Into the Abyss: Mortality and Morbidity Among Detained Immigrants

Homer Venters, * Dana Dasch-Goldberg, **
Andrew Rasmussen*** & Allen S. Keller****

ABSTRACT

The lack of transparency in immigration detention in the United States has contributed to serious concerns about the fate of immigrants who are detained in the United States and require medical care. In particular, deficiencies in initial screening, chronic disease management (including referral to outside care), and pain management of detainees have been identified by numerous governmental and nongovernmental groups. We have identified a number of detainee deaths and poor medical outcomes that are related to substandard medical care and suggest system-wide problems in US Immigration and Customs Enforcement (ICE) health care. This article provides an overview of the current ICE health care system, presents four cases of detainee deaths and independent reporting of similar systemic problems, and recommends several specific changes to the ICE health care system.

I. INTRODUCTION

Unlike persons convicted of crimes, immigration detainees in the United States are not held with the goal of punishment or rehabilitation, but instead

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* Homer Venters is an internist and works as an attending physician with the Bellevue/NYU Program for Survivors of Torture. Dr. Venters is also a public health research fellow with NYU.
** Dana Dasch-Goldberg is a program assistant at the Bellevue/NYU Program for Survivors of Torture. She holds an M.A in Human Rights Studies from Columbia University and a B.A in Anthropology from The George Washington University.
*** Andrew Rasmussen is the director of research at the Bellevue/NYU Program for Survivors of Torture as well as a practicing psychologist.
**** Allen Keller is an internist, is the founder and director of the Bellevue/NYU Program for Survivors of Torture and serves as a primary care physician for many patients in the Program.

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5. BRIEFING MATERIALS, supra note 3, at 45–47.
7. BRIEFING MATERIALS, supra note 3, at 47.
The health care provided for ICE detainees is directed by a set of administrative DHS rules that falls under the Detention Management Control Program. This standard prescribes policies and procedures for the broad spectrum of ICE detention operations but does not carry the force of law. The specific health care standards have been determined by the Division of Immigration Health Services (DIHS). Until late 2007, DIHS was a component of the Health Resources and Services Administration of the US Department of Health and Human Services, but DIHS has since been transferred into ICE. The only remaining presence of the Department of Health and Human Services within detention centers is a small number of medical personnel employed by the US Public Health Service. Having created the health care standards, the DIHS guidelines are incorporated into the overall set of ICE rules for detention operations. Detention facilities operated by ICE are required to maintain accreditation by the National Commission on Correctional Health Care (NCCHC) and encouraged to seek eventual accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO). Over 50 percent of all ICE detainees are held in local jails and prisons, however, and it is unclear whether or not ICE requires these facilities to maintain either of these accreditations.

Given the lack of public, verifiable information about ICE detainee conditions, it is difficult to address the veracity of ICE claims that detainees are afforded high quality care for acute and chronic health problems. Thus far, one study has attempted to address the health status and treatment of asylum seekers, a relatively small subset of all ICE detainees, but a population with significant health needs. This study, conducted jointly by the Bellevue/ NYU Program for Survivors of Torture and Physicians for Human Rights in 2003, found that “the mental health of asylum seekers interviewed for this study was extremely poor and worsened the longer that individuals were in detention.” Specifically, “[s]ignificant symptoms of depression were present in 86% of the 70 detained asylum seekers, anxiety was present in 77% and PTSD in 50%.” Detainees often reported that both their mental and physical health status worsened as their time in detention lengthened. Many detainees interviewed for this study reported verbal abuse by ICE personnel and widespread use of solitary confinement as a form of punishment. Although this study did not include review of medical records or detainees not seeking asylum, it provided a rare glimpse into the health and well being of persons held by ICE. As the first rigorous, scientific study of the health status of ICE detainees, this report helped to sound the alarm that ICE detainees may not receive the medical care that they deserve.

A more recent investigation by the non-partisan US Commission on International Religious Freedom (USCIRF) in 2005 did not address health care of detainees specifically, but found that detainees were widely ill-informed of their rights as detainees. This report focused on the practice of expedited removal of detainees. Since the report was issued, ICE has twice expanded the use of expedited removal, but according to updates from the USCIRF, ICE has done little or nothing to address the issue of detainees' knowledge about their rights. As the following cases will reflect, detainees' knowledge of their rights and their ability to advocate for those rights play a central role in the medical care that they receive.

Since 2004, at least eighty-three detainees are acknowledged to have died while in the custody of ICE or immediately after release, but little is known about the circumstances surrounding these deaths. These deaths were only acknowledged by ICE after numerous and ongoing efforts by advocacy groups, including one successful Freedom of Information Act application. Public reporting to the United States Congress and the United Nations Special Rapporteur on the Human Rights of Migrants reflects details of approximately twenty of these deaths, many of which appear to involve substandard medical care. Further Congressional testimony has revealed significant problems with ICE detainee health care that may have contributed to the morbidity of other detainees. We present four cases of detainee death that suggest systemic problems in the ICE health care system (see Table 1). For each case, we provide supporting evidence from other similar cases as well as independent analysis by the DHS Office of Inspector General (OIG) and the US Government Accountability Office (GAO). In December 2006, the DHS

12. Id. at 2.
13. Id.
14. Id.
OIG reported on its auditing of five ICE detention facilities. The OIG found instances of non-compliance with ICE health care standards at four of the five facilities it visited. Equally troubling, the OIG found that ICE inspectors routinely failed to note instances of facility noncompliance with standards related to health care.19 The following year, the GAO reported problems with ICE detainee conditions, specifically the mechanisms for detainee complaints. Equally troubling, the OIG found that ICE inspectors routinely failed to note instances of facility noncompliance with standards related to health care. These individual cases and supporting documentation are followed by specific recommendations that we feel are urgently needed in order to ensure basic health care for this growing and vulnerable population.

