

Disparities in Justice and Care: Persons With Severe Mental Illnesses in the U.S. Immigration Detention System

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As the total number of persons held within the U.S. immigration detention system has grown, the number of detained persons with severe mental illnesses has grown correspondingly. Reports issued by the government, legal and human rights advocates, and the media have brought to light a problematic and growing detention system with pervasive legal and mental health care disparities. Described are the structure and funding of the U.S. immigration detention system, the legal state of affairs for immigration detainees with mental illnesses, and what is known about the present system of mental health care within the U.S. immigration detention system. Attention is given to the paucity of legal protections for immigration detainees with severe mental illnesses, such as no right to appointed legal counsel and no requirement for mental competence before undergoing deportation proceedings. A case example and discussion of potential alternatives to detention highlight the need for wide-ranging reform.

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Immigration law, due process, and access to care for immigration detainees are new and rapidly evolving areas for both forensic and correctional psychiatry. Little has been reported in the literature on this subject. The following article is the first to review the unique public health and legal problems that arise when a person with a severe mental illness is detained within the U.S. immigration system. Emerging standard of care and human rights concerns implicated by this topic require diligent scrutiny from a forensic, legal, and advocacy perspective and make this an important area for increased awareness among forensic psychiatrists.

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A Rapidly Growing System

U.S. Immigration Detention is expanding at such a pace that Immigration and Customs Enforcement (ICE) and the U.S. Department of Justice have solicited thousands of beds in commercial facilities to accommodate the increasing number of detainees.^{1–3} The enacted budget for fiscal year 2010 is \$2.55 billion for ICE Detention and Removal Operations.⁴ The U.S. Department of Health and Human Services, Office of Inspector General, which audits ICE activities related to detainee health and welfare, has issued two reports in the past three years calling for improvement of oversight at facilities housing immigration detainees to ensure adherence to standards of medical and mental health care.^{5,6} The most recent report released by Dr. Dora Schriro, former Director of the ICE Office of Detention Policy and Planning, describes a costly, punitive immigration detention system that is growing despite management and monitoring flaws and failures to maintain adequate detainee health and safety.⁷ In large part because of highly publicized detainee deaths, detention health standards have become a persistent topic in the media, and human rights organizations are beginning to make recommendations to close the gap between detainee health needs and the services actually pro-

vided. The Obama administration has pledged more oversight and accountability of the immigration detention system, including plans to overhaul health and mental health care provision.^{7,8}

Publicly available government reports of demographic data on immigrants within the U.S. immigration detention system are limited, although aggregate numbers are published by the government annually. What is clear is that the detention population is growing rapidly. The growth is due in part to the passage of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, which vastly increased the number of crimes for which noncitizens could be removed and expanded the categories of persons subject to mandatory detention.⁹ Since 1994, the immigration detention system has expanded sixfold, from 6,785 beds per night to 33,400.¹⁰ During fiscal year 2008, ICE detained a record 378,582 persons, representing a 60 percent increase from 2005.¹¹ The Detention Watch Network projects that by 2010, the U.S. government will hold in excess of 440,000 people in immigration custody, more than triple the number of people in detention just 10 years ago, in a network of over 400 facilities, and at an annual cost of more than \$1.7 billion.¹²

The United States immigration detention system is civil and subjects immigrants to detention for the primary purpose of preventing their absconding from civil deportation proceedings, not to punish or rehabilitate.^{7,13} Its function stands in contrast to the criminal justice system, which utilizes detention and incarceration, not only to prevent flight during the pendency of the criminal process, but also to punish and rehabilitate those convicted of crimes. The government's most recent reports indicate that 11 percent of immigration detainees had committed violent crimes and that the majority of the population is characterized as "low custody" with a low propensity for violence.⁷ Immigrants are detained in many different types of settings, with varying access to medical and psychiatric care, under the purview of U.S. Immigration and Customs Enforcement. ICE reported an average detention stay of 30.49 days in fiscal year 2008¹⁴; however, according to a 2003 study, asylum seekers who were eventually granted asylum spent an average of 10 months in detention with the longest reported period being 3.5 years.¹⁵ Those immigrants who seek to appeal an immigration judge's order of deportation also typically spend

much longer periods in custody. There is also growing evidence that immigration detainees with mental illnesses are likely to experience prolonged detention.¹⁶

