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THE GRAPES OF WRATH: ON THE HEALTH OF IMMIGRATION DETAINEES

STACEY A. TOVINO, JD, PHD*

Abstract: This Article challenges the lack of health care provided to individuals in U.S. Immigration and Customs Enforcement ("ICE") custody. As background, many immigration detainees are physically and emotionally vulnerable at the time of initial confinement due to a history of torture and trauma, which may include human trafficking, sexual violence, political oppression, psychosocial trauma, and acculturative stress. Detention can exacerbate preexisting vulnerabilities and contribute to severe physical and mental illness as well as death. Between October 2003 and October 2015, 153 individuals died while in ICE custody. Although most proposals for detainee health reform borrow heavily from constitutional law, international human rights law, and tort law, this Article argues that these areas of the law lack the specificity, enforceability, and ex ante perspective necessary, respectively, to effect comprehensive reform. Instead, this Article uses state and federal health law as a model for change. Involuntary commitment laws, long-term care facility laws, and behavioral health laws provide a lens through which the lack of access to health care in detention might be assessed and through which the unenforceable standards governing detention centers might be improved. This Article makes eight specific recommendations that, if promulgated by the Department of Homeland Security into legally enforceable regulations, will improve the health and safety of detainees.

INTRODUCTION

On April 6, 2015, Raul Ernesto Morales-Ramos, a forty-four-year-old Salvadoran national who had been in U.S. Immigration and Customs En-

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forcement ("ICE") custody since 2010, died of intestinal cancer.[1] The Adelanto Immigration Center in Adelanto, California ("Adelanto"), which ignored Morales-Ramos's complaints of severe abdominal pain, uncontrollable leakage of urine, and diarrhea, refused to provide the detainee any medical care.[2]

On March 4, 2012, Fernando Dominguez Valdivia, a fifty-eight-year-old Mexican national, died of multiple organ failure caused by an infection that spread to his bloodstream following one hundred days in ICE custody, also at Adelanto.[3] Following an investigation of his death, the Federal Office of Detention Oversight ("ODO") determined that Adelanto's medical staff failed to properly examine Dominguez Valdivia, failed to create medical records that would ensure the continuity of his health care, and failed to access available, off-site health care.[4] The ODO concluded that the care Dominguez Valdivia received was unacceptable and that his death was preventable.[5]

Morales-Ramos and Dominguez Valdivia are two of 153 detainees who died in ICE custody between October 2003 and October 2015.[6] Other detainees who died during this time period include Tiombe Kimana Carlos, a thirty-four-year-old woman with schizophrenia from Antigua and Barbuda who hanged herself on October 23, 2013, at York County Jail in York, Pennsylvania, where she had been detained for more than two-and-a-half years.[7] An ICE report investigating Carlos's death found a series of lapses in care by the jail, including a failure to conduct a health examination within a reasonable

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[1] Kate Linthicum, *Salvadoran Immigrant Held at Adelanto ICE Facility Dies*, L.A. TIMES (Apr. 7, 2015, 6:37 PM), http://www.latimes.com/local/lanow/la-me-ln-detainee-death-20150407-story.html [http://perma.cc/N6MF-5RNW].

[2] Ray Downs, *Immigrant Dies in GEO Group Facility After Three Weeks of Ignored Symptoms, Says Attorney*, BROWARD PALM BEACH NEW TIMES (Apr. 13, 2015), http://www.browardpalmbeach.com/news/immigrant-dies-in-geo-group-facility-after-three-weeks-of-ignored-symptoms-says-attorney-6930614 [http://perma.cc/ARP4-QNRJ].

[3] *See* U.S. IMMIGRATION & CUSTOMS ENF'T, LIST OF DEATHS IN ICE CUSTODY, OCTOBER 2003–MAY 26, 2015, at 3 (2015) [hereinafter LIST OF DEATHS], https://www.ice.gov/sites/default/files/documents/FOIA/2015/detaineedeaths2003-present.pdf [https://perma.cc/G6WW-B447] (disclosing Dominguez Valdivia's death, but spelling his name "Dominguez-Valvivia"); Alonso Yáñez, *Living in the Shadows: Detention Center Deaths Raise Immigrant Rights Questions*, UNIVISIÓN (Feb. 19, 2014), http://newamericamedia.org/2014/02/living-in-the-shadows-detention-centers-deaths-raise-immigrant-rights-questions.php [http://perma.cc/9FFL-XVMA] (placing Dominguez Valdivia's death in context).

[4] OFFICE OF DET. OVERSIGHT, U.S. DEP'T OF HOMELAND SEC., COMPLIANCE INSPECTION: ADELANTO CORRECTIONAL FACILITY, ADELANTO, CALIFORNIA 2 (2012), https://www.ice.gov/doclib/foia/odo-compliance-inspections/adelantoCorrectionalFac_Adelanto-CA-Sept_18-20-2012.pdf [https://perma.cc/4VQA-M3HS] [hereinafter ADELANTO INSPECTION REPORT].

[5] *Id.* ("ODO concluded the detainee's death could have been prevented and that the detainee received an unacceptable level of medical care . . . .").

[6] LIST OF DEATHS, *supra* note 3, at 1–15.

[7] *Id.* at 1.

time of detention and a failure to implement a treatment plan with measurable goals and objectives.[8]

This Article tackles a problem that is broad in scope; that is, individuals' general lack of access to physical and mental health care while in detention. Using contemporary health care standards applicable to voluntary and involuntary health care providers as a reference point,[9] this Article proposes to replace the unenforceable health care guidelines currently set forth in ICE's detention standards[10] with rigorous federal regulations.[11]

This Article proceeds as follows: Part I examines immigration detainees' lack of access to adequate physical and mental health care.[12] Using publicly available information, including ICE's List of Deaths in ICE Custody,[13] as well as internal detention center investigation reports, autopsy reports, and other inter-agency memoranda, Part I identifies the immediate causes of detainee deaths, including untreated staph infections, sepsis, tuberculosis, pneumonia, meningitis, emphysema, aneurysms, hypertension, diabetes complications, HIV complications, cancer, seizure disorders, liver

[8] Memorandum from Div. Dir., Office of Prof'l Responsibility, U.S. Immigration & Customs Enf't, to Thomas Horman, Exec. Assoc. Dir., Enf't & Removal Operations 2, 5 (July 17, 2014), http://media.philly.com/documents/Carlos+Detainee+Death+Report.pdf [http://perma.cc/44TP-FLGE] [hereinafter Carlos Investigation Memorandum] (noting that Tiombe Kimana Carlos was not physically examined until her sixteenth day of detention); *ICE Finds Deficiencies at York County Prison Related to 2013 Inmate Suicide*, YORK DAILY REC. (Feb. 4, 2015), http://www.ydr.com/crime/ci_27448414/ice-releases-report-york-county-prison-inmate-suicide [https://perma.cc/manage/vest/R35U-MJEL] (reporting same).