III. CASE STUDIES

A. Case 1: Initial Evaluation & Sick Call

Case Summary: In 2006, a thirty-year-old Ecuadorian woman was detained by ICE officials in Minnesota and taken to a county jail. The detainee had reported new onset, severe headaches and dizziness to her family several days before her detention and reported the same complaint to detention medical staff. Over the initial week of her detention, the detainee was seen and examined by jail medical personnel, reporting increasingly severe headaches and dizziness that were treated, but not relieved, with Tylenol. The detainee continued to complain of worsening headaches and dizziness over several weeks until she fell from her bunk during her fifth week of detention and became unresponsive. After a four hour period of evaluating the unresponsive detainee at the detention center, she was transported to a nearby hospital where a diagnosis of parasitic infection of the central nervous system was made. The detainee died one week later.21

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19. TREATMENT OF IMMIGRATION DETAINES, supra note 4, at 5.
20. GAO, ALIEN DETENTION STANDARDS supra note 8, at 39.
Case Discussion: While this case involves several apparent deficiencies in health care, it is clear that the detainee did not receive an appropriate early medical evaluation. The acute onset of new, progressing headaches and dizziness in an otherwise healthy thirty-year-old patient are symptoms that merit neurologic evaluation. The lack of relief from over the counter analgesics, combined with the detainee's Ecuadoran nationality, were additional early indicators that a more thorough evaluation was needed. ICE has not released the medical records of this detainee, but a reasonable concern in this case is whether or not the headaches and dizziness were dismissed as stress-related. The ICE Detention Standard for Medical Care requires all new arrivals to “receive initial medical and mental health screening immediately upon arrival by a health care provider or an officer trained to perform this function.” The health care provider must also conduct a health appraisal and physical examination on each detainee within fourteen days of arrival. Given the quick reliance on Tylenol for this detainee's symptoms, it is clear that whatever medical evaluation she was afforded was incomplete, particularly since these medications were ineffective. A recent investigation of ICE detention centers by the DHS OIG found numerous deficiencies in both initial screening and physical examination within two weeks among ICE detention centers. These deficiencies were found in both public and private detention centers and mirror reporting by advocacy groups that detainees often receive incomplete initial medical evaluations and may have longstanding medicines stopped upon detention.

A related problem for detainees is the time they must wait for sick call—that is, the time between when they request medical care and when they are actually evaluated. Detention centers maintain individual standards on how quickly a detainee requesting sick call should be evaluated, but generally it is within forty-eight to seventy-two hours. ICE standards further mandate that detention centers should have regular times for open sick call. Of three facilities where sick call response was examined by the OIG, between one third and one half of all sick call requests were not responded to in the required time. Compounding this problem, paper sick call forms filled out by detainees have been alleged to be both difficult to obtain and not incorporated into their medical record. Consequently, review of detainee medical records gives no information of how long detainees waited for their care, leaving facilities unable to detect this problem. Also, detainees are not given their own copy of their sick call request, leaving them ill-prepared to advocate for timely evaluation.

B. Case 2: Ongoing Care & Referral

Case Summary: In 2006, a detainee held at San Diego Correctional Facility and San Pedro Service Processing Center complained of painful bleeding penile lesions. Over eleven months of detention, the detainee was able to receive approval for visits with several urologists and an oncologist. These specialists, concerned that the detainee's lesions were cancerous, recommended a skin biopsy as well as circumcision to relieve pain. However, a physician employed by DIHS denied these recommendations, asserting that both procedures were elective, despite a written opinion from an oncologist who, concerned that these lesions were potentially malignant, reported, “in this extremely delicate area ... there can be considerable morbidity from even benign lesions which are not promptly treated.” After nearly one year, the detainee was released from custody, at which time he was diagnosed with penile cancer, underwent removal of his penis and commenced chemotherapy. Shortly after beginning this treatment regimen, the detainee died from metastatic penile cancer. A Federal District Court Judge recently allowed a suit against the Federal Government by the detainee's family to proceed. In his opinion, Judge Pregerson criticized DIHS and ICE medical personnel for their “attempt to sidestep responsibility for what appears to be ... one of the most, if not the most, egregious” constitutional violation of the prohibition against cruel and unusual punishment that “the court has ever encountered.” The Judge further identified the unwillingness to pay for treatment as a factor in the denial of this detainee's care and concluded: “The government's own records bespeak of conduct that transcends negligence by miles. It bespeaks of conduct that, if true, should be taught to every law student as conduct for which the moniker ‘cruel’ is inadequate.” The repeated inability of this detainee to gain approval for a needed biopsy and circumcision, despite the recommendations of medical experts, reveals the uphill battle that detainees face in advocating for their own health care.

