembly Line Injustice*, FOIA requests in the area of immigration simply waste time and resources, as they are almost universally granted.) Without medical records, a detainee’s attorney may not be able to communicate effectively with the client or to advocate for better treatment or appropriate relief in immigration court. An attorney’s inability to obtain a client’s medical history can also have a detrimental impact on effective representation of the client.

Case Study

Despite repeated written requests for access to his client's medical records over a period of six months, an Akin Gump pro bono attorney was unable to access them. He recalled that "after finally making contact with someone in the medical department, I was told that despite numerous written requests and a signed authorization, no medical record would be provided without filing an additional FOIA application and waiting an additional several months for a response. The medical director and I had a heated argument in which I asked why the client's attorney, acting with the client's written authorization, could not have access to records that were the property of the client when the client's merits hearing was weeks away and the information contained therein was vital to the presentation of the case. I did not receive a satisfactory answer to that question." In this instance, the detained client was unable to recount his own medical history accurately, including the medication he received after an attempted suicide. Compounding the usual problems associated with self-reporting, the language barrier made it difficult for staff to ascertain the client's medical history. After several months, the attorney was finally able to gain access to his client's medical records.

Implementation Strategies:

In order to provide detainees and their attorneys with appropriate access to medical records, DIHS should:

- Require all facilities to disclose medical and mental health records requested by a detainee or attorney within 24 hours, without a FOIA request. This will be easier to implement once an electronic medical records system is in place.
- Generate a standard form to be used at all detention facilities to request and authorize the release of medical information. This form should be compliant with the privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA).¹¹²

Credible Fear Interview: Asylum Seekers with Mental Disabilities Fall Through the Cracks

Immigrants with mental disabilities face hurdles even before immigration court. Any alien arriving in the U.S., who claims a fear of returning home, must pass a credible fear interview, part of the “expedited removal process” conducted by a DHS asylum officer, before a claim for asylum can be heard in immigration court. For an immigrant with mental disabilities, passing the credible fear interview process is difficult, as success depends heavily on the applicant’s ability to articulate a credible and coherent account of persecution that would qualify the applicant for asylum. Nonetheless, no protections exist for the large number of asylum seekers with mental disabilities.¹¹³

The lack of accommodation for mental disabilities in the credible fear interview process is particularly troublesome because the vast majority of asylum seekers do not have an attorney or other representative available. Even when an attorney or other representative is present, the outcome of the interview depends almost entirely on the conversation between the asylum officer and the applicant.

The story of Liliana¹¹⁴ illustrates why DHS must develop protections for individuals with mental disabilities in credible fear interviews. She was detained by DHS after fleeing severe domestic violence in Central America. Her abuser was involved with the drug cartel and used his connections to harm, torment, follow and threaten her. Liliana fled her country and came to the United States. At the time of her detention, she heard voices telling her to kill herself, was unable to sleep, and had difficulty functioning normally, often refusing to eat or leave her cell. At her credible fear interview, Liliana was unable to communicate her history of abuse. Liliana said the interviewer rushed her through the interview, and she felt like the interpreter did not understand her. She did not discuss the domestic violence she had suffered because it was too difficult to revisit the trauma.

During the appeal, Liliana felt as though the words she wanted to say were stuck in her head and she could not get them out. Liliana failed both interviews and was scheduled to be deported the following week. Fortunately, before she was deported, a legal services lawyer at the detention center was able to obtain a psychological evaluation, which was sent to the asylum office supervisor, as well as to the immigration judge. The asylum office supervisor quickly denied any request for review, stating that Liliana had been asked whether she suffered from any health issue that might affect her ability to communicate at the start of her interview and responded “no.” The judge was more receptive and issued a reversal of the decision after receiving the psychological evaluation. Without the help of her lawyer and the judge’s understanding of the situation, Liliana would have been deported within days of her last interview.

Liliana’s case demonstrates the significant impact a mental disability can have on a credibility determination. A process must be created to allow immigrants with mental disabilities a fair chance to pass credible fear interviews. Not only should asylum officers be more prepared to deal with immigrants with mental disabilities, a system should be in place for applicants with mental disabilities to bypass the credible fear process, to be given an advocate, or to be evaluated under a more lenient standard.

SECTION 3:

Ensuring Fair Treatment of Immigrants with Mental Disabilities in Immigration Court

“The impact of deportation upon the life of an alien is often as great if not greater than the imposition of a criminal sentence...Return to his native land may result in poverty, persecution and even death.”

—*Bridges v. Wixon*, 326 U.S. 135, 164 (U.S. Supreme Court, 1945)

“[D]eportation is a drastic measure and at times the equivalent of banishment or exile.”

—*INS v. Errico*, 385 U.S. 214, 225 (U.S. Supreme Court, 1966)

Care in detention is critical; fair process in immigration court is equally vital. Immigration court decisions can affect a lifetime, or even a life: preserving citizenship or stripping it away, uniting or separating families, securing protection for refugees or sending them back to persecution. Given the weight of these decisions, it is particularly important that immigration courts identify and accommodate immigrants with mental disabilities to ensure that they receive fair treatment and due process.

An individual deemed incompetent to fully participate in court proceedings needs special protections; however, competency should not be the only standard to accommodate mental disabilities. Mental disabilities that do not rise to the level of incompetency may still substantially interfere with a respondent’s presentation of her case in immigration court. For instance, in many cases survivors of torture suffer from debilitating disorders that make it impossible for them to relate their stories of persecution, or cause them to omit details that could lead an immigration judge to find the story not credible. Because so many immigrants are unrepresented in immigration court—84 percent of detained immigrants and 60 percent of immigrants overall are without counsel¹¹⁵—a mental health disorder can have a particularly devastating impact on the ability of an immigrant to receive a fair hearing.

As summarized at the end of this section, Texas Appleseed contributed to a recent national Appleseed report, *Assembly Line Injustice*, which documents the many problems with the U.S. immigration court system, from poorly trained judges to hostile DHS prosecutors, from inadequate translation to the prejudicial use of videoconferencing for hearings. Not surprisingly, our examination found that immigrants with mental disabilities struggle to receive a fair hearing in immigration court.

Case Study

The story of one Jamaican immigrant illustrates how the immigration system can fail respondents who suffer from mental illness. After about 20 years of living in the United States, he was placed into removal proceedings because he had committed petty criminal offenses such as turnstile jumping. He sought asylum because he feared violence and abuse if he returned to Jamaica. After the removal hearing, the immigration judge found that he suffered from a psychotic disorder, adult antisocial behavior, and mental retardation; he also suffered from seizures. The immigration judge also found that in Jamaica, there was little or no treatment for mental illness, that persons with mental illness are persecuted because Jamaican society views people with mental illness as victims of evil spirits, and that persons with mental illness suffer abuse in the Jamaican prison system. Based on these findings the immigration judge granted his request for asylum. DHS appealed the judge's order to the Board of Immigration Appeals, which vacated the grant of asylum and ordered the man removed on the grounds that if he just stops committing petty crimes, he won't be abused. The BIA demonstrated no understanding that his mental illness could be the cause of his petty criminal behavior or that such behavior could cease with proper treatment—treatment he couldn't get in Jamaica.