[9] *See infra* notes 201–370 and accompanying text (arguing that constitutional law, international human rights law, and tort law are not the best methods to create comprehensive, nationwide detainee health reform).

[10] *See* IMMIGRATION & CUSTOMS ENF'T, U.S. DEP'T OF HOMELAND SEC., PERFORMANCE-BASED NATIONAL DETENTION STANDARDS 277–320 (2011) [hereinafter 2011 PBNDS]; IMMIGRATION & CUSTOMS ENF'T, U.S. DEP'T OF HOMELAND SEC., PERFORMANCE-BASED NATIONAL DETENTION STANDARDS (2008) [hereinafter 2008 PBNDS]; U.S. IMMIGRATION & NATURALIZATION SERV., NATIONAL DETENTION STANDARDS (2000) [hereinafter 2000 NDS].

[11] *See infra* notes 371–448 and accompanying text (offering recommendations for creating legally enforceable regulations that would improve the health and safety of immigration detainees). In an article published in the *Minnesota Law Review*, this author analyzed ICE's widespread practice of secluding immigration detainees for lengthy periods of time for purported administrative, disciplinary, or protective reasons. *See* Stacey A. Tovino, *Of Mice and Men: On the Seclusion of Immigration Detainees and Hospital Patients*, 100 MINN. L. REV. (forthcoming June 2016) (manuscript at 4–5) (on file with author). That article focused only on detention centers' excessive use of the seclusion intervention; that is, the involuntary confinement of a detainee alone in a cell or other area that the detainee is physically prevented from leaving. *Id.* (manuscript at 20). Although detention centers offer a range of justifications for their frequent use of seclusion, the article argued that these justifications are not proportionate to the dangers of seclusion, including the risk of injury and death. *Id.* (manuscript at 21–31). It concluded by proposing structure and content for new, legally enforceable federal regulations that would limit detention centers' use of the intervention. *Id.* (manuscript at 42–51).

[12] *See infra* notes 31–200 and accompanying text.

[13] LIST OF DEATHS, *supra* note 3, at 1–15.

failure, renal failure, and multiple organ failure, as well as electrocution, drowning, rabies, cardiac arrest, shock, traumatic brain injury, methamphetamine intoxication, suicide by hanging, and suicide by other forms of strangulation.[14] These deaths are clinically unsurprising; that is, many individuals are extremely physically and emotionally vulnerable at the time of initial detention due to a history of torture and trauma, which may include human trafficking, sexual violence, political oppression, psychosocial trauma, and acculturative stress.[15] Detention can exacerbate preexisting vulnerabilities and contribute to severe physical and mental illness without proper diagnosis and treatment.[16]

Using internal ICE memoranda as well as interviews with detainees conducted by human rights organizations, Part I also identifies the underlying, or root, causes of these deaths, including: detainees' lack of access to comprehensive physical and mental health examinations within a reasonable period of time following detention; individualized plans of care with measureable goals and outcomes; timely and proper treatments and follow-up care; protections from and treatments for infectious diseases; and effective suicide precautions, including suicide prevention, monitoring, and intervention.[17]

Thus far, proposals to improve health care in detention have relied primarily on constitutional prohibitions against punishment without due process of law,[18] international documents establishing rights to health care,[19] international human rights prohibitions against cruel, inhuman, and degrading treat-

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[14] *See id.* (identifying each detainee's cause of death in the right-hand column); *infra* notes 96–200 (discussing the many causes of deaths in detention facilities and considering those causes that are preventable).

[15] *See* RoseMarie Perez Foster, *When Immigration Is Trauma: Guidelines for the Individual and Family Clinician*, 71 AM. J. ORTHOPSYCHIATRY 153, 154 (2001) ("[A]nxiety, depression, posttraumatic stress disorder (PTSD), substance abuse, and higher prevalence of serious psychiatric disorders have all been associated with multiple immigrant populations both in and outside of the United States.").

[16] *See, e.g.*, Amicus Brief of 46 Social Science Researchers and Professors in Support of Petitioners-Appellees/Cross-Appellants and Urging Affirmance at 2, Rodriguez v. Robbins, 715 F.3d 1127 (9th Cir. 2014) (No. 13-56706) [hereinafter *Robbins* Brief] ("Prolonged detention exacerbates the physical, mental, societal, and economic harms of transitory detention, and presents unique harms and risks of its own." (footnote omitted)).

[17] *See infra* notes 45–200 and accompanying text.

[18] *See, e.g.*, Lisa A. Cahan, *Constitutional Protections of Aliens: A Call for Action to Provide Adequate Health Care for Immigration Detainees*, 3 J. HEALTH & BIOMEDICAL L. 343, 351–54 (2007) (using constitutional law to argue for improved detainee health care).

[19] *See, e.g.*, Gwynne Skinner, *Bringing International Law to Bear on the Detention of Refugees in the United States*, 16 WILLAMETTE J. INT'L L. & DISP. RESOL. 270, 272, 293–94 (2008) (identifying rights to physical and mental health care set forth in the Universal Declaration of Human Rights and the Covenant on Economic, Social, and Cultural Rights; concluding that the United States is in violation of its obligations to refugees under international law).

ment,[20] and reasonable care obligations under tort law.[21] Although supportive of these proposals, Part II of this Article argues that constitutional law, international human rights law, and tort law lack the specificity, enforceability, and ex ante perspective necessary, respectively, to effect comprehensive detainee health reform.[22]