22. Parasitic infections of the central nervous system, such as neurocysticercosis, are more common among Latin American immigrants. Peter M. Schantz, *Taenia Solium Cysticercosis: An Overview of Global Distribution and Transmission*, In *TAENIA SOLIUM CYSTICERCOSIS: FROM BASIC TO CLINICAL SCIENCE* 63, 67 (Gagandeep Singh & Sudesh Prabhakar eds., 2002).
23. U.S. DETENTION STANDARD, supra note 9, at 3.
24. TREATMENT OF IMMIGRATION DETAINES, supra note 4, at 3.
25. BRIEFING MATERIALS, supra note 3, at 56.
26. TREATMENT OF IMMIGRATION DETAINES, supra note 4, at 4.
27. Id. at 5.
31. Weinstein, supra note 29.
32. Id.
33. BRIEFING MATERIALS, supra note 3, at 57.
In a similar case in 2004, a detainee in need of a cystoscopy recommended by a urologist was refused approval for the procedure by DIHS. The detainee was being held at the York County Prison in Pennsylvania, and he was able to appeal the DIHS refusal to the York County Solicitor and then to the county’s Complaint Review Board, which determined that the procedure was clearly required and within the obligation of DIHS to reimburse. Upon this decision, ICE promptly transferred the detainee to a jail in another Pennsylvania county, where the ruling of the York County officials was not enforceable.34

Case Discussion: One of the most problematic areas of medical care for detainees is securing care for chronic disease. Given the large number of detainees with chronic medical conditions, estimated at 25 percent by ICE officials, it stands to reason that some detainees will need expert evaluation and care outside the medical unit of a detention center. Most of the medical care that ICE detainees receive occurs on-site, in the medical unit of the jail, prison, or ICE detention center where they are held. In these settings, detainees may be seen by a physician, nurse, physician’s assistant, nurse practitioner, or other allied health professional.

As demonstrated above, referrals for medically necessary, specialized care are subject to refusal by DIHS physicians. These referrals are best examined in the context of the DIHS health plan. This document, the DIHS Medical Dental Detainee Covered Services Package, establishes guidelines for payment, approval and refusal of care.36 An introductory comment in the plan explains: “The DIHS Medical Dental Detainee Covered Services Package primarily provides health care services for emergency care.” Emergency care is defined as “a condition that is threatening to life, limb, hearing or sight.”37 This narrow focus on emergency care belies a vocal public commitment by ICE to meeting the true medical needs of detainees, particularly given the estimate by the Assistant Director of ICE for Detention Management that 25 percent of ICE detainees suffer from chronic diseases such as diabetes and hypertension.38 The acute care model of ICE and the Covered Services Package creates multiple deficiencies in medical care for detainees with chronic health conditions. With regard to referrals for care outside the facility, the Covered Services Package states: “Elective, non-emergent care requires prior authorization. . . . Requests for pre-existing, non-life threatening conditions, will be reviewed on a case by case basis.”39 Each of these requests for care is submitted as a Treatment Authorization Request (TAR), and every non-emergent visit, test, or procedure outside the detention center requires that a new TAR be submitted and approved beforehand.40 In the case of the detainee above who died of metastatic penile cancer, his TARs for visits with urologists and an oncologist were approved but those for a biopsy and circumcision were not. Several other specific deficiencies in chronic care coverage allowed by the Covered Services Package are addressed in the discussion below.

C. Case 3: Pain Management

Case Summary: A twenty-two-year-old Salvadoran man was taken into custody by ICE agents in 2007 and held at the Bergen County Jail in New Jersey. Prior to detention, the detainee was taking several prescription pain medicines for a poorly healing leg wound suffered in a motorcycle accident. In detention, other detainees noted this man to be crying and in extreme pain from his leg wound, although over the counter pain medicines were the only relief provided. After five days in detention, the detainee hung himself. A Bergen County Jail spokesperson denied that untreated pain contributed to the suicide and speculated that the detainee took his life because of a fear of deportation.41 Difficulty obtaining pain medicine other than ibuprofen or acetaminophen is a very common complaint among detainees. One year before this case, a woman was detained in New Mexico by ICE and complained of severe abdominal pain for several weeks before she was taken to a nearby hospital where she was diagnosed with pancreatic cancer. The detainee, who died shortly thereafter, was given antacids for her abdominal pain. A review of deaths in ICE custody by the DHS OIG failed to comment on the lack of adequate pain control for this detainee, simply concluding that “the [detention center] medical team could not have saved the individual’s life, even with quicker onsite treatment or expedited transportation to the hospital.”42

Case Discussion: Pain is a common complaint in any medical setting. Reluctance to use sufficiently strong pain medicines leaves patients with undertreated pain, represents substandard care,43 and may worsen the pa-