The problems we heard from practitioners and judges are twofold: first, immigration judges and DHS trial attorneys have very little time or training to recognize respondents suffering from mental disabilities; and second, only two regulations speak to the treatment of incompetent respondents, leaving immigration judges to improvise, at best, ways to help respondents with mental disabilities, which may or may not rise to the level of incompetency. All too often, these improvisations either compromise the rights of the immigrant or ignore the immigrant's mental disability altogether.

Legal Standard

When it is impracticable for the respondent to be present at the hearing because of mental incompetency, the attorney, legal representative, legal guardian, near relative or friend who was served with a copy of the notice to appear shall be permitted on behalf of the respondent. If such a person cannot reasonably be found or fails or refuses to appear, the custodian of the respondent shall be requested to appear on behalf of the respondent.

—8 C.F.R. § 1240.4

Legal Standard

The immigration judge shall not accept an admission of deportability from an unrepresented respondent who is incompetent...and is not accompanied by a guardian, relative, or friend; nor from an officer of an institution in which a respondent is an inmate or patient. When...the judge may not accept an admission of deportability, he or she shall direct a hearing on the issues.

–8 C.F.R § 1240.48 (b)

These two applicable regulations, which only minimally address the accommodation of respondents with mental disabilities in immigration court, are each limited to issues of competency. Based on these narrow regulations, immigration courts routinely find that an incompetent respondent's due process rights are satisfied if some representative appears on the respondent's behalf, regardless of the adequacy of the representation. The regulations do not require that the representative, be it an attorney, legal guardian or friend, have any knowledge of the immigration system, the respondent's mental illness, or be acting in the best interest of the respondent. Even more troubling, under current interpretation of these standards, courts have permitted detention center employees to represent respondents in deportation proceedings, a practice one immigration attorney described as "...really outrageous. That regulation needs to be wiped out and redone." An immigration judge related a similar story and echoed that sentiment in one of our interviews.

Allowing an admission of deportability from an incompetent respondent creates an ethical conflict for the respondent's attorney, who is under an obligation to "abide by a client's decisions concerning the objectives of representation" and thus cannot substitute their own judgment regarding the client's best interests.¹¹⁶ This potential conflict highlights serious deficiencies in the current system.

The current ad hoc system in immigration courts for respondents with mental disabilities fails to provide any meaningful guidance to respondents or their families, judges or attorneys. The system needs consistent procedures for recognizing and accommodating court respondents with mental disabilities.

"Immigration Judges are challenged to provide fundamental fairness to individuals who may not be able to represent themselves effectively and cannot obtain representation. Immigration Judges do so within a limited regulatory framework and with sparse precedent case law."

–Immigration Judge Mimi E Tsankov, Los Angeles Immigration Court,
"Incompetent Respondents in Removal Proceedings,"
Immigration Law Advisor, April 2009

POLICY RECOMMENDATION 11:

The U.S. Department of Justice should establish consistent procedures for recognizing respondents who may have mental disabilities.

Immigration judges must be given the tools to identify situations where an immigrant's mental disorder may interfere with his ability to participate in court proceedings. Under the current system so many immigrants are unrepresented in immigration court that the responsibility for detecting this situation falls on the immigration judge or DHS counsel in most cases.

"I think people with acute psychotic episodes are recognized....There are others with serious mental health issues who do not get recognized. I have a client with moderate to mild mental retardation. He had an IQ of between 60 and 70. He is an example of a person who will not get recognized. If he is not represented in court, he does not stand a chance."

—California Immigration Attorney

The current regulations do not provide practical guidance for immigration judges to identify immigrants with mental disorders, nor does it appear that any other meaningful guidance exists. In July 2009, in response to deficiencies in the system, more than 70 immigration and mental health advocacy organizations, including Texas Appleseed, submitted a letter to U.S. Attorney General Eric Holder proposing meaningful reforms for the immigration court system. In October 2009, the Executive Office for Immigration Review (EOIR) responded on the Attorney General's behalf, stating that "EOIR is presently focusing on providing training to all appropriate EOIR legal staff on mental health issues in removal proceedings,"¹¹⁷ but provided no information about the scope or content of the training. Indeed, in July 2009, an EOIR spokesperson told a Texas newspaper that no such guidelines exist. Immigration judges later indicated to us that any such training is minimal, at best, and does not give them the tools needed to identify immigrants with mental disabilities.

"There are no rules or any guidelines or any laws related to determining mental competency....When judges encounter someone who seems to be mentally incompetent, they do try as much as possible to arrange for some kind of pro bono counsel."

—EOIR Spokesperson, July 2009¹¹⁸

"The immigration judge didn't recognize there was a mental illness issue until we brought it up. If this guy hadn't been represented, he would have been out of here."

—Texas Immigration Attorney

Judges also lack clear procedural mechanisms to determine whether a respondent has a mental disability that may interfere with his ability to participate fully in the proceedings. For instance, there is nothing on the subject in the Immigration Judge Benchbook, a web-based resource maintained by EOIR that is intended to share “useful information with immigration judges to assist in the adjudication of immigration cases.”¹¹⁹ To the extent any discussion of applicable procedures exists in written immigration court decisions, this handful of opinions is limited to issues of legal competency and does not appear to be followed or distributed in any meaningful way to provide guidance to immigration courts.

“I think immigration judges want guidance on these issues too, because most of them care about doing a good job and want to do right by people.”¹²⁰

– California Immigration Attorney

Both the detention and the immigration court systems can improve the chances for immigrants with mental disabilities to receive a fair hearing.

Implementation Strategies:

First, mental health professionals, other officials in detention centers and DHS trial attorneys can help immigration judges recognize when a detainee with mental disabilities may need assistance in immigration court.

Accordingly, ICE or DIHS should:

- Provide notice to the immigrant’s counsel or, if unrepresented, to the immigration court that a respondent is receiving mental health treatment or otherwise has a mental disability. Notice should be provided as soon as detention center medical staff has knowledge of the detainee’s condition.
- Develop a HIPAA-compliant standardized authorization form for use by all mental health providers in the immigration detention system. Before providing notice to the immigration court, DIHS must first obtain authorization permitting the disclosure of a respondent’s mental health records. To protect the immigrant’s privacy, any notice to the immigration court should state simply that the immigrant has a mental disability or has received mental health treatment in the facility.
- Promulgate regulations to impose duties on DHS trial attorneys to provide to respondent, and respondent’s counsel or guardian (if applicable), all health information about the respondent to which the DHS attorney has access.
- Promulgate regulations to impose duties on DHS trial attorneys to notify respondent’s counsel, if any, or the immigration court if DHS has a “bona fide doubt” that a respondent with a mental disability can participate fully in the hearing, a standard similar to that used in criminal proceedings.¹²¹

- Provide DHS trial attorneys with at least five hours of training per year on issues related to mental disability and the immigration process, including how to recognize signs of mental disability and how to appropriately question respondents with mental disabilities.