Rather, Part II offers three sets of health laws that may better guide detainee health reform.[23] These laws include state involuntary commitment laws,[24] federal requirements applicable to long-term care facilities, including Medicare-participating skilled nursing facilities and Medicaid-participating nursing facilities,[25] and federal and state behavioral health laws (collectively, the reference laws).[26] As explained in more detail in Part II, the reference laws require: timely physical and mental health examinations; the creation, documentation, and implementation of individualized care plans; adequate treatment and follow-up care; comprehensive infection controls; and rigorous suicide precautions and monitoring. Part II justifies the use of the reference laws as contemporary standards that may be used to assess the adequacy of the health care (or lack thereof) provided in immigration detention.[27]

Using the reference laws as a benchmark, Part III examines ICE's current detention guidelines, finding them to be legally unenforceable and substantively inadequate.[28] Part III offers eight specific recommendations that, if promulgated by the Department of Homeland Security into federal regulations, would improve the health and safety of immigration detainees.[29]

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[20] *See, e.g.*, Hilary Hamell, *The International Human Right to Safe and Humane Treatment During Pregnancy and a Theory for Its Application in U.S. Courts*, 33 WOMEN'S RTS. L. REP. 244, 253 (2012) (discussing international human rights' prohibitions against cruel and inhuman treatment in the context of pregnant, laboring, and delivering detainees).

[21] *See, e.g.*, Note, *Improving the Carceral Conditions of Federal Immigration Detainees*, 125 HARV. L. REV. 1476, 1491–97 (2012) [hereinafter *Improving Carceral Conditions*] (proposing the classification of nonfederal prison facilities as agents of the federal government under the Federal Tort Claims Act as "the most viable approach to ameliorating the carceral conditions of federal immigrant detainees").

[22] *See infra* notes 201–370 and accompanying text.

[23] *See infra* notes 201–370 and accompanying text.

[24] *See, e.g.*, N.Y. MENTAL HYG. LAW § 9.37(a) (McKinney 2014) (setting forth the standard for involuntary inpatient commitment under New York law); *id.* § 9.60(c)(1)–(7) (setting forth the criteria for involuntary outpatient commitment, called "assisted outpatient treatment," under New York law).

[25] *See* 42 C.F.R. pt. 483 (2014) (establishing federal requirements for long-term care facilities).

[26] *See, e.g.*, 42 C.F.R. §§ 482.60–.62 (2014) (establishing the Medicare Conditions of Participation for Psychiatric Hospitals); COLO. CODE REGS. § 1011-1:XVIII (2014) (regulating psychiatric hospitals in Colorado).

[27] *See infra* notes 201–370 and accompanying text.

[28] *See infra* notes 371–448 and accompanying text.

[29] *See infra* notes 371–448 and accompanying text.

I. DETAINEE HEALTH AND SAFETY CONCERNS

The United States is home to more than 250 immigration detention centers[30] that are designed to confine one or more aliens[31] pending a determination regarding whether each alien is to be removed from the United States or, once a final order of removal has been entered, initiate the alien's return transportation to his or her country of citizenship.[32] In theory, ICE's detention system serves two purposes, including ensuring that aliens are available to attend immigration proceedings (i.e., preventing flight) and segregating aliens from community members to whom they may pose a safety risk (i.e., protecting the community).[33] Data showing that most detainees have committed only minor or non-violent crimes, if any, and are not flight or safety risks effectively counter these theories.[34]

In 2013, the most recent year for which data are available from the Federal Office of Immigration Statistics, ICE detained nearly 441,000 individuals,[35] ninety percent of whom were nationals of Mexico, Guatemala, Honduras, or El Salvador.[36] Scholars have detailed a number of serious concerns associated with ICE's detention system, including detainees' grossly inade-

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[30] *Detention Management*, U.S. IMMIGRATION & CUSTOMS ENF'T (Nov. 10, 2011), http://www.ice.gov/factsheets/detention-management#wcmsurvey-target-id [http://perma.cc/B8N2-8CYT].

[31] An alien is a person who is neither a U.S. citizen nor national. 8 U.S.C. § 1101(a)(3) (2012).

[32] This sentence and its internal references and citations first appeared in Tovino, *supra* note 11, manuscript at 10–11, and is re-printed here with permission of the author. For additional background regarding the United States' immigration detention system, *see* Tovino, *supra* note 11, manuscript at 10–31 (summarizing the ownership, operation, and management of the United States' immigration detention centers and thoroughly documenting critiques of this system by civil rights, human rights, and immigrant advocacy groups, as well as by legal scholars, law school-based immigration clinics, and other stakeholders).

[33] *See* Zadvydas v. Davis, 533 U.S. 678, 690–91 (2001) (discussing the two justifications for immigration detention).

[34] *See, e.g.*, Yolanda Vazquez, *Constructing Crimmigration: Latino Subordination in a "Post-Racial" World*, 76 OHIO ST. L.J. 599, 605 (2015) (noting that the vast majority of those removed as "criminal aliens" are removed for non-violent offenses); Adina B. Appelbaum, Note, *Challenging Crimmigration: Applying* Padilla *Negotiation Strategies Outside the Criminal Courtroom*, 6 GEO. J.L. & MOD. CRITICAL RACE PERSP. 217, 219–20 (2014) ("[A] significant number of those deported with criminal convictions . . . have been convicted only of relatively minor or nonviolent crimes . . . . Today, the largest deportation increases are of immigrants with traffic violations . . . .").

[35] JOHN F. SIMANSKI, OFFICE OF IMMIGRATION STATISTICS, IMMIGRATION ENFORCEMENT ACTIONS: 2013, at 1, 5 & tbls.5 & 6 (2014) ("ICE detained 440,557 aliens during 2013, a decrease of 8 percent from 2012."); *see Immigration Statistics*, U.S. DEP'T OF HOMELAND SEC., http://www.dhs.gov/immigration-statistics [http://perma.cc/66CX-PT8F] (providing statistics regarding immigration enforcement actions from 2013 but not for later years).

[36] SIMANSKI, *supra* note 35, at 5 tbls.5 & 6 (providing numbers and percentages of aliens detained by country of citizenship).

quate and inhumane living conditions,[37] detainees' severely limited recreation and visitation opportunities,[38] the excessive and inappropriate use of the restraint and seclusion interventions by detention center staff,[39] the abuse of power by detention center staff,[40] and the high rates of all types of detainee abuse, including physical, sexual, and emotional abuse.[41] Legal scholars, in particular, also have identified significant due process concerns,[42] human rights concerns,[43] and empirical concerns[44] associated with the U.S. system of detention and deportation. This Article makes an important contribution to this literature by examining one particular concern that requires further academic analysis and comprehensive change: immigration detainees' lack of access to adequate physical and mental health care.