37. Id. at 1.
39. COVERED SERVICES PACKAGE, supra note 36, at 1.
40. Id.
tient’s prognosis.44 A twenty-seven year old woman detained by ICE in the Bay County Florida jail was recuperating from a documented ankle fracture when she fell, re-injuring the same ankle. Staff at the jail gave her an ace bandage and waited one month to x-ray the re-injured ankle, all the while providing only ibuprofen for the detainee’s pain. The detainee was subsequently transferred to another facility, was not informed of the x-ray results, and developed limited mobility of her ankle.45 In addition to medical and traumatic causes of pain, dental problems are a very common source of pain among ICE detainees. The reliance on over-the-counter pain medication, combined with a system-wide deficiency in dental care, makes this a top concern for many detainees.46

While securing adequate medical treatment of pain is a challenge that many ICE detainees face, ICE and DHIS also appear reluctant to approve treatments that might eliminate a detainee’s pain altogether. One detainee held by ICE complained of severe pain from a bullet lodged in his groin. Over two and a half years of detention, this detainee was unable to obtain approval for surgical removal of the bullet.47 Another detainee, who sustained a rotator cuff injury while detained by ICE, was able to obtain surgical repair of his injury eight months after his original injury, but DHIS then refused approval of the physical therapy ordered by the surgeon.48 Physical therapy after rotator cuff surgery is the standard of care and is included in post-operative care recommended by the American Academy of Orthopaedic Surgeons.49 This detainee’s rotator cuff was then re-torn when he was restrained by a CCA employee, a re-injury that was documented by MRI. The most recent information available about this detainee’s injury is that he never received approval for surgical repair of the second, documented injury, and at no time did he receive any physical therapy for his injuries.50 Despite the absolute medical necessity of physical therapy after this and many other surgeries, and the potential cost savings of rehabilitation as an alternative to surgical and medical approaches to chronic pain, the updated Covered Services Package is explicit: “No coverage for acute rehabilitation facilities or rehabilitative services (e.g., physical, occupational, speech or cognitive therapy).”51

Case Summary: A twenty-three year old transgender woman with AIDS was detained by ICE in 2007 and remanded to an ICE detention center in San Pedro, California. This detainee had been prescribed dapsone by her treating physician as a prophylaxis against opportunistic infection. For patients with AIDS, prophylactic medicines such as dapsone are used to ward off otherwise inevitable opportunistic infections that prey upon weakened immune systems.52 Upon arrival at the ICE facility, the detainee informed health officers of her medications but did not receive any dapsone. The detainee requested her medication multiple times over the first weeks of her detention. By the sixth week of her detention, she reported a cough, fever, and nausea to detention center personnel, her family, and her attorneys. The detainee was seen by ICE facility medical personnel, given Amoxicillin by a nurse practitioner, and returned to her cell. The detainee’s condition worsened over the following several days, and her cellmates, noting profuse vomiting, diarrhea, and hallucination, staged a mass protest that resulted in the detainee being transferred to a local hospital for twenty-four hours. Upon her return to the ICE detention center her symptoms persisted, and she was transferred to a second local hospital where she died in the intensive care unit, shackled to her bed. An internal review of this death by a DHIS infectious disease physician noted that “The clinical staff at all levels failed to recognize early signs and symptoms of meningitis... [The patient] was evaluated multiple times and an effort to rule out those infections was not even mentioned.”53

Case Discussion: This case demonstrates several apparent deficiencies in medical care, all of which flow from the discontinuation of a life-saving medicine. In this case, an adequate intake by any medical provider would have determined the necessity of continuing the detainee’s dapsone. Assuming the detainee’s initial intake missed this detail, history and physical examination in the first two weeks would have yielded a recommendation to continue dapsone and obtain new blood work from any practitioner trained to care for patients with HIV. Once ICE medical staff did evaluate the detainee for her fever and cough (symptoms that raise alarm for opportunistic pneumonia in a patient with AIDS), the use of oral Amoxicillin was inadequate.54 Unfortunately, the death of this detainee comes against

45. BRIEFING MATERIALS, supra note 3, at 58.
46. See Physicians for Human Rights, supra note 11, at 99–100.
47. Id. at 146–47.
51. Div. of Immigration Health Serv. (DHIS), Summary of Changes to the DHIS Detainee Covered Services Package (2005) (on file with author).
53. Priest & Goldstein, supra note 17.
a backdrop of system-wide complaints about the care afforded to detainees with HIV/AIDS. In particular, detainees report many missed doses of their medicines and great difficulty in having their CD4 and viral load checked by ICE medical staff.\textsuperscript{55}

In a report dedicated to these specific failures, Human Rights Watch presented a journal kept by a detainee with HIV who was prescribed three medicines, taken twice a day. Over a one month period in July 2007, this detainee received all of his medicines on only eleven days. On many days, the diary revealed that either all morning or evening medications were not given. In preparing their report, Human Rights Watch interviewed current ICE detainees and detention staff in four different states and ex-detainees who had been held in five other states. In addition to widespread failures in routine medication administration and lack of access to prophylactic treatment to prevent opportunistic infections, Human Rights Watch documented a culture of harassment and discrimination against detainees with HIV. When Human Rights Watch arrived at the San Pedro facility where the abovementioned detainee died after being deprived of sleep, they found that over twenty key witnesses to that detainee’s illness had been suddenly transferred days before.\textsuperscript{56}