Second, the Executive Office for Immigration Review (EOIR) also can ensure that immigration judges are properly trained to handle cases involving immigrants with mental disabilities. Accordingly, EOIR should:

- Provide immigration judges with at least three hours of training per year on issues related to mental disabilities and the immigration process, including how to recognize the signs of mental disability and how to ensure a fair hearing for respondents with mental disabilities. Judges assigned to a mental health docket, discussed below, should have at least eight hours of training per year.
- Incorporate in-depth training on recognizing of mental disabilities and procedures for handling respondents with mental disabilities into existing conferences for immigration judges. EOIR should also provide training in special seminars or webcasts and in the Immigration Court Practice Manual, Immigration Judge Benchbook, and BIA Practice Manual. Training materials should also be provided to EOIR staff members.¹²²
- Develop a set of questions for the Immigration Judge Benchbook that will guide questioning to elicit responses that would indicate the need for further inquiry into a potential mental disability.¹²³
- Train immigration judges to understand limitations on the ability of respondents with mental disabilities to provide credible testimony, and to ensure that negative credibility determinations are not based on a respondent's limitations. In particular, immigration judges should be instructed that some asylum-seekers are unable to express fear or recount past persecution because of trauma or other mental disabilities, and that such difficulties should not lead to negative credibility findings.

POLICY RECOMMENDATION 12:

The U.S. Department of Justice should establish standards for proceeding once a court recognizes a mental disability.

The federal statutes and regulations provide little to no guidance regarding the evaluation, representation or examination of respondents with a mental disability, nor has EOIR or the Board of Immigration Appeals issued any binding authority on these issues. The controlling law requires only that immigration proceedings satisfy the most basic protections of due process and that respondents be given an opportunity to present, examine and object to evidence. No guidance exists for determining when a respondent's mental disability impairs his or her right to a fair hearing. The Attorney General currently has authority under the Immigration & Nationality Act to adopt regulations "to protect the rights and privileges" of incompetent respondents, and should act under that authority.¹²⁴

The U.S. immigration court process is complicated and can be difficult for an unrepresented respondent with no mental disabilities to navigate. It is a nearly impossible challenge for an immigrant with a mental disability. Indeed, one practitioner opined that DHS trial attorneys view incarcerated immigrants with mental disabilities as “easy targets.” That same practitioner recounted the story of a detainee who was classified as “slightly mentally retarded;” he said that the immigration judge attacked his client’s credibility and found him to be competent. The concepts of legal competency and mental disability that interfere with the presentation of testimony present distinct issues, but both require accommodation in immigration court.

“A lot of judges would like competency hearings. What happens, though, when a respondent is found incompetent? There is no process right now to accommodate that finding.”

–Texas Immigration Attorney

Establishing a separate docket and procedures to adjudicate cases involving immigrants with mental disabilities would bring fairness and efficiency to the process. Separate immigration court dockets are currently used for unaccompanied minors and detained immigrants, allowing judges to learn to identify issues particular to the relevant population. A mental health docket can be established to adjudicate any case in which an immigration judge suspects or is alerted to the fact that a respondent suffers from a mental disability. Separate dockets with specially trained judges would allow those judges to develop a more specialized knowledge of the procedures and concerns relevant to competency and capacity. A mental health docket would allow a judge to conduct more focused hearings, helping to ensure fair proceedings for respondents with mental disabilities.

“[T]here are a lot of mental health cases [in the detention facility]. It is a slower docket. In [that facility], you could justify a separate docket. We have 20 cases in a master here. If you have an impairment docket, there would only be five cases in the morning. Those cases should be heard separately and take longer.

–Immigration Judge

Once a respondent’s mental disability is recognized and the case is transferred to the mental health docket, the immigration judge should conduct an initial capacity hearing to determine whether the respondent’s mental disability may impair his ability to represent himself in the immigration court proceedings. Whether the respondent has the ability to represent himself or not presents a question separate from whether the respondent is competent. Indeed, the United States Supreme Court recently recognized the wisdom in having different standards for competency to stand trial and the capacity to represent oneself, holding “that the Constitution permits judges to take realistic account of the particular defendant’s mental capacities by asking whether a defendant

who seeks to conduct his own defense at trial is mentally competent to do so.”¹²⁵ If the immigration judge finds that the respondent’s ability to represent himself is impaired, and the respondent is unable to obtain his own counsel, counsel should be appointed.

Appointment of counsel would represent a significant change in immigration law. Current federal regulations provide for the right of access to counsel, but only at the respondent’s own expense. Immigration courts now have no regulatory authority to appoint counsel or a guardian for a respondent, regardless of the respondent’s mental capacity or ability to pay. A necessary component of our recommendations is an amendment of the federal regulations to allow for the appointment of counsel and guardians by immigration judges. The Petition for Rulemaking to Promulgate Regulations Governing Appointment of Counsel for Immigrants in Removal Proceedings submitted to the U.S. Department of Justice (DOJ), dated June 29, 2009, requests that current regulations be amended to provide for the appointment of counsel where necessary for the fundamental fairness of the proceedings. The DOJ should act on these proposed regulations immediately, at least to require appointment where the immigration judge finds that respondent with mental disabilities cannot afford counsel and will be unable to receive a fair hearing without representation.

Given the issues at stake, all persons in removal proceedings should be represented by counsel. We recognize the practical difficulties of providing counsel to all indigent respondents, but fundamental fairness dictates that those least able to advocate for themselves, including immigrants with mental disabilities, be represented.

Case Study

Bernard, who suffered from a psychotic disorder, was deemed incompetent by a Massachusetts criminal court to stand trial and sent to a hospital for psychiatric treatment. The day after Bernard arrived at the hospital, he was detained by ICE, removed from the hospital, and moved 2,000 miles away. Bernard’s immigration attorney could only demonstrate that he was prematurely removed from the hospital by obtaining information from Bernard’s prior criminal lawyer. Bernard, because of his mental disability, would not have been capable of obtaining or presenting evidence regarding his premature removal from the hospital without assistance from an attorney, and likely would have been unjustly deported.¹²⁶

Establishing a clear procedure for appointing counsel and evaluating competency would not only make immigration proceedings more fair, it would make them more efficient.

Case Study

A Texas immigration attorney described a case involving a client who suffers from schizophrenia. “In late August, the court called and asked me if I could come to the courtroom where the client was appearing for a hearing. The judge asked if I was willing to go speak to this client at the detention center. The judge made it clear to me that he was concerned about the client’s mental health. By the time the respondent was represented by an attorney, he had attended at least six court hearings with no progress in his case.” Once the attorney became involved, she was able to establish that the respondent suffered from schizophrenia and was indeed incompetent, and the case was able to proceed.