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[37] *See* Nina Rabin, *Immigration Detention in Arizona: A Quietly Growing System Crying Out for Reform*, 45 ARIZ. ATT'Y 31, 31 (2009) (detailing detainees' poor living conditions).

[38] *See* DET. WATCH NETWORK, EXPOSE & CLOSE: BAKER COUNTY JAIL, FLORIDA 3 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-bakernov12.pdf [http://perma.cc/TSF6-7AFM] [hereinafter BAKER COUNTY JAIL REPORT] (reporting a lack of outdoor recreation); DET. WATCH NETWORK, EXPOSE & CLOSE: ONE YEAR LATER 6–8 (2013), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-1yrlaternov13_0.pdf [http://perma.cc/Q3DZ-ZXUH] (reporting a lack of visitation and outdoor recreation).

[39] *See* Tovino, *supra* note 11, manuscript at 2, 10–31 (proposing stringent federal regulations that would limit detention centers' use of restraint and seclusion).

[40] *See* AM. CIV. LIBERTIES UNION OF GA., PRISONERS OF PROFIT: IMMIGRANTS AND DETENTION IN GEORGIA 12, 106 (2012), http://www.acluga.org/files/2713/3788/2900/Prisoners_of_Profit.pdf [http://perma.cc/7ABD-UD9V] [hereinafter PRISONERS OF PROFIT] ("[G]uards overstep their authority by being verbally and physically abusive to detainees, retaliating against detainees for small infractions . . . .").

[41] *See* DET. WATCH NETWORK, EXPOSE & CLOSE: THEO LACY DETENTION CENTER, CALIFORNIA 3–4 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-theolacynov12.pdf [http://perma.cc/TV67-S2UX] [hereinafter THEO LACY DETENTION CENTER REPORT] (reporting detainee physical and psychological abuse).

[42] *See, e.g.*, Farrin R. Anello, *Due Process and Temporal Limits on Mandatory Immigration Detention*, 65 HASTINGS L.J. 363, 363 (2014) (arguing that the mandatory detention statute should be construed to govern detention for no longer than six months, after which time a bond hearing should be required); Fatma E. Marouf, *Incompetent but Deportable: The Case for a Right to Mental Competence in Removal Proceedings*, 65 HASTINGS L.J. 929, 967–80 (2014) (arguing that courts should recognize a substantive due process right to competence in removal proceedings).

[43] *See, e.g.*, Michelle Brané & Christiana Lundholm, *Human Rights Behind Bars: Advancing the Rights of Immigration Detainees in the United States Through Human Rights Frameworks*, 22 GEO. IMMIGR. L.J. 147, 164 (2008) (exploring possibilities for holding U.S. detention officials accountable to international human rights standards).

[44] *See* Fatma Marouf et al., *Justice on the Fly: The Danger of Errant Deportations*, 75 OHIO ST. L.J. 337, 337–404 (2014) (shedding light on the doctrinal controversies surrounding stays of removal by empirically analyzing 1646 cases in all the circuits that hear immigration appeals; finding that the circuit courts denied stays of removal in about half of the appeals that were ultimately granted, "an alarming type of error that could result in people being errantly deported to countries where they risk persecution or torture").

A. Examination and Treatment

Immigration detention centers routinely fail to provide physical and mental health examinations of detainees within a reasonable time following their detention.[45] When examinations are conducted, detention centers frequently misdiagnose or fail to diagnose chronic and acute health conditions.[46] When a health condition is diagnosed, some detention centers fail to create, document, and implement appropriate plans of care.[47] Even when a plan of care is established, medications orders and other forms of treatment may be delayed, ignored, or canceled.[48] As discussed in more detail below, many detainees become sick and die without proper examination, diagnosis, and treatment.[49]

For example, the Eloy Detention Center in Eloy, Arizona ("Eloy"), refused to conduct a physical examination of thirty-two-year-old Jose Lopez-Gregorio, a Guatemalan national, until his twenty-first day of detention.[50] After Lopez-Gregorio finally received a physical examination, medical staff ignored for seven days a sick call placed by the detainee.[51] Lopez-Gregorio hanged himself with a bed sheet on September 29, 2006.[52] An ICE report investigating Lopez-Gregorio's suicide stated, "Medical care in this facility does not meet ICE standards. Physical examinations are not occurring within 14 days and a sick call request made by [the detainee] was deferred for

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[45] *See, e.g.*, Flores v. United States, 689 F.3d 894, 897 (8th Cir. 2012) ("Although ICE standards require a physical examination within fourteen days of a detainee's arrival at a facility, Iñamagua was not examined.").

[46] *See, e.g.*, Dana Priest & Amy Goldstein, *Suicides Point to Gaps in Treatment*, WASH. POST (May 13, 2008), http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html [http://perma.cc/F5YX-PAPJ] ("[S]ome psychiatric patients undergo months and sometimes years of undermedication or overmedication, misdiagnosis or no diagnosis.").

[47] *See, e.g.*, Carlos Investigation Memorandum, *supra* note 8, at 28 ("[Detainee Tiombe Kimana] Carlos's medical record does not document any treatment plan . . . at [York County Jail].").

[48] *See, e.g.*, Priest & Goldstein, *supra* note 46 (reporting the story of detainee Junior Bannister, who was not given his medication for five months following a detention official's order for such medication).

[49] *See, e.g.*, Complaint for Injunctive and Declaratory Relief at 19, Woods v. Myers, No. 07-cv-01078-DMS-PCL (S.D. Cal. Oct. 29, 2007) [hereinafter *Woods* Complaint] ("The failure to properly monitor detainees with chronic illnesses and to appreciate the complications that can arise from poor disease management has had grave consequences at [San Diego Correctional Facility]."); *infra* notes 50–96 (providing examples of individual detainees who became very ill or died without receiving proper medical treatment).

[50] Memorandum from Det. & Deportation Officer, Det. Standards Compliance Unit, Office of Det. & Removal Operations, U.S. Immigration & Customs Enf't, U.S. Dep't of Homeland Security, to John P. Torres, Dir., Office of Det. & Removal Operations 1 (Oct. 11, 2006), https://bsl.app.box.com/s/7n451fvcsmas6jjy3jhu8ubuonhpyrwz [https://perma.cc/2RYG-U8HZ] [hereinafter Lopez-Gregorio Investigation Memorandum].