ICE reports that in fiscal year 2008, it performed 29,423 mental health interventions¹⁷ and managed a daily population of between 1,350 to 2,160 detainees with serious mental illnesses¹⁸ (based on ICE population data, this represents approximately 4%–7% of detainees), but in confidential memos, officials estimate that about 15 percent are mentally ill,¹⁹ a percentage resembling that of U.S. prison inmates, of whom 15 to 24 percent are estimated to have a severe mental illness.^{20,21} There has been much controversy about preventable deaths and the accurate reporting of those deaths within the U.S. immigration detention system. *The New York Times* obtained and published the government's unofficial roster of detainee deaths from 2003 to 2008, showing that 13.5 percent were ruled suicides.²² In a similar report, *The New York Times* reported that ICE's Office of Professional Responsibility found that ICE officials obscured facts of detainee suicides to appear less culpable.²³ ICE reviewers have called for welfare checks, key and tool control, noninvasive searches, and a viable suicide prevention program.⁷

Lack of Due Process for Detained Persons With Mental Illnesses

Deportation proceedings are civil legal proceedings that are adversarial in nature. Immigration judges preside over the proceedings. A trained ICE attorney leads the legal efforts to deport the person who has been placed in deportation proceedings. In a typical immigration case, the ICE attorney will lay out the legal reasons that the person in proceedings should be deported. The person is then given a chance to respond with the legal reasons that he or she should not be deported. After both cases have been presented, the immigration judge issues a decision.

The United States Supreme Court has affirmed that people in deportation proceedings are entitled to due process and basic fairness.²⁴ In *Bridges v. Wixon*,²⁵ the Court recognized that due process plays an especially vital role in deportation proceedings because of the fundamental interests at stake:

... [T]hough deportation is not technically a criminal proceeding, it visits a great hardship on the individual and deprives him of the right to stay and live and work in this land of freedom. That deportation is a penalty—at times a

most serious one—cannot be doubted. Meticulous care must be exercised lest the procedure by which he is deprived of that liberty not meet the essential standards of fairness [Ref. 25, p 154].

In *Ng Fung Ho v. White*, the Court also acknowledged that deportation can result “in loss of both property and life, or of all that makes life worth living” (Ref. 26, p 284) and in *Fong Haw Tan v. Phelan*, the Court noted that deportation “is . . . at times the equivalent of banishment or exile” (Ref. 27, p 10).

Because of the interests at stake in deportation proceedings, immigration law contains protections available to all persons in removal proceedings. Primary among these protections is the right to an attorney. According to 8 U.S.C. §1362, a person in deportation proceedings has “the privilege of being represented. . . by counsel”; however, the right is limited, because such representation must be “at no expense to the Government.” Stated differently, if a person in deportation proceedings cannot afford an attorney, he must proceed *pro se*, even though immigration law and deportation proceedings have been described as “complicated”²⁸ and “labyrinthine”²⁹ to the extent that *pro se* litigants are unlikely to know the law well enough to avoid deportation.³⁰

The practical result is that most people in deportation proceedings proceed *pro se* because they are unable to afford legal assistance. According to statistics from the Executive Office of Immigration Review (EOIR), the percentage of unrepresented immigrants for fiscal years (FYs) 2004 to 2008 ranged from 55 to 65 percent.³¹ Those percentages are much higher for detained individuals according to advocacy groups, which have reported that 84 to 90 percent of detainees go without counsel.^{32,33}

This situation has been described as an “immigration representation crisis”³⁴ and is troubling not just to the legal community, but to the U.S. Department of Justice itself, which has called on immigration judges “to ensure that [individuals appearing *pro se*] understand the nature of the proceedings, as well as their rights and responsibilities [and] take extra care and spend additional time explaining this information” (Ref. 31, p G1).