After the respondent obtains counsel, the immigration court should then hold a competency evaluation and hearing if necessary. While some immigration courts have held competency hearings, immigration judges currently have no guidance for when or how to determine whether a respondent is incompetent. DOJ should adopt regulations for competency hearings, looking to well-developed standards in criminal law. Indeed, at least one South Texas immigration court used these standards to determine whether a respondent in removal proceedings was competent. The standard of competency applied in criminal trials asks whether the respondent has (1) sufficient present ability to consult with his lawyer with reasonable degree of rational understanding, (2) the capacity to assist in preparing for his defense, and (3) a rational as well as factual understanding of the proceedings against him.¹²⁷

As in criminal proceedings, an immigration court competency evaluation should be conducted by an independent licensed or certified psychiatrist or psychologist, designated by the immigration judge, at the government’s expense and for the sole purpose of determining competency. For instance, the federal criminal code requires that a licensed or certified professional conduct a competency evaluation at the state’s expense in criminal cases.¹²⁸ To facilitate the competency evaluation process, the Executive Office of Immigration Review (EOIR) should maintain a list of qualified mental health professionals, independent of ICE or IGSA medical staff, who can be called on for competency hearings in immigration court. The list should include mental health professionals for each region where detention facilities are located. The respondent should also be permitted to request an additional examination by an examiner of his choice at his own cost.

Following the completion of the competency evaluation, the immigration judge should hold a competency hearing to evaluate the respondent’s mental competence. As is the case with any immigration hearing, a detainee in a competency hearing in immigration court should be afforded the opportunity to testify, present evidence, call witnesses, and confront and cross-examine witnesses appearing at the hearing. After the hearing the immigration judge should make findings of fact and determine whether the respondent is mentally incompetent.

If the immigration judge finds that the respondent is incompetent, the immigration judge should then appointment a guardian ad litem, separate from the respondent’s

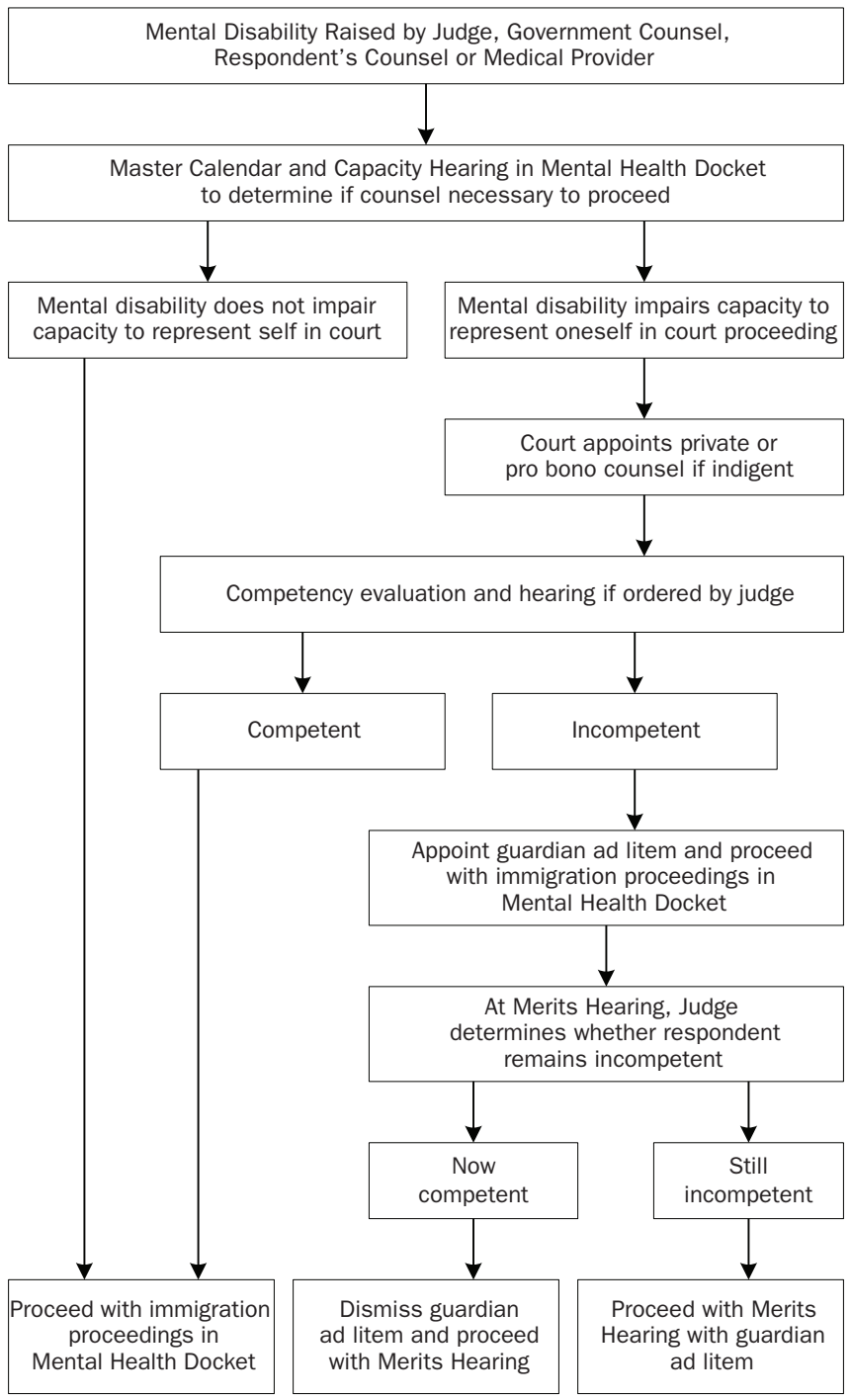
counsel. The guardian ad litem should be either a volunteer advocate, who has been certified by EOIR as a volunteer advocate; a professional, other than an attorney, who holds a relevant professional license and whose training relates to the determination of the best interests of a person with mental disabilities; or an adult having sufficient training and expertise as determined by the immigration judge to represent the best interests of the respondent.

Requiring the appointment of a guardian ad litem in addition to the respondent's counsel in cases of incompetency allows for a proper attorney-client relationship.¹²⁹ Ethical considerations limit the ability of counsel to act in the best interests of the client if such action conflicts with the client's expressed wishes. Appointing a guardian removes this potential ethical conflict because the guardian stands in the shoes of the mentally incompetent respondent, providing direction to the attorney. If possible, the guardian ad litem will represent the respondent based on his expressed interests. If the respondent is unable to express his interests, the guardian ad litem will represent the respondent based on his best interests.

Once a respondent is deemed incompetent, DIHS should use its best efforts to ensure that the respondent receives appropriate mental health care while awaiting his merits hearing, with a goal of restoring the respondent to competency whenever possible. These efforts should include placement in an appropriate mental health facility when warranted. At the merits hearing, but prior to conducting the hearing, the immigration judge should reassess the respondent's competency. If the immigration judge finds the respondent has regained competency, the immigration judge should dismiss the guardian ad litem and proceed with the merits hearing. If the immigration judge finds that the respondent remains incompetent, the merits hearing should proceed with the guardian ad litem representing the respondent's interests.