[51] *Id.* at 1–2.

[52] LIST OF DEATHS, *supra* note 3, at 8; *see also* Priest & Goldstein, *supra* note 46.

seven days."[53] The report concluded, "The most significant concern was found in the areas of 14-day physical examinations that are being conducted at 21 days and the lack of responsiveness to requests for sick call[s] . . . ."[54]

Eloy also has no record of conducting a physical examination of twenty-seven-year-old Mario Francisco Chavez-Torres, a Colombian national who displayed symptoms of a brain aneurysm, including weakness and dizziness, and died of that aneurysm on December 13, 2006.[55] Eloy does have a record, however, showing that Chavez-Torres placed a sick call from solitary confinement and that the sick call was ignored for four days.[56] When a nurse finally responded, she took one hour to walk to Chavez-Torres's cell, located two minutes from the medical staff office.[57] Once she arrived, the nurse told the officer who worked there that she was not qualified to assess Chavez-Torres's health condition: "I am only a pill pusher."[58] There is no medical record evidence showing that a physician ever saw Chavez-Torres at Eloy.[59] An ICE memorandum investigating his death concluded that Chavez-Torres should have been referred for outside treatment and that Eloy failed to protect Chavez-Torres's health, safety, and welfare.[60]

Eloy is not the only detention center to ignore evidence of poor detainee health. Medical staff at Stewart Detention Facility in Lumpkin, Georgia, failed to treat Roberto Medina-Martinez, a thirty-nine-year-old Mexican national, despite clear evidence of the detainee's myocarditis, an inflammation of the heart muscle that is usually caused by a viral infection and is often treatable.[61] Following Medina-Martinez's death on March 11, 2009,[62] the American Civil Liberties Union ("ACLU") of Georgia on behalf of Medina-Martinez's widow sued the federal government under the Federal Tort

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[53] Lopez-Gregorio Investigation Memorandum, *supra* note 50, at 1.
[54] *Id.* at 2.
[55] LIST OF DEATHS, *supra* note 3, at 8; *see also* Phoenix Field Office, Office of Det. & Removal, U.S. Dep't of Homeland Security, Special Assessment Detainee Mario Chavez-Torres 5 (Dec. 8, 2006), https://bsl.app.box.com/s/uzr9e6gb7ntzv9n47yivo4xp8cavpr6k [https://perma.cc/B6UH-ZJ6T] [hereinafter Chavez-Torres Assessment].
[56] Chavez-Torres Assessment, *supra* note 55, at 5.
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] *See* DET. WATCH NETWORK, STEWART DETENTION CENTER, GEORGIA 3–4 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-stewartnov12.pdf [http://perma.cc/DNV7-U5A5] [hereinafter STEWART DETENTION CENTER REPORT] (discussing Medina-Martinez's death); Jeremy Redmon, *Immigrant's Wrongful Death Suit Settled*, ATL. J.-CONST. (July 18, 2012, 5:30 PM), http://www.ajc.com/news/news/local/immigrants-wrongful-death-suit-settled/nQXLJ/ [http://perma.cc/HG8T-AX6X] (discussing the lawsuit filed following Medina-Martinez's death).
[62] LIST OF DEATHS, *supra* note 3, at 5.

Claims Act in a one million dollar wrongful-death lawsuit.[63] The government settled with the plaintiff in 2012 for an undisclosed sum.[64]

Other detention centers also have ignored clear evidence of serious medical conditions, eventually resulting in detainee death. Upon his admission to the San Diego Correctional Facility ("SDCF") on March 27, 2006, for example, Salvadoran national Francisco Castaneda told SDCF medical staff about a white and yellow raised lesion on the foreskin of his penis that was bleeding and discharging pus.[65] A consulting urologist, who examined Castaneda almost three months later, recommended an immediate biopsy and definitive treatment due to his concern about a malignancy and the risk of morbidity associated with untreated lesions.[66] Notwithstanding the urologist's recommendation, the Division of Immigration Health Services within the U.S. Public Health Service declined to approve the standard diagnostic procedure, classifying the biopsy as elective.[67]

Without treatment, Castaneda's lesion continued to grow in size, causing the detainee considerable pain and suffering.[68] On November 17, 2006, officials transferred Castaneda from SDCF to the San Pedro Service Processing Center ("SPSPC").[69] The paperwork that accompanied Castaneda on his transfer stated that he had "no 'current medical problems.'"[70] Castaneda's condition continued to deteriorate, and consulting physicians continued to recommend definitive diagnosis and urgent treatment.[71] Instead of approving these requests, ICE released Castaneda from custody on February 5, 2007.[72] Immediately upon his release, Castaneda presented to the emergency room of a local hospital.[73] After performing a biopsy, physicians the

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[63] *See* Complaint at 7–8, Hernandez-Gonzalez v. United States, No. 4-12-CV-75 (M.D. Ga. Aug. 24, 2014) [hereinafter *Hernandez-Gonzalez* Complaint] (alleging that the government's failure to provide adequate health care to Medina-Martinez breached the standard of care and constituted negligence); Redmon, *supra* note 61 (discussing the lawsuit).

[64] Redmon, *supra* note 61.

[65] Castaneda v. United States, 546 F.3d 682, 684 (9th Cir. 2008), *rev'd sub nom.* Hui v. Castaneda, 559 U.S. 799 (2010).

[66] *Castaneda*, 546 F.3d at 685.

[67] *Id.*; *see* Robert Barnes, *Immigrant's Survivors Cannot Sue Federal Health Officials, Supreme Court Rules*, WASH. POST (May 4, 2010), http://www.washingtonpost.com/wp-dyn/content/article/2010/05/03/AR2010050304419.html [http://perma.cc/8P5B-HFWS] ("Despite advice from three specialists who recommended a biopsy . . . U.S. Public Health Service doctors called the procedure 'elective' and refused to approve it.").

[68] *Castaneda*, 546 F.3d at 685–86.

[69] *Id.* at 686.

[70] *Id.* (quoting the Medical Summary of Federal Prisoner/Alien in Transit that was filed for Castaneda's transfer).