The widespread concern about the lack of due process and basic fairness for unrepresented people in removal proceedings is heightened where those people have mental illnesses. Although persons with severe mental illnesses, especially those unrepresented by counsel, often face greater difficulties throughout

the legal process, there are few regulations that safeguard their guarantee of due process under the Constitution. There is anecdotal evidence that people with mental illnesses, and in particular those who are detained and without community support, have reduced capacity to obtain counsel and are therefore especially likely to proceed *pro se*.³⁵

Moreover, existing immigration laws and regulations do not adequately address what additional procedures or protections must be provided to ensure that those people in deportation proceedings who are unrepresented by counsel and who have mental illnesses are afforded due process and basic fairness.³⁵ These regulations are narrow in scope and do not address the broader question of what overall legal framework is necessary to ensure due process and basic fairness to the mentally incompetent and unrepresented person in deportation proceedings.

Advocates have pointed to the paucity of guidelines and the lack of an overall legal framework for protecting the rights of those with mental illness as a cause of inconsistent immigration court practices in which uncertain immigration judges sometimes proceed without addressing a detainee’s mental illness or repeatedly reset deportation hearings while the individual remains in prolonged detention.³⁵ Indeed, immigration judges are challenged to provide fundamental fairness to potentially incompetent individuals despite limited guidance, sparse precedent case law, and a lack of issued policy memoranda.³⁶ Both administrative and judicial efficiency for the U.S. Department of Justice could be gained by confronting the problem, which leads to procedural errors and protracted litigation³⁷ and presumably increases detention and health care costs.

In marked contrast with criminal proceedings, where a criminal defendant must be mentally competent to be subjected to the criminal process, even when represented by counsel, U.S. immigration authorities have taken the legal position that deportation proceedings may be conducted against a person who is unrepresented by counsel and mentally incompetent.³⁸ “Trial competence” does not yet exist conceptually under American immigration law. Although this has been identified as a growing problem for detainees with mental illness,³⁹ the EOIR has confirmed that although a respondent is determined to be incompetent in immigration court, there is no rule that an attorney be appointed.³⁹

Although the U.S. Supreme Court has yet to rule on the issue, a few courts have held that mentally incompetent persons can be deported. In *Nee Hao Wong v. INS*,⁴⁰ the Ninth Circuit Court determined that due process was not violated when a litigant with an attorney was found incompetent because the proceedings were civil and not criminal. In *Jaadan v. Gonzales*,⁴¹ the Sixth Circuit Court ruled that Mr. Jaadan did not have a right to a competency hearing and that a determination of mental incompetence did not preclude deportation; he was subsequently deported.⁴¹ In *Mohamed v. Gonzales*,⁴² the Eighth Circuit Court determined that the lack of a competency hearing was not an abuse of discretion and did not violate Mr. Mohamed's right to procedural due process.

There is an apparent conflict between these cases, which suggest that a mentally incompetent person can be deported consistent with due process in some situations and the U.S. Supreme Court's definitive holding that people in removal proceedings must be provided with due process and basic fairness. There is also an apparent conflict between these cases and Section 240(b)(3) of the Immigration and Nationality Act. Although the meaning of this section remains unclear and largely unaddressed by case law, the section seems to expressly protect the rights of those who are mentally incompetent in deportation proceedings in that it instructs the Attorney General to "prescribe safeguards to protect the rights and privileges" of respondents who are not "present" by reason of mental incompetence. Clarification of what Section 240(b)(3) actually requires of immigration authorities in terms of increased protections would be likely to increase fairness and prevent the delays, errors, and expenses caused by the status quo.