Capacity and competency hearings discussed above will necessarily require disclosure of a respondent's mental health status and records to the court and counsel. Therefore, procedures governing capacity and competency hearings should include rules limiting the use of the competency evaluation, and any other records relating to respondent's mental health status, to the competency hearing, unless the DHS trial attorney is otherwise entitled to those records. The rules should specifically prevent DHS trial attorneys from using a finding of mental disability, or the results of a mental health evaluation, against a respondent. For example, current immigration law renders inadmissible (to the U.S.) an immigrant with a mental disorder that may pose or may have posed a threat to the property, safety or welfare of the respondent or others.¹³⁰ Information obtained to determine mental competency, and not otherwise available to DHS counsel, should not be used later as evidence of inadmissibility.

Proposed Process Once Mental Disability Raised with the Court



The Executive Office for Immigration Review (EOIR) can improve the fairness of removal proceedings for respondents with mental disabilities.

Implementation Strategies:

The EOIR should:

- Create a special mental health docket which should be assigned all cases in which a concern has been raised regarding the respondent's mental capacity. This docket should be presided over by a judge with specialized training regarding mental health issues, and have an appropriate caseload considering the difficulty of issues presented.
- Develop procedures for capacity hearings. An initial capacity hearing should be conducted for all respondents on the mental health docket to determine whether the respondent's mental disability impairs her ability to represent herself.
- Adopt regulations allowing for appointment of counsel and guardians.
- Promulgate regulations allowing immigration judges to appoint counsel for respondents with mental disorders who are deemed unable to represent themselves at the capacity hearing. If a respondent is indigent and cannot access pro bono counsel within a reasonable time, the immigration court should appoint counsel at the government's expense.
- Require that any case in which an immigrant with mental disabilities is not provided counsel, subsequent to establishing a new right to counsel, be re-opened to allow for a rehearing. At the rehearing, the respondent will be represented by counsel without requiring any specific showing of prejudice.

EOIR should develop procedures for assessing competency that:

- Require competency evaluations and hearings to be conducted after counsel has been appointed when a respondent's competency is in question.
- Develop procedures, similar to current criminal procedures, for the conducting of competency evaluations and hearings.
- Maintain a list of psychiatrists/psychologists, independent from ICE and IGSA medical staff, who are qualified to conduct competency evaluations for each region where there are detention facilities located.
- Require the appointment of a guardian ad litem for any respondent found to be incompetent.
- Promulgate standards that limit use of a respondent's competency evaluation, mental health records and testimony in a competency or capacity hearing. This information should be used only in the context of a capacity or competency hearing, unless the DHS trial attorney is otherwise entitled to the information.

- Require that the immigration judge reassess a respondent’s competency at the merits hearing. If, at the merits hearing, the immigration judge finds the respondent is no longer incompetent, the judge should dismiss the guardian and proceed with the hearing. If the immigration judge finds that the respondent remains incompetent, the hearing should proceed with the guardian ad litem.

POLICY RECOMMENDATION 13:

The U.S. Department of Justice should establish procedures for meaningful collection of data regarding respondents with mental disabilities in the immigration system.

Interviews with immigration judges and practitioners indicate that no one knows how many immigrants with mental disabilities and mental competency issues are processed through the immigration system each year. One immigration judge reported seeing only two respondents with severe mental health issues in two decades on the bench. Local immigration court practitioners strongly disputed that notion, asserting instead that many unrepresented respondents with mental disabilities are not recognized in a system laden with huge caseloads and system backlogs. Another immigration judge estimated that as many as 20 percent of respondents in detained dockets have mental disabilities. EOIR needs improved data collection mechanisms to better quantify the number of immigration respondents facing challenges in the court system due to mental disabilities or competency issues.

What is “Code 53?”

Code 53 is an EOIR code used to signify that a case has been “adjourned because the Department of Homeland Security (DHS) requests a certification of the alien’s mental competency.” One immigration judge uses Code 53 when asking DHS to conduct a competency assessment. Another immigration judge admitted only recently learning about the code despite many years on the bench.

EOIR Data on Code 53 Cases in Texas and Nationally

Immigration Court	2006	2007	2008
El Paso	8	2	2
Houston	0	1	2
San Antonio	0	0	3
Total-Texas	8	3	7
Total-USA	97	101	82

Source: EOIR

Cases allocated a mental competency-related adjournment code account for only a small fraction of the cases in immigration court. In FY 2009, U.S. immigration courts received 327,735 new cases and completed 290,233.

Implementation Strategies:

The EOIR should improve data collection mechanisms and:

- Allow more than one code to be applied to cases.
- Create a new code that indicates a competency hearing was held in a case.
- Create new codes that fine tune existing ones. For example, adjournment code 01, adjourned for alien to seek representation could include an additional sub code if mental competency issues are suspected or recognized

Assembly Line Injustice: A Blueprint To Reform America's Immigration Courts

In 2009, Texas Appleseed and Akin Gump contributed to the report *Assembly Line Injustice* issued by Appleseed and Chicago Appleseed,¹³¹ which chronicled systemic problems in the U.S. immigration courts, from inadequate resources and training for immigration judges to poor in-court translation. The conclusions and recommendation in *Assembly Line Injustice* are relevant to all immigrants who encounter the immigration court system, but two issues identified in the report apply with particular force for immigrants with mental illness and bear repeating briefly here.

Videoconferencing. Conducting immigration court hearings via videoconference, where the judge in the courtroom can only see and communicate with respondents via a television screen, has become a widespread practice. *Assembly Line Injustice* recommends eliminating the use of videoconferencing to conduct immigration court hearings where an immigrant's right to relief is decided ("merits hearings"). Using videoconferencing makes it even more difficult for immigration judges to detect whether or not an immigrant has a mental disability that can impair his or her capacity to participate fully in immigration court. Separating an immigrant from the courtroom makes identifying and accommodating a mental disability nearly impossible. The evaluation of a respondent's mental health, as well as the merits of his claims, depends in large part on determinations regarding the credibility of the respondent. Videoconferencing makes it difficult for immigration judges or mental health professionals to make credibility determinations and to analyze demeanor. Further, videoconferencing dehumanizes the respondent and distances immigration judges from the proceeding.

As one practitioner stated, "[Videoconferencing] allows immigration judges to distance themselves from the humanity of it all." Another noted that "[videoconferencing] is institutionalized processing designed to deport people faster."

Exercise of Prosecutorial Discretion by DHS Trial Attorneys. One of the problems that clogs immigration court dockets is the endemic refusal by many DHS trial attorneys to exercise prosecutorial discretion and prioritize cases. *Assembly Line Injustice* reported that DHS trial attorneys "invariably seek the worst outcome possible for the immigrant and unnecessarily drag out cases by litigating every issue," a practice that can only compound the problems faced by immigrants with mental disabilities in immigration court. By changing their attitude from "deport at all costs" to finding a just result within the law, DHS trial attorneys can improve the situation faced by immigrants with mental disabilities. Specifically, DHS trial attorneys should be instructed, both by policy memorandum and by encouragement from district chief counsel, to help the court to ensure that every immigrant is capable of understanding the hearing and participating fully, and to help determine the best outcome under the law for an immigrant with mental disabilities.