[71] *Id.*

[72] *Id.*

[73] *Id.*; *see* Adam Liptak, *Justices Agree on Detainee Death Case*, N.Y. TIMES (May 3, 2010), http://www.nytimes.com/2010/05/04/us/04scotus.html?_r=0 [http://perma.cc/996X-RMJH] (reporting Castaneda's story).

hospital diagnosed Castaneda with squamous cell carcinoma, a type of skin cancer, and amputated his penis, leaving a two-centimeter stump.[74] Unfortunately, the surgery did not save Castaneda's life.[75] Castaneda died on February 16, 2008, at the age of thirty-six, of metastatic cancer.[76] The federal government later conceded negligence in its treatment of Castaneda[77] and the Castaneda family received $3.2 million in two separate settlements.[78]

The deaths of Lopez-Gregorio, Chavez-Torres, Medina-Martinez, and Castaneda gained national attention from civil liberties, human rights, and other legal organizations. In 2011, the ACLU of Arizona issued a report documenting 115 face-to-face interviews it conducted with detainees and more than 500 grievances authored by detainees.[79] The report highlighted systemic civil and human rights abuses in several key areas, including deficient physical and mental health care.[80] In 2012, the ACLU of Georgia issued a similar report detailing detainee conditions in Georgia, emphasizing "serious concerns about . . . inadequate medical and mental health care."[81]

In 2012, Detention Watch Network, a national coalition of organizations and individuals working to expose and challenge the injustices associated with immigration detention and deportation,[82] released ten "Expose and Close" reports documenting poor conditions in detention centers located across the United States.[83] Among other serious concerns, the reports highlight detainees' lack of access to adequate physical and mental health

[74] *Castaneda*, 546 F.3d at 686.

[75] *Id.*

[76] Henry Weinstein, *Feds' Actions 'Beyond Cruel': Immigration Officials Failed to Treat Detainee Who Later Died of Cancer, a Judge Says*, L.A. TIMES (Mar. 13, 2008), http://articles.latimes.com/2008/mar/13/local/me-cruel13 [http://perma.cc/2FZZ-T24Q].

[77] *Hui*, 559 U.S. at 804 n.3 ("[T]he government filed a formal notice admitting liability with respect to respondents' claims for negligence under the [Federal Tort Claims Act].").

[78] *See Court Approves $1.25 Million Settlement for Family of Deceased Prisoner Francisco Castaneda*, PUB. JUST. (Sept. 9, 2014), http://publicjustice.net/content/court-approves-125-million-settlement-family-deceased-prisoner-francisco-castaneda [http://perma.cc/4V7J-4NUH] (reporting a $1.25 million constitutional violation settlement with two California state employees in September 2014); Editorial, *Obama's Moral Obligation to Detainees Regardless of Immigration Status*, L.A. TIMES (Apr. 8, 2011), http://articles.latimes.com/2011/apr/08/opinion/la-ed-detention-20110408 [http://perma.cc/3YL7-6UM7] (reporting a $1.95 million wrongful death settlement with the federal government in April 2011).

[79] AM. CIV. LIBERTIES UNION OF ARIZ., IN THEIR OWN WORDS: ENDURING ABUSE IN ARIZONA IMMIGRATION DETENTION CENTERS 2 (2011), http://www.acluaz.org/sites/default/files/documents/detention%20report%202011.pdf [http://perma.cc/R6KV-N5MR] (summarizing the report).

[80] *Id.*

[81] PRISONERS OF PROFIT, *supra* note 40, at 12.

[82] *Who We Are*, DET. WATCH NETWORK, http://www.detentionwatchnetwork.org/whoweare [http://perma.cc/7YJ7-U6EG].

[83] *Detention Watch Network Expose and Close Reports on 10 of the Worst Immigrant Prisons in the US*, DET. WATCH NETWORK, http://www.detentionwatchnetwork.org/ExposeAndClose [http://perma.cc/EE3H-CJ2R] (linking to all ten reports).

care in Baker County Jail in Macclenny, Florida,[84] Etowah County Jail in Gadsden, Alabama,[85] Houston Processing Center in Houston, Texas,[86] Hudson County Jail in Kearny, New Jersey,[87] Irwin County Detention Center in Ocilla, Georgia,[88] Pinal County Jail in Florence, Arizona,[89] Polk County Detention Facility in Livingston, Texas,[90] Stewart Detention Center in Lumpkin, Georgia,[91] Theo Lacy Detention Center in Orange, California,[92] and Tri-County Detention Center in Ullin, Illinois.[93] The Detention Watch Network reports reveal not just that preventable deaths occur in ICE custody, but also that detainees who manage to survive their confinement experience significant pain and suffering due to a lack of health care.[94]

Even the federal government—the Office of Inspector General within the Department of Homeland Security—has reported that more than fifty percent of the individuals detained at one California detention center whose records government officials reviewed did not receive a physical examination within fourteen days of admission and were not seen by a doctor or other qualified health professional within seventy-two hours of a formal request for health care.[95]

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[84] BAKER COUNTY JAIL REPORT, *supra* note 38, at 4.

[85] DET. WATCH NETWORK, EXPOSE & CLOSE: ETOWAH COUNTY JAIL, ALABAMA 4–5 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-etowahnov12.pdf [http://perma.cc/8727-6NM7].

[86] DET. WATCH NETWORK, EXPOSE & CLOSE: HOUSTON PROCESSING CENTER, TEXAS 3–4 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-houstonnov12.pdf [http://perma.cc/G9K8-8PX2].

[87] DET. WATCH NETWORK, EXPOSE & CLOSE: HUDSON COUNTY JAIL, NEW JERSEY 5 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-hudsonnov12.pdf [http://perma.cc/C37K-RJZK].

[88] DET. WATCH NETWORK, EXPOSE & CLOSE: IRWIN COUNTY DETENTION CENTER, GEORGIA 2–3 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-irwinnov12.pdf [http://perma.cc/UG3A-GFFE] [hereinafter IRWIN COUNTY DETENTION CENTER REPORT].

[89] DET. WATCH NETWORK, EXPOSE & CLOSE: PINAL COUNTY JAIL, ARIZONA 6 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-pinalnov12.pdf [http://perma.cc/C2XC-G5L2] [hereinafter PINAL COUNTY JAIL REPORT].