Regarding screening, the most basic element of confronting HIV, ICE, and DIHS have significantly departed from US Preventive Services Task Force (USPSTF) recommendations and basic primary care guidelines. The USPSTF has a clear and unambiguous recommendation that all adults be screened for HIV. In contrast, the DIHS policy on HIV testing from the Covered Services Package reads: “HIV testing will be approved if a provider determines that the HIV testing is indicated based on clinical evaluation or if the detainee requested the test and it is deemed necessary by the medical provider.”\textsuperscript{57}

It is unclear what constitutes medical necessity in the case of HIV testing, and this guideline prevents a detainee from obtaining HIV testing without demonstrating necessity. Ambiguity in determining the risk of HIV is the exact reason that the USPSTF guideline exists. In addition, the CDC has recently published specific guidelines for HIV screening and care in correctional settings that includes advocating for universal testing.


\textsuperscript{56} Id. at 26. ICE does not track the number of detainees with HIV or the type of care that they receive. A FOIA application by Human Rights Watch concerning these issues is pending.

\textsuperscript{57} Covered Services Package, supra note 36, at 29.

\textbf{III. OTHER CONCERNS}

Several other areas of significant concern have arisen with regard to ICE detainee health care. Mental health services afforded detainees have been judged by the OIG as well as advocacy groups to be substandard. In particular, segregation has been used as a punitive intervention for detainees with mental health problems.\textsuperscript{58} Combined with a system-wide lack of mental health counseling, the punitive use of segregation creates a disincentive for detainees to seek mental health care. Several groups have documented the use of segregation in response to detainees asking for mental health services as well as a means to control verbal arguments, questions about detainee rights, and other minor infractions.\textsuperscript{59} In their 2003 report on the health status of detained asylum seekers, The Bellevue/NYU Program for Survivors of Torture and Physicians for Human Rights found high levels of mental health problems among detained survivors of torture and widespread use of segregation by ICE.\textsuperscript{60} For many of these detainees, segregation had been a component of their original torture experiences and now was applied as a means to control behavior and address mental health concerns. For detainees who are suicidal, care is also substandard. The OIG report from 2006 noted that four of five facilities inspected failed to comply with the ICE standards on suicide watch, including a lack of regular, documented checks on detainees in segregation.\textsuperscript{61} Other reporting submitted to the US Congress documents detainees with mental health problems being held in a common area with mentally ill criminal detainees.\textsuperscript{62} The housing of ICE detainees in the same space as the criminal population of a facility is a clear violation of ICE policy and standards of the United Nations High Commission on Refugees,\textsuperscript{63} but nonetheless remains a common complaint.\textsuperscript{64}

Another concern for detainees is the administration of medical or pharmacologic intervention without their consent. In 2007, an ICE detainee held in a Florida county jail reported that he was escorted to the medical unit and physically restrained while medical staff used a scalpel to cut and drain an abscess on his back. The procedure was not explained to the detainee and he attempted to refuse the intervention, prompting security and medical staff to restrain the detainee face-down.\textsuperscript{65} In another instance, a survivor of torture

\textsuperscript{58} Physicians for Human Rights, supra note 11, at 56, 78.

\textsuperscript{59} Briefing Materials, supra note 3, at 59.

\textsuperscript{60} Allen S. Keller et al., The Impact of Detention on the Health of Asylum Seekers, 26 J. Ambulatory Care Mgmt. 383, 384 (2003).

\textsuperscript{61} Treatment of Immigration Detainees, supra note 4, at 5.

\textsuperscript{62} Briefing Materials, supra note 3, at 59.

\textsuperscript{63} Id. at 4–7.

\textsuperscript{64} Complaint, Woods v. Myers, supra note 28, at 9.

\textsuperscript{65} Briefing Materials, supra note 3, at 58.
and rape was detained upon her arrival in the United States. Because of her initial anguish at this unexpected incarceration, the detainees were given an antipsychotic medicine, Risperdal, an unwarranted response for a newly detained person with a history of detention and torture. This medicine caused troubling side effects for this detainee, including confusion, lethargy and lactation. The detainee was able to secure legal representation, and her attorneys were able to consult with a psychiatrist, who confirmed that the medication was inappropriate. After these communications, the detainee stopped taking the Risperdal and her side effects abated. This case raises questions about whether or not the medication and possible side effects were explained to the detainee. It also highlights the troubling use of psychiatric medications to control or change the behavior of people without history of mental illness. A number of detainees without history of medical illness have reported that, at the time of their deportations, they were administered a combination of Haldol (an antipsychotic medication) and Cogentin (a medication approved for use in Parkinson’s disease but sometimes used for agitation) against their will as a means to render them more submissive. ICE regulations expressly prohibit the forcible medication of detainees for the purpose of staff convenience, and this particular complaint has been addressed by ICE with an agreement to obtain court orders for such actions in the future. Nonetheless, as with detainee deaths, ICE is under no mandate to reveal how often or under what circumstances detainees are administered treatment against their will or absent informed consent.

