Improving Medical Care for Detained Immigrants: A Call for a Legislative Solution

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Abstract: Health care services provided to detained immigrants are inadequate to provide for the needs of this population. We analyzed the medical care policies and procedures for immigrants in detention, government reports on detainee medical care, and available mortality and morbidity data. We conclude that the current system of medical care for this vulnerable population needs improvement. We suggest that a federal legislative solution is one essential component to address this issue and improve medical care. Principles to be embodied in a legislative proposal necessary to address the inadequacies in the current system are presented.

Key words: Immigrant health, immigration reform, health care quality, immigration policy analysis, health care for the underserved.

The release of data concerning the deaths of detained immigrants due to inadequate health care brought national attention to the quality of medical care provided to this population. The media,[1,2,3,4] government agencies,[5,6,7] and advocacy groups[8] have expressed concerns over delays in and denials of detainee medical treatment and unnecessary deaths. A Department of Homeland Security (DHS) official's recent legislative testimony reported 90 detainee deaths from January 2004 and March 2009.[9] Reports of detainee's deaths, however, are often conflicting or unavailable. Prompted by a Freedom of Information Act (FOIA) request, the government has since acknowledged 104 in-custody detainee deaths since fiscal year (FY) 2004.[10,11]

Approximately one-third of reported deaths may have been avoidable according to medical experts.[7] In a 2008 *Washington Post* article, medical experts reported on 83 detainee deaths they had reviewed; they found that 30 of these deaths were attributable to inadequate medical care in Immigration and Customs Enforcement (ICE) facilities.[7] Thirty-two of the deaths were of detainees under 40 years of age, and only six deaths occurred in detainees over 70 years old.[7] A DHS official acknowledged that "the medical

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and custodial care that those detainees received before expiring appeared to be contrary to [government agency] policy."[9[p.4]]

This inadequate care is and will increasingly be problematic. The population of immigrant detainees in the U.S. has increased every year, from 231,804 detainees in 2004 to 311,213 in 2007.[12] The number of detainees in government custody was predicted to increase to 442,941 for FY 2009.[13] These individuals are housed in over 350 facilities[14] where the "organizational structure for providing health care is not uniform across facilities."[15[p.3]] Considerable variation exists in the amount of on-site medical care available.[16] Even when services exist, the absence of oversight and a system to monitor adherence to medical protocols often prevents detainees from receiving needed health care.[5,6,7]

Federal legislation is one way to address this issue, with legally enforceable standards and responsibility established to improve access to and quality of health care for detained immigrants. This paper provides background, examines concerns about the Immigration and Custom Enforcement's (ICE) health care policies and standards, reviews current legislative proposals, and recommends principles necessary for a legislative solution.

Background. Immigration and Customs Enforcement (ICE), a division of the Department of Homeland Security (DHS), seeks out non-citizens to reduce the illegal alien population in the U.S., doing so both in cases of individuals who are arrested and those who are waiting to be awarded political asylum. The Immigration and Nationality Act authorizes ICE to arrest, detain, and remove certain aliens from the United States,[17] which leads to a high census in detention centers.[5] Immigration and Customs Enforcement is responsible for ensuring that any illegal alien who poses a public health, criminal, or national security risk is removed from the U.S.[18]

Immigration and Customs Enforcement's program for detaining and removing illegal aliens is administrated through the Detention and Removal Operations office (DRO), a division of the ICE. The DRO identifies illegal, fugitive and criminal aliens, manages them while they are in U.S. custody, and enforces removal orders in a fair, effective, and professional manner.[18]

Illegal aliens not removed from the U.S. are placed into detention centers. Immigration and Customs Enforcement owns eight detention facilities and augments its capacity to house detainees with contract detention facilities and state and local jails.[19] Over 350 facilities house detainees.[16] Most of these facilities are "largely designed for penal, not civil, detention."[20[p.1]]

Under the supervision of ICE, the Division of Immigration Health Services (DIHS), a sector of the Bureau of Primary Health Care of the Public Health Service of the Department of Health and Human Services,[18] is responsible for health care for detainees housed in ICE's detention centers. Contract detention facilities use Commissioned Corps Officers in the Public Health Service to provide in-house medical care.[5[p.3]] Detention centers that are part of a jail usually contract with onsite clinicians hired by a local public health department.[5[p.3]]

Immigration and Customs Enforcement provides administrative guidance to the detention facilities through its National Detention Standards,[21] which include provisions for the delivery of medical care. Immigration and Customs Enforcement recently adopted higher standards for their detention facilities, *Performance Based National*