[90] DET. WATCH NETWORK, EXPOSE & CLOSE: POLK COUNTY DETENTION FACILITY, TEXAS 4 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-polknov12.pdf [http://perma.cc/R5XN-4KLR] [hereinafter POLK COUNTY DETENTION FACILITY REPORT].

[91] STEWART DETENTION CENTER REPORT, *supra* note 61, at 3–4.

[92] THEO LACY DETENTION CENTER REPORT, *supra* note 41, at 5.

[93] DET. WATCH NETWORK, EXPOSE & CLOSE: TRI-COUNTY DETENTION CENTER, ILLINOIS 4 (2012), http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-tricountynov12.pdf [http://perma.cc/3FFR-HLY9] [hereinafter TRI-COUNTY DETENTION CENTER REPORT].

[94] *See supra* notes 84–93 (reporting detainees' lack of access to adequate physical and mental health care).

[95] OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HOMELAND SEC., TREATMENT OF IMMIGRATION DETAINEES HOUSED AT IMMIGRATION AND CUSTOMS ENFORCEMENT FACILITIES, No. OIG-

Indeed, ICE's own *List of Deaths in ICE Custody* hints at additional access problems and reveals a wide range of causes of death in detention, including untreated staph infections, sepsis, tuberculosis, pneumonia, meningitis, emphysema, aneurysms, hypertension, diabetes complications, HIV complications, cancer, seizure disorders, liver failure, renal failure, and multiple organ failure, as well as electrocution, drowning, rabies, cardiac arrest, shock, traumatic brain injury, methamphetamine intoxication, suicide by hanging, and suicide by other forms of strangulation.[96] Some of these deaths are discussed in further detail below.

B. Infection Control

Due to a lack of comprehensive infection controls, many immigration detainees contract contagious, preventable, treatable infections, and some die of these infections. On July 12, 2014, Santiago Sierra-Sanchez, a Mexican national, died at Utah County Jail in Spanish Fork, Utah.[97] Although Sierra-Sanchez had complained of severe back pain, medical officials failed to conduct any diagnostic tests to determine the cause of his distress. The Utah State Medical Examiner later determined that Sierra-Sanchez died of staphylococcus aureus,[98] a treatable infection.[99]

On November 28, 2009, forty-eight-year-old German national Guido Newbrough died after eleven months in ICE custody at Piedmont Regional Jail in Farmville, Virginia.[100] Newbrough, who had lived in the United States for forty-two years and proudly wore a "Raised American" tattoo on

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07-01, at 4 (2006), https://www.oig.dhs.gov/assets/Mgmt/OIG_07-01_Dec06.pdf [https://perma.cc/WPL4-JZMK].

[96] List of Deaths, *supra* note 3, at 1–15 (listing detainee causes of death in the right-hand column).

[97] Press Release, U.S. Immigration & Customs Enf't, ICE Detainee Dies at Utah Hospital (July 13, 2014), https://www.ice.gov/news/releases/ice-detainee-dies-utah-hospital [https://perma.cc/8P5C-Y2ZU].

[98] List of Deaths, *supra* note 3, at 1.

[99] *See, e.g.*, Kevin E. Chan et al., *Prevalence and Outcomes of Antimicrobial Treatment for Staphylococcus Aureus Bacteremia in Outpatients with ESRD*, 23 J. Am. Soc'y Nephrology 1551, 1551 (2012) ("Staphylococcus bacteremia is a common and life-threatening medical emergency, but it is treatable with appropriate antibiotic therapy.").

[100] List of Deaths, *supra* note 3, at 6. ICE likely spelled Newbrough's name incorrectly on its *List of Deaths*. *Compare id.* (spelling the detainee's last name as "Newborough"), *with* Newbrough v. Piedmont Reg'l Jail Auth., 822 F. Supp. 2d 558, 580 (E.D. Va. 2011) (spelling the detainee's last name "Newbrough"), *and* Nina Bernstein, *Another Jail Death, and Mounting Questions*, N.Y. Times (Jan. 27, 2009), http://www.nytimes.com/2009/01/28/us/28detain.html [http://perma.cc/FTW9-ERNB] (same).

his shoulder, died of endocarditis caused by a virulent staph infection that is typically cured by antibiotics.[101]

In addition to failing to diagnose infections, detention centers also poorly manage known infections. For example, Jose Javier Hernandez-Valencia, a forty-four-year-old Mexican national was diagnosed with possible tuberculosis upon his detention, which began February 21, 2014 at the Houston Contract Detention Facility in Houston Texas.[102] Despite the facility's knowledge of his preventable and curable infection,[103] Hernandez-Valencia received no further diagnostic examinations or treatment.[104] On April 12, 2014, he died from complications of tuberculosis.[105]

The experience of Martin Hernandez Banderas further illustrates detention centers' inadequate management of known infections. Shortly after his October 26, 2006, arrival at SDCF in Otay Mesa, California, Banderas incurred a minor foot injury.[106] The injury turned into an infected ulcer that eventually turned gangrenous.[107] Although Banderas complained of increasing pain in his foot and foul-smelling discharge from the ulcer, a physician at SDCF ignored these complaints as well as laboratory tests suggesting that the general antibiotic initially given to treat Banderas's infection was not working.[108] On January 17, 2007, Banderas was rushed to a local emergency room, where he was diagnosed with a bone infection as well as gangrenous tissue surrounding the infected area.[109] Banderas, who required six weeks of inpatient intravenous antibiotics and several operations, was in danger of losing his leg.[110] Banderas sued SDCF and other defendants based on negligence and other tort theories of liability, and the U.S. District Court for the Central District of California found that the physician at SDCF was

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[101] *See* Bernstein, *supra* note 100 ("An autopsy report last week cited a virulent staph infection as an underlying cause of his death from endocarditis, an infection of the heart valves that is typically cured with antibiotics.").

[102] *ICE Detainee Passes Away in Houston*, PASADENA CITIZEN (Apr. 14, 2014), http://www.yourhoustonnews.com/pasadena/news/ice-detainee-passes-away-in-houston/article_e1473a67-86e7-50de-8b62-5410820fc02a.html [http://perma.cc/JH33-R62F].

[103] *Id.*; *see* CHRISTOPHER DYE, GLOBAL EPIDEMIOLOGY OF TUBERCULOSIS 3, 7 (2006) (identifying tuberculosis as a preventable, curable condition and listing cost-effective interventions for the disease).