SECTION 4:

Ensuring Safe Release or Repatriation of Detainees with Mental Disabilities

When an immigrant with a mental disability is released from detention, relief may quickly give way to panic. ICE simply allows detainees to walk out the door when released, or takes them to a nearby bus stop, without sufficient opportunity to contact their families or lawyers. Immigrants who are deported may fare worse, suffering the shock of dislocation as well as being transported without appropriate medication and few safeguards to ensure continued care upon repatriation. The problems faced by immigrants with mental disabilities upon release and removal are related, yet present slightly different difficulties. In both cases, DHS needs to recognize a continuing obligation to ensure that the detainees it releases or removes are not put in danger.

POLICY RECOMMENDATION 14:

ICE should adopt clear procedures governing safe domestic release of detainees.

We heard a number of accounts of immigrants with mental disabilities left to their own devices upon release, some of whom had been transferred thousands of miles from their communities. Such a trip home, daunting under any circumstances, is made even more difficult when the facility does not give assistance, including cash, to detainees upon release; even for those who carried cash at the time of arrest, many receive only a check they rarely can cash immediately. Such release practices are especially problematic for detainees with mental disabilities who are confused as to where they are, where they should go, and how to reach their destination.¹³² Detainees are put into danger because ICE has no policies or protocols to ensure that they can safely return to their communities.

ICE release procedures focus mainly on administrative details such as processing mandated paperwork and returning personal property to detainees. The few measures prescribed to help ensure the safety of detainees upon release are implemented so carelessly as to be ineffective.

ICE Policy

When a detainee is released from the facility, the facility shall ensure that the release point is an acceptable one. Facilities that are not within a reasonable walking distance of, or that are more than one mile from, public transportation shall transport detainees to local bus/train/subway stations prior to the time that the last bus/train leaves such stations for the day. If public transportation is within walking distance of the detention facility, detainees shall be provided with an information sheet that describes those transportation services. Upon release, detainees shall also be provided with a list of shelter services available in the immediate area. Prior to their release, detainees shall be given the opportunity to make a free phone call to a friend or relative to arrange for pick up from the facility.

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Upon transfer to another facility or release, the medical provider shall ensure... at least 7 days'...supply of medication shall accompany the detainee.

—PBNDS, *Part 2.4.VH.11 and Part 4.22.VS*

The above standard is insufficient to ensure the safety of detainees with mental disorders, especially for those who may not be able to orient themselves, travel on their own, or access adequate care or medication. For instance, the Performance Based National Detention Standards (PBNDS) allow detainees a free phone call to a friend or relative before release to arrange for pick up, but in practice this call can often be made only at the last minute, if at all.

Case Study

Immigration attorneys offered a host of stories about detainees with mental disabilities who ran into mishaps upon release, including the following:

- A detainee with schizophrenia, speaking only Russian, was left alone at 1 a.m. at a bus station in a dangerous part of town with only the clothes she was wearing.
- A man unable to orient himself went missing for a week after his release in Texas before he finally reached his family in Maryland, thanks to the detailed itinerary his lawyer had given him before he embarked on his journey. No one knows where he was that week.
- A refugee with severe mental limitations was released by ICE at a gas station without any money. His lawyer found an unintelligible message on her cell phone late one Friday night and managed to recognize the voice of her client. She immediately called the detention center, and was told where he had been released. She eventually reached a nun at a local refugee house who agreed to pick him up—a challenging enterprise, as the client refused to follow someone he did not know.

The PBNDS do not specify how much notice should be given to the detainee before release or what the procedure should be for detainees who could not immediately reach someone able to pick them up. The PBNDS mandate that a list of nearby shelters be given to detainees upon release, but no further action is required to ensure that the detainees will be able to reach, and be accepted by, a shelter. We heard stories of detainees released at night, in an area they do not know, and without means of transportation. The PBNDS identify as acceptable release points local bus, train or subway stations prior to the time that the last bus or train leaves for the day, or release directly from the detention facility itself if it is within “walking distance” of such station, even though such places may be unsafe or isolated. We heard reports that because of the prevalence of nighttime release, detainees regularly end up spending the night at the station; in many small towns this “station” is merely a gas station or a truck stop.

ICE has the responsibility to ensure that detainees in its care and custody are not put into harm’s way upon release, a responsibility that is particularly critical for immigrants with mental disabilities. Better treatment upon release is mostly a matter of common sense, not complicated protocol, but standards must be adopted, disseminated and enforced.

Implementation Strategies:

Detainees with mental disabilities should:

- Be released in their community of origin. In cases where a detainee has been transferred away from his community, ICE should take responsibility for returning that immigrant to the place of apprehension, unless otherwise requested by the immigrant.
- Be released to a family member, a responsible party or a mental health facility with adequate notice. ICE should give known family members or responsible parties advance notice sufficient to allow them to meet the detainee at the point of release from ICE custody. In cases where no family member or other responsible party is available and the detainee has a profound mental disability, the detainee should be released directly to a mental health or a medical facility.
- Be released with a copy of their medical records and a four-week supply of medication.

Detention center medical staff should:

- Ensure that detainees have clear instructions for using the medications, including dosage and frequency.

POLICY RECOMMENDATION 15:

ICE should ensure safe repatriation of immigrants with mental disabilities.

The problems we found with ICE’s release practices were repeated in its deportation process, despite the existence of guidelines for the removal of immigrants with mental disabilities. Both internal guidelines and international laws relating to repatriation

should prevent ICE from putting immigrants with mental disorders in these types of dangerous situations.

ICE Policy

A presentation should be made in cases involving mentally ill aliens if the passport is valid. This should include a medical and clinical summary from the place of hospitalization. Arrangements should be made through the consular office in the United States for possible hospitalization upon arrival at foreign port. Advance travel arrangements are required.

–ICE Office of Detention and Removal, 2006 Detention and Deportation Field Manual

Additionally, various international conventions, such as the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol, and customary international law prohibit refoulement (forced return to a country where a person faces persecution). The Convention Against Torture prohibits return if it exposes the immigrant to a risk of cruel, inhuman or degrading treatment or punishment, torture or arbitrary deprivation of life. While the law on the scope of refugee protection afforded individuals with mental disabilities is evolving, some courts have indicated that these persons may belong to an identifiable “social group” and thus qualify for protection. At the very least, ICE should guarantee that these individuals are not removed to countries where they will be mistreated.

Case Study

A delusional Mexican national suffering from schizophrenia was deported to Mexico without any provision for his continued care. He still remains missing two years later. The immigrant’s father had arranged with ICE for his son’s voluntary departure by plane to Mexico, where he was to be picked up by his mother. When the father called the ICE deportation officer to confirm the travel arrangements, he was told that his son had been deported four days earlier than originally planned, due to the vacation plans of his deportation officer. The father, realizing that his son would be unable to orient himself if dropped off at an airport and would be at great risk of getting lost, attacked or killed, immediately made desperate attempts to locate his son. His efforts, seconded by his family in Mexico, have not been successful, though the body of a young man who fits his son’s description (but who allegedly died days before the deportation) remains in a morgue in Tijuana.