For people in deportation proceedings who are mentally ill and without counsel, the greater likelihood of *pro se* status, the lack of an adequate legal framework to ensure basic fairness, and the unsettled state of the law have sometimes resulted in gross miscarriages of justice, such as when people who are actually U.S. citizens have been deported.⁴³

There are signs that efforts at reform are afoot. Advocates have urged the appointment of counsel for all people with mental illnesses who are in deportation proceedings and have also suggested appointment of a guardian *ad litem* for those found mentally incompetent.³⁵ The appointment of a guardian is not unprecedented in removal proceedings,⁴⁴ and if a

family member of the litigant is not available, "public" guardians could be assigned by the EOIR. Moreover, in February of 2009, the U.S. House of Representatives passed a bill encouraging the EOIR "to work with experts and interested parties in developing standards and materials for immigration judges to use in conducting competency evaluations of persons appearing before the courts" (Ref. 36, p 2). However, it is apparent that much work remains before due process and basic fairness are guaranteed to all people in deportation proceedings, especially to those with mental illnesses.

A Broken System of Care for Detainees With Mental Illness

The provision of health care, including mental health care, for persons in ICE custody is directed by the Division of Immigration Health Services (DIHS), which also sets medical policies and reimbursement guidelines.⁴⁵ DIHS procedures, and ICE standards as a whole, do not constitute formal federal administrative regulations and thus do not carry the force of law.^{46,47} In July 2009, the Obama administration affirmed Bush-era ICE policy by refusing to codify detention standards in a federal regulation.⁴⁸ As a consequence, when an individual detention center, or ICE as an agency, fails to provide adequate care for detainees, accountability is limited. Moreover, the current ICE medical care standards do not require accreditation by the National Commission on Correctional Health Care (NCCCHC) or the Joint Commission (formerly the Joint Commission on Accreditation of Health Care Organizations; JCAHO).⁴⁹

Detainees are often held in facilities designed for criminal offenders because the industry of immigrant detention is mostly an expansion of existing corrections infrastructure.⁴⁶ The most common detention venues (350 facilities holding over 50% of all detainees) are state prisons and local jails that ICE pays to house immigrants through Intergovernmental Service Agreements.¹ ICE also houses immigrants in for-profit prisons known as Contract Detention Facilities, in its own Service Processing Centers, in the federal Bureau of Prisons system, in shelters for minors run by the Office of Refugee Resettlement, and in other less restrictive facilities like medical centers, shelters, and hotels.⁵⁰

Most immigrants held in detention have no criminal record,⁵¹ yet advocates have argued that they receive health care of lower quality than do crimi-

nally incarcerated persons in the United States.¹² Several stories in the media of detainees suffering and dying because of delayed or denied medical and mental health care have emerged amid a mounting critique of the ICE detention medical system as a whole.^{46,52,53} In addition to reports from the media, Congressional hearings, United Nations Reports, lawsuits, and nongovernmental organization reports have unearthed instances of facilities' ignoring sick-call requests, poor monitoring of persons at risk of suicide, not delivering medication, losing medical records, failing to provide translation services, impeding access to specialist care, and denying needed treatment.^{46,54–58}

Medicolegal experts question whether ICE's information systems (particularly ENFORCE, their electronic record-keeping system) contain sufficient data to allow compliance with existing detention standards or with potential new standards created as part of the proposed detention system transformation.⁴⁹ For example, ICE standards require that detainees, their families and their attorneys be notified of imminent transfers and that official health records accompany transferred detainees, but the OIG has reported noncompliance with this rule, citing electronic record shortcomings and staff failures to properly fill out notification forms for 143 of the 144 transfers tested.⁵⁹

There have been reports of noncitizens with severe mental illnesses being transferred and held for prolonged periods without contact with family and counsel in privately contracted psychiatric hospitals.^{60,61} Standards of care and patient's rights within these facilities appear to vary widely, often failing to meet applicable state laws as well as ICE's own detention standards.⁵⁹ For example, one hospital shackled immigration detainees to beds 24 hours a day, kept them in virtual isolation, denied them opportunities for exercise, socialization, group therapy, phone calls, visitors, watching television, or using the telephone.⁶⁰ Disability rights attorneys in California issued a demand letter to the aforementioned hospital, which halted its acceptance of ICE detainees as patients.⁶²