IV. DISCUSSION & RECOMMENDATIONS

The cases presented here include incomplete clinical information. Alone they serve as a poor overall indicator of the ICE health care system. But these cases, bolstered by OIG and GAO investigations, testimony to the United States Congress, and reporting to the United Nations Special Rapporteur on the Human Rights of Migrants, paint a picture of inadequate detainee medical care that dramatically contradicts the claims of ICE. In particular, these deaths and the supporting information we have presented suggest systemic wide failures in the initial screening, continuing care, and outside referral for detainees who need medical attention.

Among the many elements of the ICE health care apparatus, the referral plan for payment of detainee health care particularly reveals a reliance on an acute care model that runs counter to the claims by ICE that detainees are afforded quality care for chronic diseases. The true nature of the Covered Services Package as an acute care plan is laid bare when examining allowances for chronic care visits. In the past several years, ICE and DIHS have changed guidelines several times concerning “chronic care” visits, but one common complaint has been that, while detainees with diabetes, hypertension, and asthma may receive a chronic care appointment with ICE medical staff, they may never receive urine, blood tests, or expert eye exams that represent the standard of care for their respective conditions. Prior to changes in 2005, persons with chronic diseases such as diabetes and hypertension were entitled to receive one “chronic care” visit with a medical provider every three months. While the frequency of these visits may not have been enforced, an effort was made to comply with these requirements at many facilities. However, in August 2005, DHHS eliminated any standardized approval of chronic care visits with this explanation: “We have clarified to providers that DHHS does not mandate the frequency a detainee is seen or what testing needs to be done by the onsite physician. The responsibility will lie with the provider.” The practical effects of this change are clear: for diabetic detainees who require two to four annual visits for their regular care, individual providers at detention centers will be required to submit a new TAR for each visit instead of having a pre-approved set of visits at the ready. This extra bureaucratic hurdle for ICE medical providers, combined with the reliance on individual providers to determine optimal frequency of care, will undoubtedly result in less care for detainees with chronic medical conditions. Ironically, these changes come at a time when standardized care protocols for chronic disease have been shown to lead to improved outcomes in patients with diabetes, hypertension, asthma, and heart failure.

67. Id.
68. Id.
70. Id.
71. Id.
74. DIHS, SUMMARY OF CHANGES, supra note 51.
76. Leif I. Solberg et al., Practice Systems are Associated with High-Quality Care for Diabetes, 14 AM. J. MANAGED CARE 85, 85 (2008).
77. Barbara Every, Better for Ourselves and Better for our Patients: Chronic Disease Management in Primary Care Networks, 10 HEALTHCARE Q. 70-74 (2007).
78. See Alexander C. Tsai, Sally C. Morton, Carol M. Mangione & Emmett B. Keeler, A Meta-Analysis of Interventions to Improve Care for Chronic Illnesses, 11 AM. J. MANAGED CARE 478 (2005).
While these guidelines foster sub-par care of detainees with chronic disease, there is another problematic component of the Covered Services Package. In establishing the approval of non-emergent care, the Covered Services Package states: “Other medical conditions which the physician believes, if left untreated during the period of ICE/BP custody, would cause deterioration of the detainee’s health or uncontrolled suffering affecting his/her deportation status will be assessed and evaluated for care.” This provision links approval of care for a detainee’s medical condition to 1) a physician’s estimation of time of detention and 2) whether or not deterioration of the condition might impact deportation. These two non-medical criteria place any physician or provider in ethical jeopardy, making the delivery of needed care contingent on details of detention and deportation. In contrast, the referral plan used by the US Marshalls service relies on medical necessity alone to legitimize an outside referral and places no mandate on physicians or nurses to weigh medical necessity against length of detention or other non-medical criteria.\(^\text{79}\)

A final aspect of the Covered Services Package that places detainees in medical peril deals with health screening. The clear authority regarding health screening in the United States is the US Preventative Services Task Force (USPSTF), a panel of independent experts in prevention and primary care convened by the US Public Health Service in 1984. In fact, the DIHS explanation of the Covered Services Packages footnotes the USPSTF several times in support of their pre- and post-2005 guidelines for screening.\(^\text{80}\) Regrettably, the health screening directives of the Covered Services Package are largely at odds with the recommendations of the USPSTF.

Prior to 2005, the Covered Services Package appeared to grant approval for basic health screening tests such as pap smears, mammograms, and colonoscopies, but only to detainees who met USPSTF criteria and were held for more than one year.\(^\text{81}\) This screening regimen was woefully inadequate because it excluded detainees held for less than one year and who might never have had such screening tests. For example, USPSTF guidelines recommend cervical cancer screening at least every three years, starting within three years of sexual activity or at the age of twenty-one, whichever arrives first.\(^\text{82}\) For female detainees who may have never had a pap smear, waiting until they have been detained for one year before allowing them to be screened for cervical cancer only increased the likelihood that cervical cancer might go undetected. Similarly, for female detainees over the age of forty who had never had any medical care, denying a mammogram to those detained for less than one year served to potentially delay diagnosis of a common, treatable, and sometimes fatal disease. Since the entire purpose of health screening is to detect disease early enough to treat, all of those detainees who were detained for less than one year, and thus denied screening tests, represented missed opportunities to detect and treat potentially fatal disease. Health screening for cancer is one of the most effective and worthwhile components of health care; indeed, other corrections settings have recognized the importance of early cancer detection as an ethical obligation. Detainees at Rikers Island Jail in New York are offered gynecological exams including pap smears, as well as mammograms.\(^\text{83}\) One of the two bodies that grant accreditation to correctional institutions (including some ICE facilities), the NCCHC, has advocated following the recommendations of medical societies to provide care not conditioned by time of detention since 1994.\(^\text{84}\)