Detention Standards,[21,22] partly in response to the publication of *ICE Policies Related to Detainee Deaths and the Oversight of Immigration of Detention Facilities*.[6]

The medical standards call for all detainees to receive a medical screening within 12 hours of admission, a physical exam within two weeks of detention, a timely and appropriate response to emergent medical requests, and timely medical care appropriate to the anticipated length of detention.[22] Detainees can request medical care through a sick call procedure that provides detainees an opportunity to request health care services from a physician or other medical staff member.[22] Non-emergency, off-site care requires the completion of a Treatment Authorization Request (TAR).[23] The TAR is submitted for approval and reviewed by managed care nurses based on existing covered benefits as defined by DIHS Medical Dental Detainee Covered Services Package.[24] In addition to these standards, each facility has its own handbook that outlines policies, rules, and procedures for its specific location.[25]

These standards are not codified in statute or administrative regulation and therefore not legally binding. The Special Advisor to The Secretary on Detention and Removal Operations acknowledges adherence to these standards "does not always happen."[9[p.6]]

Issues with medical care for detainees. Human rights groups,[8,26] news accounts,[1,2,3,4] and government agencies[5,6,7,27] have all reported substandard treatment of detained immigrants in the U.S. Delays in medical care, denial of care, and critical staffing shortages are among the issues contributing to substandard health care for detainees. Reports urge DHS to improve its detention standards to meet both national and international guidelines; to establish written, enforceable standards; and consistently to monitor medical services provided in its facilities. These recommendations are keys to improving the quality of medical care for detained immigrants.

Delays in medical care. Delays in accessing needed medical treatment is one of the chief complaints of aliens in detention.[26,28,29] Detainees have reported medical care delays occurring at all points in the medical care process from the initial screening to medication arrival to scheduling of medical specialists.[28,29,30] For example, half the detainees interviewed by the organization Human Rights Watch reported delays in requested medical care.[29] In another report, 56% of detainees who reported having serious health problems recounted substantial difficulty accessing medical services.[30[p.95]]

Immigration and Customs Enforcement policy requires completion and submission of care request forms for detainees to obtain medical services. These request slips (known as *sick calls*), by policy, allow detainees to request health care services from qualified medical staff with no restrictions. The procedure for sick call includes clear written policies and procedures, verbal and written communication of these policies to each detainee upon admission, and regular sick time hours.[22] Prior to the recently adopted Detention Standards for Medical Care,[22] no specific policy existed on response time required for non-emergency sick calls; instead, each detention facility established its own policy.[7] An Office of Inspector General (OIG) audit report found in the facilities reviewed 41% of immigrant detainee non-emergency sick call requests were not answered in the time frame stipulated by the facility.[7[p.4]]

Linguistic barriers present complications in a detainee's ability to complete the sick call request form and contribute to delays in medical treatment. Medical care request slips must be available in English and the primary language spoken by the majority of

detainees in the facility with translation/interpretation assistance provided for individuals who cannot fill out the form.[22] Although the written policy exists, the standards are often not upheld. An OIG report documents a concern from a facility official: We are "not really prepared to translate, interpret, and assist that kind of population."[6[p.7]]

Delays in medical care: untimely medical screening upon intake. Initial health screenings upon admission and subsequent medical exams are important for identifying a detainee's medical service and treatment needs. Immigration and Customs Enforcement, in policy, does have a reasonable intake system. However, the implementation and medical follow-up is often lacking or unavailable. An OIG audit report found significant non-compliance with initial screening and medical exam standards.[7[pp.4–5]] A subsequent OIG report included similar findings and the recommendation that detention facilities implement internal controls to comply with standards for timeliness of initial medical screenings and physical examinations.[5[p.12]]

These delays in medical screenings may pose serious health consequences. Detainees' medical screenings should include assessment of a detainees' health status, potential suicide risk, and tuberculosis testing.[22] Non-compliance with ICE's own medical screening standards can result in a treatable diseases going undetected or the spread of an infectious disease.[5[p.11]]

Denials of medical care. Immigration and Customs Enforcement standards provide for "access to a continuum of health care services"[22[p.1]] which should include care for pre-existing conditions. Care for chronic diseases, however, is often insufficient.[31] Detention centers are meant to be temporary and therefore provide only emergency care. Policies do not "adequately allow for coverage for conditions that do not appear to be medical emergencies."[6[p.16]]