Case Example

A 47-year-old Latino male with schizoaffective disorder and alcohol dementia, held in a privately contracted detention facility in California, entered the United States at the age of 17 and gained lawful

permanent resident status. He was put into deportation proceedings following criminal convictions that occurred principally as a result of his untreated mental illness. The severity of his symptoms often required a high level of care; thus, he was held largely in a patchwork of psychiatric hospitals all over the United States. These hospitalizations lasted for over two years, during which time he was held incognito, without a hearing and without access to counsel or family. Finally able to contact his family, he gained legal representation. After a psychiatric evaluation and with the help of his attorney, he was found to be incompetent to undergo deportation proceedings by an immigration judge who was concerned about the unfairness of the man's situation and who made the ruling in the absence of clear law. At the urging of the defendant's counsel, the immigration judge also appointed a guardian *ad litem* and granted the defendant's release on bond, which would have allowed him to receive community psychiatric treatment during the pendency of his deportation proceedings. The ICE attorney, however, opposed the granting of bond, arguing that the man's mental illness made him dangerous, and appealed the immigration judge's decision to the Board of Immigration Appeal, which reversed the immigration judge. At this writing, the man remains in immigration custody, over five years after first being placed into immigration detention.

Alternatives to Detention

Persons with severe mental illness in the U.S. immigration detention system are similar to those within U.S. jails and prisons, in that they too have been affected by the profound paradigm shift over the past few decades from hospitalization to incarceration.⁶³ Indeed, the concept of therapeutic jurisprudence, which emphasizes that the law should be used to promote the mental and physical well-being of the people it affects,⁶⁴ should afford one plausible remedy, which is not to detain persons with severe mental illnesses at all.

To meet the challenges of this growing public health and human rights problem outside of the detention system, there should be forms of available community treatment, including assisted outpatient treatment and hospitalization, as alternatives. Even ICE concedes that many immigrants should be in facilities less restrictive than jails and prisons⁸ and that alternatives to detention, such as conditional

release, reporting requirements, bond, or financial deposits, appear to be the way forward.⁶⁵

Alternative programs have already been championed by ICE and others as providing a cost-effective, humane alternative to detention.⁶⁶ ICE estimates that its three alternative programs cost far less than hard detention and enjoy relatively high rates of success.⁶⁷ In 2004, ICE implemented its Intensive Supervision Appearance Program which uses electronic monitoring devices (ankle bracelets), check-in by telephone, home visits, and restrictions on movement to make sure that an individual complies with his or her conditions of release and shows up for immigration court proceedings.⁵⁷

The ICE fiscal year 2010 enacted budget includes \$69.9 million for alternatives to detention.⁶⁸ These programs might be better characterized as “constructive custody” whereby noncitizens can receive services, including greater access to health and mental health services, before or upon adjudication, that avoid inappropriate detention or deportation. If this were to occur, the potential savings to the government and benefits to individuals with severe mental illnesses would be immense.

Conclusions

The fate of immigration detainees with severe mental illnesses in the U.S. immigration detention system has far-reaching public health and legal implications. It is also a rapidly changing and evolving area for the field of forensic and correctional psychiatry. Forensic psychiatrists will be increasingly called on to give opinions on cases involving mentally ill immigration detainees and provide expertise for immigration detention reform efforts. This topic, which presently receives little or no attention in forensic psychiatry training programs nationally, is important to teach to fellows who are more likely than ever to encounter ICE detainees and immigrants in deportation proceedings during their careers. Forensic psychiatrists are poised to provide scholarly work, including research and analysis, as well as increased oversight, to ensure quality of care for detained immigrants with mental illnesses.

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