Numerous reports and experts also indicate that ICE increases the risk to some detainees with mental disabilities during repatriation by allowing unlicensed immigration personnel, who do not have access to or adequate understanding of the detainees’ medical files, to administer drugs without proper medical supervision. Some detainees are not provided with sufficient drugs upon release, and even those who are may not have sufficient understanding of proper dosage.

“Once you are out, you are out. They were supposed to give two weeks of meds (to a detainee upon release). The 59-year-old man with schizophrenia had other physical ailments. He was sent back to Trinidad after not being there for 40 years with a bag full of different meds. Nurses commented that he would not be able to figure out what to do with those meds.”

– Detention Center Nurse

Repatriation must be performed responsibly, and with an understanding of the unique needs of individuals with mental disabilities.

Indefinite Detention After a Removal Order

Immigrants who are ordered removed, but cannot be repatriated within six months, are entitled to be released from detention under Supreme Court precedent.¹³³ DHS regulations require a review of post-removal order custody at 90 days and 180 days to determine whether the detainee is likely to be removed in the reasonably foreseeable future and is cooperating with removal efforts, and, if released, would be a danger to the community or a flight risk.¹³⁴ Reports by both governmental and non-governmental organizations have shown that DHS does not fully comply with these requirements, leaving many immigrants detained for longer than 180 days after they have been ordered removed.¹³⁵ Immigration attorneys reported that detainees with mental disabilities fare particularly poorly in this regard, some languishing in detention far longer than the presumptive six-month post-removal order detention period. In some cases, unnecessarily lengthy detention is caused by ICE’s failure to consider the inability of an immigrant with mental disabilities to cooperate with the removal process by, for example, providing accurate information to obtain home country travel documents. On the other hand, we learned of one case in Texas where ICE worked with a detainee’s attorney to release him to receive appropriate care when it became clear that his mental disability precluded him from providing information to establish his true identity and his country of origin. We urge ICE to train all officers responsible for post-removal order custody determinations to consider an immigrant’s mental disability when judging whether the detainee is sufficiently cooperating with removal efforts, or poses a danger to the community or a flight risk.

Implementation Strategies:

ICE should adopt and enforce the following removal policies:

- Notice of removal should be given to a family member, a responsible party, a mental health facility, or the relevant consulate sufficient to ensure continuity of care upon repatriation. This notice should include any information needed to help organize the detainee’s trip home and subsequent reintegration into the society and health care system in their country of origin.

- Drugs should be given to detainees before deportation only with proper medical prescription and supervision. ICE policy, adopted in 2008 after a lawsuit was filed by deportees who had been drugged against their will, requires a court order before administering drugs to deportees. Consistent with this policy, drugs should be administered only as prescribed and by licensed personnel.
- Deportees requiring medications should be provided at least a four week supply of medication. Medical staff should ensure that detainees have clear instructions for using the medications, including dosage and frequency. This will assist with continuity of care upon repatriation.
- ICE should ensure that it complies with the United States' international obligations and refrain from repatriating an immigrant with a mental disability who may be at risk of harm and persecution in his country of origin on account of his mental disability. Furthermore, the Department of Justice and the Department of Homeland Security should provide further guidance or regulations on situations where a mental disability constitutes an appropriate basis for a claim of refugee status or other relief.

CONCLUSION

“The measure of a country’s greatness should be based on how well it cares for its most vulnerable populations.”

– Mohandas Gandhi

Our year-long investigation revealed that immigrants with mental disabilities fare poorly in all facets of the U.S. immigration system, from apprehension to detention, from adjudication to release. This vulnerable population presents unique challenges to the immigration system. Texas Appleseed and our team of Akin Gump pro bono attorneys are offering specific recommendations and implementation strategies to ensure that this vulnerable population is promptly identified, their mental health needs more quickly and appropriately addressed in the least restrictive environment, their cases adjudicated with greater attention to fairness and due process, and their health and safety protected upon release or deportation.

The federal government already acknowledges that changes are needed to the immigration court and detention system. We believe immigrants with mental disabilities are deserving of special protections under the law, and that these safeguards must be part of any systemic overhaul. Ultimately, the success of any reforms to the immigration system must be measured—openly and with accountability—by how the system treats the most vulnerable populations, including those with mental disabilities.

END NOTES

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- 3 Asylum seekers suffering from post-traumatic stress disorder, for instance, are often re-traumatized by being jailed upon arrival in the United States. *See e.g.*, "From Persecution to Prison: The Health Consequences of Detention on Asylum Seekers," Physicians For Human Rights & The Bellevue/NYU Program for Survivors of Torture (June 2003), *available at*: <http://physiciansforhumanrights.org/library/documents/reports/report-perstoprison-2003.pdf>. ("[T]he mental health of asylum seekers...was extremely poor and worsened the longer that individuals were in detention. The study also raises concerns about the manner in which asylum seekers are treated...in detention. These findings support assertions that detention has a harmful impact on the health and well-being of asylum seekers.")
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- 5 "Immigration Detention Overview and Recommendations," Dora Schriro, Director of the Office of Detention Policy and Planning, U.S. Immigration & Customs Enforcement (Oct. 6, 2009), *available at*: http://www.ice.gov/doclib/091005_ice_detention_report-final.pdf (hereafter "2009 Schriro Detention Report").
- 6 2009 Schriro Detention Report at 11-13 (explaining that 60 percent of aliens detained by DHS come through the Criminal Alien Program, which identifies immigration violators within U.S. prison systems, and 287(g) agreements, which empower local officials to enforce federal immigration law. Not all of these aliens have criminal convictions, and the vast majority are non-violent.)
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- 8 1996 Illegal Immigration Reform & Immigrant Responsibility Act (IIRIRA), H.R. 3610; Pub.L. 104-208; 110 Stat. 3009-546.
- 9 "2002 Review of Department of Justice Immigration Detention Policies," Hearing on the Subcommittee on Immigration and Claims of the Committee on the Judiciary of the U.S. House of Representatives (Dec. 19, 2001), *available at*: http://commdocs.house.gov/committees/judiciary/hju76810.000/hju76810_0f.htm. Note that in 1994, ICE did not exist, but rather was part of the Immigration & Naturalization Service ("INS").
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- 11 *Compare* 2009 Schriro Detention Report at 10 (380,000) *with* "Immigration and Custom Enforcement Policies and Procedures Related to Detainee Transfers," DHS Office of Inspector General, OIG-10-13 (Nov. 2009) *available at*: http://www.dhs.gov/xoig/assets/mgmttrpts/OIG_10-13_Nov09.pdf (442,000) (hereafter "2009 DHS OIG Detainee Transfer Report")
- 12 2009 Schriro Detention Report at 10.
- 13 *Compare* Immigration Detention: Can ICE Meet Its Legal Imperatives and Case Management Responsibilities, Migration Policy Institute (Sept. 2009) *available at*: <http://www.migrationpolicy.org/pubs/detentionreportSept1009.pdf> (estimating cost at \$141) *with* "ICE: Tab to Remove Illegal Residents Would Approach \$100B," *available at*: <http://www.cnn.com/2007/US/09/12/deportation.cost/index>.