The DIHS Covered Service Package, which dictates the covered medical services for detainees outside the facility, emphasizes benefits are "provided for emergency care . . . and not for pre-existing conditions."[24[p.1]] Emergency conditions are defined as a "condition that poses an imminent threat to life, limb, hearing or site."[24[p.1]] Yet, in Fiscal Year 2007, initial medical screenings identified 34% of the detainee population with a chronic condition.[32]

Longer stays for detainees in detention facilities increases the importance of making care for chronic conditions available. While the average length of stay is 37.5 days,[33] as of April 2007, ICE reported that cumulatively 25% of detainees remained in detention for a long as 44 days and 10% of detainees for as long as 85 days.[34[p.48]] If we apply these figures to the estimated 442,491 individuals in ICE's custody in Fiscal Year 2009, 44,294 will stay as long as 85 days and one-third or approximately 15,000 these detainees will have a chronic condition.[31] With one-third of the population having a chronic disease and longer stays in detention centers, there is an important need to provide medical services for chronic conditions. Left untreated, chronic conditions such as hypertension[35] and diabetes[36] can develop into significant health issues.

Anecdotal accounts also supply instances where individuals are held for long periods of time, during which they require more than just emergency medical and mental health services.[8] One such case is that of Francisco Castaneda. Mr. Castaneda was detained by ICE for a period of 11 months.[37] During this time, he repeatedly requested medical care for a bleeding lesion on his penis. On-site physicians suspected penile cancer and

recommended a biopsy for suspected cancer and appropriate follow-up treatment.[37] Despite these recommendations, multiple sick call requests and grievance filings, DIHS refused to permit a potentially lifesaving biopsy calling it instead "elective surgery."[37[p.14]] Mr. Castaneda was eventually diagnosed with penile cancer and died one year after release from the detention center at the age of 36.

Critical health care staffing shortages. Staffing shortages at detention facilities almost certainly exacerbate the problem of providing detainees with adequate and timely medical care. Clinical staffing shortages raised concerns from the OIG about ICE's ability to provide proper health care to detainees.[6[p.33]] A *Washington Post* article has described the staffing shortages at some facilities as acute.[38] For example, the Willacy County Detention Center in South Texas has no clinical director, no pharmacist, and only a part-time psychiatrist.[38] The Elroy Arizona center, at times, had a 50% vacancy rate for nurses.[5[p.10]]

These staffing shortages cause delays in implementing ICE's policies for immediate intake medical screening and a medical exam within 14 days of admission to the facility. A government audit found that detainees did not always receive timely intake screenings and some facilities did not conduct intake screenings during busy detainee book-in periods as a result of staffing shortages.[5[p.10]] The OIG also examined two facilities for compliance with the medical exam timeliness standard. Both facilities had difficulty meeting ICE's standard. Detention facility officials reported that staffing shortages and overworked clinicians caused delays in meeting the medical exam standard.[6[p.22]] Neil Sampson, at the time the interim director of DIHS, in an internal memorandum expressed concerns about maintaining ICE's own medical procedures as a result of staffing shortages.[39]

Lack of accurate mortality and morbidity data. A June 2008 OIG report recommended ICE adopt a policy for prompt reporting of detainee's deaths to the OIG.[6[p.17]] Immigration and Customs Enforcement responded to this recommendation by instituting a policy of reporting detainee deaths to the OIG as well as appropriate House and Senate committees.[40] Prior to this policy change, facilities were not required to report detainee deaths to the OIG, leaving many of the deaths unaccounted for and skewing the scarce data, thus making the problems resistant to remedy.[6] As a result, no accurate mortality data existed for immigrants in detention in the U.S., limiting the focus and attention this topic warrants. As recently as August 2009, ICE (in response to an FOIA request) identified 10 additional detainee deaths from Fiscal Year 2004 to Fiscal Year 2007 not previously included on the agency's list of detainee deaths. The Assistant Secretary of ICE, subsequently, issued a press release calling the "appropriate tracking and accounting of the deaths of individuals in ICE custody [an] imperative."[10[p.1]] The new detainee death-reporting policy, as with all ICE's policies and procedures, are not codified in either statute or regulation, making this and other medical care related policies legally unenforceable.