But DIHS apparently judged that standard to be too comprehensive. In August 2005, the Covered Services Package was altered with this explanation:

> Screening for disease processes (e.g., breast, cervical, prostatic, colorectal cancer) are considered on a case by case basis, subject to clinical findings. ... In other words, clinical findings must support the need for the requested screening. This change will remove the impression that these tests are automatically approved for a detainee who is in custody for over 12 months.\(^\text{85}\)

Cancer epidemiologist Alexandra Barratt explains that “[s]creening is the systematic application of a test or inquiry, to identify individuals at sufficient risk of a specific disorder to benefit from further investigation or direct preventive action, among persons who have not sought medical attention on account of symptoms of that disorder.”\(^\text{86}\) The new DIHS criteria subverts this basic concept of epidemiology and recasts screening tests into diagnostic tests, giving approval only when a clinical suspicion, symptom or sign of disease is present. These clinical findings, whether a lump in a detainee’s breast, unexplained vaginal bleeding, or new rectal bleeding, are the very signs of disease progression that screening tests are designed to prevent. In short, these tests no longer involve screening, and based on the DIHS language, they bear no relation to the guidelines of the USPSTF or any other medical organization.

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79. COVERED SERVICES PACKAGE, supra note 36, at 1.
81. COVERED SERVICES PACKAGE, supra note 36, at 27, 29.
82. Id. at 26.
86. DIHS, SUMMARY OF CHANGES, supra note 51.
87. A. Barratt et al., Cancer Screening, 56 J. EPIDEMIOLOGY & COMM. HEALTH 899 (2002).
Based on the information above, we recommend the following changes to the ICE health care system. Given the burgeoning ranks of ICE detainees, these improvements are urgently required.

1. The DIHS Medical Dental Detainee Covered Services Package must be altered to make care for chronic disease routinely available. These changes must reflect community standards for the care of HIV, diabetes, hypertension, and other common chronic diseases. The Covered Services Package should reflect the nature of detainee health needs, not the type of care and referral that is least expensive. USPSTF recommendations on screening for cancer and other disease should be incorporated as intended by the USPSTF, without additional qualifiers or limitations. The mandate that ICE providers estimate the length of detention and balance a deteriorating condition against the ability to deport a detainee must be eliminated.

2. Mandatory reporting by ICE of detainee health indices, including deaths, accidents, and forcible medical actions against detainees, is needed. The current system, based on internal ICE monitoring of health care problems, is grossly deficient. Without transparency in health outcomes, evaluating the quality of detainee health care will remain problematic.

3. ICE medical practices and DIHS guidelines for medical care must be altered to accommodate adequate pain management. Tylenol and ibuprofen are not the only pain medications available. Management of pain must also include options for surgery and physical and occupational therapy, as deemed medically necessary to relieve pain.

4. Health care for ICE detainees must be guaranteed and defined as a matter of law. Many of the cases presented above involve violations of ICE guidelines. As the GAO and OIG have revealed, ICE is unaware of many violations of its own policy in its own facilities. Without a legal mandate to enforce these “guidelines,” detainee health care will continue to suffer.

5. Payment for routine aspects of chronic disease management, including diagnostic and therapeutic interventions as well as consultant visits, must be incorporated. Instead of relying on individual providers to submit a TAR for every consultant visit and outside test, the Covered Services Package should be altered to automatically include a package of pre-approved care based on diagnosis. These approvals should be coordinated with validated care protocols to assist ICE medical personnel in the delivery of needed care to detainees with chronic medical conditions.

6. Screening tests based on the criteria established by the USPSTF should be made available to detainees upon entry to the ICE system. This mandate will bring an extra measure of expense since detainees must be informed of results from mammograms, pap smears, and other tests in the detention center or after deportation.

The prospect for enacting these recommendations is mixed. The problems created by the DIHS Medical Dental Detainee Covered Services Package are likely to resonate with any US health care user or provider. This is an acute care plan being used for a population with both acute and chronic health problems. Fixing this problem is administratively simple but financially costly. There is no doubt that the net effect of these changes will require a larger health budget for ICE, but if increasing numbers of immigrants are to be detained in this system, an ethical and competent standard of medical care must be established immediately. ICE officials frequently cite the figure of $98 million spent annually on detainee health care. By comparison, however, Rikers Island Jail, which has one half the daily census and roughly one half the total annual visits of the ICE detention system, has been spending well over $100 million annually on health care for a decade.

Related to the cost of medical care is the length of time that a detainee is held. While some detainees are held by ICE for relatively short amounts of time (an average of nineteen days for detainees who are subject to expedited removal), ICE reports the average time of detention to be at least three months. Three months is a substantial enough time to warrant thorough medical evaluation and care, but this average length of detention may obscure an important demographic split between detainees who are rapidly deported and others who are retained for many months, even years (such as asylum seekers and detainees who contest their deportation).