- html, (quoting ICE spokesman estimate of daily detention cost at \$97). Notably, while the Schriro Report discusses detention cost, it provides no cost estimates on a daily or annual basis. *See* 2009 Schriro Detention Report at 11.
- 14 ICE Budget Fact Sheet—FY 2010, *available at*: <http://www.ice.gov/doclib/pi/news/factsheets/2010budgetfactsheet.doc>.
 - 15 2009 Schriro Detention Report at 6 n.5 (reporting that as of Sept. 1, 2009, 51 percent of ICE detainees had felony convictions, only 11 percent of which were for serious violent crimes).
 - 16 “U.S. Immigration & Customs Enforcement: 2009 Immigration Detention Reforms,” (Aug. 6, 2009), *available at*: http://www.ice.gov/pi/news/factsheets/2009_immigration_detention_reforms.htm (hereafter “ICE Aug. 2009 Detention Fact Sheet”)
 - 17 2009 DHS OIG Detainee Transfer Report; ICE Aug. 2009 Detention Fact Sheet.
 - 18 2009 Schriro Detention Report at 10.
 - 19 2009 Schriro Detention Report at 10, n.6.
 - 20 2009Schriro Detention Report at 6.
 - 21 Interview with Tom Barry, Center for International Policy on FRESH AIR, with Terry Gross, National Public Radio (Dec. 10, 2009), *available at*: http://public.npr.org/anon.npr-mp3/npr/fa/2009/12/20091210_fa_01.mp3.
 - 22 2009 Schriro Detention Report at 10. Note that the Schriro Detention Report indicates that ICE uses “over 300 facilities,” while the ICE Aug. 2009 Detention Fact Sheet, released just two months prior, lists the number at “as many as 350.” Our examination found many disturbing examples of inconsistency in ICE understanding of basic detention facts.
 - 23 2009 Schriro Detention Report at 10.
 - 24 *See* U.S. Immigration & Customs Enforcement, “Performance Based National Detention Standards Frequently Asked Questions,” *available at*: <http://www.ice.gov/PBND/faq.htm> (visited Dec. 12, 2009) (hereafter “ICE PBND FAQ”).
 - 25 *See* Letter from Jane Holl Lute, Deputy Secretary, U.S. Department of Homeland Security to Michael Wishnie and Paromita Shah, Re: “Petition for Rulemaking to Promulgate Regulations Governing Detention Standards for Immigration Detainees,” (July 24, 2009) *available at*: <http://www.clearinghouse.net/chDocs/public/IM-NY-0045-0004.pdf>.
 - 26 Since 2001, DHS and its predecessor agency, the Immigration and Naturalization Service (“INS”), have been repeatedly found to be in violation of the NDS and PBND by both governmental and non-governmental inspections. *See, e.g.*, “Treatment of Immigration Detainees and Customs and Immigration Enforcement Facilities,” Office of Inspector General, Department of Homeland Security, OIG-07-01 (Dec. 2006), *available at*: <http://trac.syr.edu/immigration/library/P1598.pdf> (finding violations of health care standards at 4 of 5 facilities reviewed).
 - 27 2009 Schriro Detention Report at 3.
 - 28 *See, e.g.*, *The Washington Post* Series, “Careless Detention: Medical Care in Immigration Prisons,” (May 2008) *available at*: <http://www.washingtonpost.com/wp-srv/nation/specials/immigration/index.html>.
 - 29 Immigration and Customs Enforcement, “Detainees Who Died in ICE Custody: October 2003-Present,” AILA InfoNet Doc. No. 10012230 (posted on 1/22/10).
 - 30 Testimony of Alicia Puente Cackley, Director of Health Care, U.S. Government Accountability Office, before the Subcommittee on Homeland Security, Commission on Appropriations, House of Representatives at 3 (March 3, 2009) *available at*: <http://www.gao.gov/new.items/d09401t.pdf> (hereafter “March 2009 GAO Testimony”).
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 - 32 Notice of Privacy Act System of Records, Alien Medical Records System of Records, 74 Fed. Reg. 57688 (Nov. 9, 2009).
 - 33 *Compare* 2009 Schriro Detention Report at 25 (describing DIHS as “a unit within Public Health Services (PHS) . . . [that is] detailed to ICE by means of a memorandum of understanding” with March 2009 GAO Testimony at 3 (stating that Memorandum of Understanding terminated in 2007, and “ICE now has a component known as DIHS which provides health care services to detainees”), with ICE Website, “Detention & Removal,” (describing DIHS as “located within the Bureau of Primary Health Care of the Public Health Service of the Department of Health and Human Services (HHS)”), *available at*: <http://www.ice.gov/pi/dro/> (visited Dec. 13, 2009).
 - 34 March 2009 GAO Testimony at 3.
 - 35 Immigration and Customs Enforcemnt, “Detainee Healthcare” (Nov. 19, 2008) *available at*: http://www.ice.gov/pi/news/factsheets/detainee_health_care.htm.
 - 36 Suicides Point to Gaps in Treatment, *The Washington Post* (May 13, 2008) *available at*: http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_day3_printer.html.

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- 39 FOIA response to Texas Applesseed from the Division of Immigration Health Services. September 18, 2009.
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- 43 *See Assembly Line Injustice* at 16-18.
- 44 Amnesty International, “Jailed Without Justice: Immigration Detention in the USA” (March 30, 2009) *available at*: <http://www.amnestyusa.org/uploads/jailedwithoutjustice.pdf>.
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- 49 Memorandum from U.S. ICE Director John P. Torres Re Discretion in Cases of Extreme or Severe Medical Concern, (Dec. 11, 2006).
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- 65 U.S. Immigration and Customs Enforcement, *Operations Manual ICE Performance Based National Detention Standards*, Part 4.22.VI.1 (Dec.2, 2008).
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- 80 Letter from Jane Holl Lute, Deputy Secretary, U.S. Department of Homeland Security to Michael Wishnie and Paromita Shah, Re: "Petition for Rulemaking to Promulgate Regulations Governing Detention Standards for Immigration Detainees," pg. 5 (July 24, 2009), available at: <http://www.clearinghouse.net/chDocs/public/IM-NY-0045-0004.pdf>. (On January 25, 2007, Families for Freedom, the National Immigration Project of the National Lawyer's Guild and two former immigration detainees petitioned the Department of Homeland Security to promulgate rules to create enforceable standards for immigration detention facilities, because of "substandard and abusive detention conditions, and widespread detainee mistreatment." On June 25, 2009, after nearly two and a half years of no response from DHS, the U.S. District Court of the Southern District of New York ordered DHS to respond within 30 days.)
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APPENDIX

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