Additionally, no accurate morbidity or medical treatment data exist for this population. The only data currently collected on the medical status of detainees is limited use of coding of either "healthy" or "unhealthy."[40[p.25]] With no diagnosis-specific data, accurate planning for medical needs, staffing, and other resources for detainees are concerns.[41]

While the foundations for a functional system are in place, ICE often fails to comply with its own standards. The system allows for errors to go unnoticed and for repeated mistakes. The result is inadequate medical and mental health services for detainees.[5,7,8,16,26,29]

Legislative proposals. The topic of detainee health care has gained national attention. Congress held a series of legislative hearings on this subject and introduced several bills aimed at improving detainee health care. Two of the more recent proposals introduced in 111th Congress are the Secure and Safe Detention and Asylum Act (S. 1594)[42] and the Safe Treatment, Avoiding Needless Deaths, and Abuse Reduction in Detention System Act (Strong STANDARDS Act) (S. 1550[43]/H.R. 4470[44]). To date, none of the legislative proposals have become law. Bills introduced in previous legislative sessions died in committee while the bills introduced during the 111th Congress are still in committee.

The Secure and Safe Detention and Asylum Act. On August 6, 2009, Senator Joseph Lieberman (ID-CT) reintroduced the Secure and Safe Detention and Asylum Act, with the intent of providing safeguards against faulty asylum procedures and improving conditions of detention for detainees.[42] This bill, among other measures, addresses three needed improvements in the delivery of health care for detained immigrants: improved oversight, mandatory compliance with medical procedures, and reporting and investigation of detainee deaths. It addresses the flaws in the current oversight system by establishing an Office of Detention Oversight, but falls short of establishing an oversight office independent of ICE, opting instead to have this office report to the Secretary of DHS.

This Act would also institute legally enforceable medical standards by providing for prompt and adequate medical care to detainees at no cost, including mental health care, emergency, primary and specialty services. Issues in delaying or denying care are further addressed in this bill by requiring timely responses to medical care requests and comprehensive intake screenings. Reporting and investigation of all in-custody detainee deaths would be also mandatory. Many of the provisions in this Act are ICE policy, but not consistently enforced or followed.[5,7,8,9,15]

Safe Treatment, Avoiding Needless Deaths, and Abuse Reduction in the Detention System Act. One other recent proposal, the Safe Treatment, Avoiding Needless Deaths, and Abuse Reduction in the Detention System Act or Strong STANDARDS Act sets out provisions for the humane treatment and delivery of adequate medical care for detainees. This bill was introduced by Senator Robert Menendez (D-NJ) in the Senate on July 30, 2009[43] and a companion bill in the House by Representative Diane Watson (D-CA 33) on January 19, 2010.[44]

The issues addressed in this legislation lie not in a lack of ICE's medical policies, but in compliance, oversight, and legal enforceability of existing medical standards. The Act establishes measures for ICE's compliance with current policies for medical care through such means as an independent oversight commission, and financial penalties and potential contract termination for detention facilities' noncompliance with requirements set for forth in this bill. Many provisions of this Act deal with the need to ensure detainees' prompt access to medical care, including a comprehensive intake screening and the detainee's need to continue prescribed medication upon admission to the facility. Other provisions of this Act recognize the need to improve care for chronic

conditions by providing provisions for a detainee's right to medical care for diagnoses that existed prior to detention.

Box 1 highlights the current system, outlines the proposed legislation, and identifies additional areas that require attention.

Box 1.

COMPARISON OF CURRENT AND PROPOSED LEGISLATION ON HEALTH CARE FOR DETAINEES

	Current System	S. 1594: Secure and Safe Detention and Asylum Act	S. 1550/H.R. 4470: Strong Standards Act
Legally Enforceable Medical Care Standards	No—Voluntary standards are in place. Procedures are not uniform across the country; implementation issues exist.	Yes—The Secretary (Secretary) of Homeland Security implements new standards to improve conditions.	Yes—Outlines procedures for timely and effective medical and mental health care delivery.
Timely Initial Health Screening	Policies require within 12 hours of admission. Compliance issues exist.	Directs the Secretary to ensure procedures for a comprehensive intake screening.	Medical and mental health intake screening upon arrival at the detention facility.
Care for Chronic Conditions	Care for chronic conditions is provided; however, DIHS Covered Services Package emphasizes emergency care only.	Provides for primary and specialty care at no cost to the detainee.	Provides for medical care for pre-existing conditions at no cost to the detainee.
Independent Oversight Office	2009, detention reforms establish an Office of Detention Oversight, independent of DRO, but reporting to assistant secretary of ICE.	Yes	Yes

(Continued on p. 444)