The effort to create mandatory reporting of health outcomes for ICE detainees may be a difficult one, but it is an essential component of improving health care for detainees. The United States Department of Justice, through the Bureau of Justice Statistics, started reporting on causes of death and illness among prisoners in 2000. A similar requirement should be made of ICE for its detainees. Many of the cases presented above involve violation of current ICE guidelines that might never have been detected by ICE personnel. The reports by the OIG and GAO both highlight ICE’s poor institutional awareness of compliance with its own regulations. That seventy-one detainees have died in detention since 2004 may appear to be relatively small given the approximately one million detainees that have been held in that time. But it is impossible to evaluate the significance of

89. Esther B. Fein, Deal to Bring Rikers Inmates Managed Care, N.Y. TIMES, 19 Sept. 1997, at B3.
this figure without knowing details of all seventy-one deaths and without
knowing basic information about rates of morbidity within the ICE health
care system. While reporting morbidity, mortality, and adverse outcomes are
bedrock principles of health quality assurance in virtually every health care
venue in the United States, ICE operates from an institutional ethos rooted in
security and corrections. Concerns over national security and public safety
often overwhelm discussions of detainee autonomy, health, or well-being.
It may be that part of establishing a legal mandate for detainee health care
includes establishing a mandatory reporting and publication mechanism for
detainee health-related outcomes.

With regard to establishing a US legal standard for detainee health
care, such a provision was introduced to the United States Senate by Sena-
tor Lieberman in 2007 as an amendment to the larger immigration reform
bill and was adopted by unanimous consent. Because the immigration
bill floundered, the Lieberman amendment also failed to be enacted. If this
seemingly popular proposal can be folded into a less controversial measure,
or if the political will is found for overall immigration reform, chances for
passage are good. As with any new mandate, simply creating a legal standard
out of the current ICE administrative rules will not alone ensure better care.
Detainees must be allowed to report substandard care and consequences for
substandard care, such as loss of lucrative contracts, must be genuine.

The struggle to forge a system of health care that better meets the needs
of detainees reflects competing interests in areas of public health, human
rights, national security, and government bureaucracy. This endeavor brings
to mind the movement to establish a right to medical care among American
prisoners in the 1960s and 1970s. As with ICE detainees, the health care
care of persons in jails and prisons was often a low priority, and adverse events
were rarely reported. While the legal contexts for these struggles are dif-
ferent, there is a common principle of human rights involved: that once a
state deprives a person of her liberty, the state becomes responsible for the
security and well being of that person, a responsibility that includes medical
care. In addition to unclear legal protection under the US Constitution, ICE
detainees also have rights to medical care based on international laws or
treaties to which the US is a signatory, including the International Covenant
on Civil and Political Rights and the UN Convention Relating to the Status
of Refugees. In the landmark US Supreme Court case that helped establish

92. See Press Release, Senate Homeland Security and Governmental Affairs, Lie-
berman Wins Better Treatment, Improved Conditions for Asylum Seekers De-
cfm?FuseAction=PressReleases.Detail&Affiliation=C&PressRelease_id=dc75fcf-0e0f-
4c0d-b31eb9987c40b31&Month=6&Year=2007.
93. Nancy Neveloff Dubler, Depriving Prisoners of Medical Care: A “Cruel and Unusual”
94. Briefing Materials, supra note 3, at 19.

96. Dubler, supra note 93, at 8.

a national right to health care for prisoners in 1977, Estelle v. Gamble, the
plaintiff suffered from longstanding back pain after an injury in prison.
His allegation was not that he never received care; in fact he was seen by
prison medical staff multiple times after his injury. But instead, the plaintiff
argued that the care he received was inadequate and incomplete. In that
light, the ICE system of health care must be considered inadequate. ICE
detainees are given some care, but based on available reports, that care
lacks transparency, enforceability, and medical sufficiency.

The unfortunate cases of detainee mortality and morbidity that we
present here resonate with the concerns about detainee health care raised
by advocacy groups and US governmental agencies. ICE detainees are not
criminals or criminal defendants. Because ICE detainees are being held to
ensure their possible deportation, there is no reason for them to endure
the same mental and physical hardships of prison; they are not undergoing
punishment or rehabilitation. But the medical system created by ICE and
DIHS is a model based on corrections, jails, and prisons, where the culture
of security and punishment prevail. Recent changes in ICE policy have ag-
gressively increased the number and proportion of persons awaiting an im-
migration hearing who are detained as opposed to paroled (i.e., residing in
the community without being detained). Ultimately, the outcome for most
ICE detainees is deportation. Given the current lack of transparency, whatever
problems a detainee may encounter with medical care are likely to vanish
upon their deportation. Based on available information, immigrants detained
by ICE are in real jeopardy of receiving unacceptable medical care. This
substandard care occurs at a time when the United States is aggressively
increasing the number of immigrants detained. These problems are set to
worsen unless several fundamental changes are made to the ICE health care
system. Medical care for detainees must be transparent, legally mandated,
and appropriate to the population of detainees. These changes will require
legislative action as well as financial investment. If ICE is to continue the
mass detention of immigrants, public health, and medical professionals must
join the effort to ensure that detained immigrants are granted an accepted
standard of medical care.