Box 1. *(continued)*

	Current System	S. 1594: Secure and Safe Detention and Asylum Act	S. 1550/H.R. 4470: Strong Standards Act
Reporting/ Investigation of Detainee's Death	Recently implemented ICE policy requires reporting to OIG and appropriate House and Senate committees and investigation.	Reports to Oversight office, OIG, and appropriate House and Senate committees with the results of the investigation.	Reports to the OIG, the DOJ and to Congress with the results of the investigation.
Sanctions for Noncompliance with Standards/Policies	No	Yes	Yes
Staffing Shortage Measures	No	No	No
Incentive Programs to Improve the Quality of Medical Care Delivered to Detainees	No	No	No

Principles for legislative action. Any legislative solution should embody principles to improve the delivery and quality of health care to detained immigrants. Reform legislation must address the absence of mandatory standards for medical care, lack of system oversight, effective enforcement mechanisms for non-compliance, data reporting to identify needed improvements, and incentives to improve the medical care delivery system. The following should characterize any legislative solution:

- *Legally enforceable health care standards required.* The new performance-based standards[22] do present promise in improving health care provided to detained immigrants. Government audit reports, however, indicate standards are not consistently adhered to or enforced.[5,6,7,15,16] ICE medical standards should be codified in statute and regulation. Congress should direct DHS to promulgate the *ICE/DRO Medical Care, Detention Standards*[22] in administrative regulations. Without these standards codified in either statute or administrative regulation, detainees have no legal recourse to address impediments to proper medical care.

- *Mechanisms for effective system oversight established.* An oversight office independent of ICE should be established to oversee the quality of medical care delivered to detained immigrants. This oversight office should be composed of immigration and medical experts. The office should make frequent and unannounced inspections of detention facilities, evaluate facilities' compliance with ICE standards, review detainees' grievances, and refer to the appropriate governmental agency, and provide recommendations on improving the quality of medical care provided to detained immigrants. This office should have enforcement authority and adequate funding and staffing.

- *Requirements for DIHS /ICE to create a covered medical service package that meets its own medical standards included.* There currently exists an incongruity between ICE's own medical standards and the covered service package. Immigration and Customs Enforcement's new performance based standards call for "detainees to have access to a continuum of health care services."[22[p.1]] The covered benefit package, however, emphasizes care for emergency services only.[24] With more than one-third of the detainee population presenting with chronic diseases and the corresponding longer length of stays for this population, it is necessary to bring the covered benefit package in line with ICE's own stated medical standards.

- *Sanctions for noncompliance with standards developed and enforced.* Methods for successful enforcement of *ICE/DRO's Medical Care, Detention Standards*[22] must exist. Legislative initiatives should establish penalties for detention centers that fail to comply with these standards. Monetary sanctions, along with renewal of detention center contracts, should be based on whether compliance with medical standards is present in a facility.

- *Mortality and morbidity data reporting required.* The lack of reliable mortality and morbidity data impedes the identification of issues, the call for necessary changes, and adequate planning for detainees' medical needs. Mandated reporting requirements should require all facilities to report deaths occurring within their facilities, establish a timeline for reporting, and require a complete investigation of the death. Reports of the investigation should be provided to Congress and a database tracking system established to trend patterns of events. Diagnosis and treatment information should also be collected on detainees. This information could assist in identifying needed system requirements and staffing.

- *Policies to address inadequate health care personnel staffing established.* Critical staffing shortages exist at almost every detainee facility leading to poor quality medical care.[5,6,38,39,45] Legislative action should require facility staffing-ratios and encourage health care professionals to provide care in these facilities. Mandated staffing-ratios establish expectations for the number of health care personnel available to care for patients. Detainee facilities should be required to have adequate numbers of licensed and other personnel to provide health care to all detainee-patients as needed. Programs such as those implemented to address the health care labor shortage in rural America should be encouraged through legislation for this population.

- *Appropriations for demonstration projects and create incentive reimbursement strategies to improve the quality of medical care delivered provided.* Demonstration projects would provide the opportunity to develop a specific set of indicators to measure the quality of medical care rendered to this unique population. Congress should also direct DIHS to create an incentive reimbursement structure where detainee facilities meeting and/or exceeding the parameters related to the developed health care quality measures would gain higher reimbursement levels. The Center for Medicare and Medicaid Services is in the process of instituting similar pay-for-performance systems for hospitals.[46]

Conclusion. The health care system for detained immigrants needs improvement. A federal legislative solution is one essential component for improvement. Any legislative solution should embody principles to improve the quality and access to care for this population. An independent office for oversight, legally enforceable standards and procedures, sanctions for non-compliance, strategies to minimize understaffing, a mortality data tracking system, and incentives to evaluate and improve the quality of care delivered to this population all must be codified in legislation.

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