[104] .*See ICE Detainee Passes Away in Houston*, *supra* note 102.

[105] LIST OF DEATHS, *supra* note 3, at 1.

[106] *Woods* Complaint, *supra* note 49, at 19.

[107] *Id*.

[108] Findings of Fact and Conclusions of Law at 7, Martin Hernandez Banderas v. United States, No. 2:08-cv-6594-PSG (C.D. Cal. May 29, 2012) [hereinafter *Banderas* Findings]; *Woods* Complaint, *supra* note 49, at 19.

[109] *Banderas* Findings, *supra* note 108, at 5–6.

[110] *Woods* Complaint, *supra* note 49, at 20.

negligent in failing to diagnose and treat Banderas.[111] The Court awarded Banderas $250,000 in civil damages.[112]

Children in detention also suffer from poor control of infections as well as other contagious conditions. In December 2014, for example, volunteer attorneys representing families in ICE custody at the Artesia Family Residential Center in Artesia, New Mexico ("Artesia"), reported several cases of untreated scabies, lice, and chickenpox, in addition to pneumonia, tonsillitis, fevers, vomiting, malnourishment, and emaciation, among the children detained at Artesia.[113] The story is the same at detention centers across the country. After touring detention centers in Brownsville and McAllen, Texas, officials from the Texas State Department of Health Services ("TSDHS") stated their belief that the detention conditions in Brownsville and McAllen "pose a high potential for infectious disease outbreak among the children and staff."[114] A spokeswoman for TSDHS told the media, "The conditions are not healthy and not acceptable for children by Texas and national public health standards."[115]

C. Suicide Prevention and Intervention

Suicide is the leading cause of death in detention.[116] Many immigration detainees with mental illness who do not receive adequate treatment attempt suicide. As an illustration, thirty-one-year-old Jose de Jesus Deniz-Sahagun, a Mexican national, committed suicide at Eloy Detention Center on May 20, 2015.[117] The day before his suicide, Deniz-Sahagun was assessed for delusional thoughts and behaviors and placed on suicide watch.[118] The day

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[111] *Banderas* Findings, *supra* note 108, at 10.

[112] *Id*. at 11.

[113] Wil S. Hylton, *The Shame of America's Family Detention Camps*, N.Y. TIMES MAG. (Feb. 4, 2015), http://www.nytimes.com/2015/02/08/magazine/the-shame-of-americas-family-detention-camps.html?_r=1 [http://perma.cc/BE39-3RVZ].

[114] Alexa Ura, *Health Officials: Immigrant Surge Is a Medical Crisis*, TEX. TRIB. (June 24, 2014), http://www.texastribune.org/2014/06/24/health-officials-docs-raise-concerns-about-immigra/ [http://perma.cc/K7V6-BS2D].

[115] *Id*.

[116] *See, e.g*., Priest & Goldstein, *supra* note 46 ("Suicide is the most common cause of death among detained immigrants.").

[117] LIST OF DEATHS, *supra* note 3, at 1; Paul Ingram, *Mexican Detainee Dies in ICE Detention Center*, TUCSON SENTINEL (May 21, 2015, 8:08 PM), http://www.tucsonsentinel.com/local/report/052115_detainee_death/mexican-detainee-dies-ice-detention-center/ [http://perma.cc/Q8KL-5CFN]; Press Release, U.S. Immigration & Customs Enf't, ICE Detainee Passes Away at Eloy Detention Facility (May 21, 2015), https://www.ice.gov/news/releases/ice-detainee-passes-away-eloy-detention-facility [https://perma.cc/ZZQ4-WZ65].

[118] Autopsy Report of Jose De Jesus Deniz-Sahagun, Case No. 2015:0892, Elroy Police Dep't, Pinal Cty., Ariz. 3 (May 22, 2015), http://archive.azcentral.com/persistent/icimages/politics/Jose-de-Jesus-autopsy-06172015.pdf [http://perma.cc/JM6E-5869] [hereinafter Deniz-Sahagun Autopsy]; Perla Trevizo, *Report: Eloy Immigration Detention Center Death Was Suicide*, ARIZ.

of his suicide, the detainee was removed from suicide watch and placed on fifteen-minute checks in an isolation cell. Sometime between checks, Deniz-Sahagun asphyxiated himself by stuffing a knee-high orange sock down his throat.[119] During his autopsy, the medical examiner also found a small white plastic handle, perhaps a toothbrush, inside his stomach.[120]

Eloy has a poor track record when it comes to suicide prevention and intervention. Twenty-four-year-old Elsa Guadalupe-Gonzales, a Guatemalan national, also committed suicide by hanging at Eloy on April 28, 2013.[121] Two days later, forty-year-old Jorge Garcia-Mejia, also a Guatemalan national, hanged himself at Eloy as well.[122] In its news release regarding Garcia-Mejia's hanging, ICE blamed Garcia-Mejia for "not seek[ing] any medical or mental health treatment."[123] ICE also stated, however, that it would deploy mental health professionals to Eloy to identify the root causes of the suicides that had occurred there and provide suicide prevention and awareness training.[124]

Although ICE later found Eloy to be "'fully compliant' with national standards on suicide prevention,"[125] fourteen detainees have died at Eloy between October 2003 and October 2015,[126] including six by "hanging" or "asphyxia."[127] In addition to Deniz-Sahagun, Garcia-Mejia, and Guadalupe-Gonzales, sixty-two-year-old Emmanuel Owusu, a barber from Ghana, hanged himself at Eloy on October 6, 2008.[128] Owusu had been a permanent

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DAILY STAR (June 17, 2015), http://tucson.com/news/local/border/report-eloy-immigration-detenti%E2%80%A6death-was-suicide/article_a740ef84-1520-11e5-bc93-134efb296bb3.html [http://perma.cc/47YU-LFFS].

[119] Trevizo, *supra* note 118; Deniz-Sahagun Autopsy, *supra* note 118, at 5.

[120] Trevizo, *supra* note 118; Deniz-Sahagun Autopsy, *supra* note 118, at 5.

[121] LIST OF DEATHS, *supra* note 3, at 2; *see also* Press Release, U.S. Dep't of Homeland Security, Immigration & Customs Enf't, ICE Detainee Passes Away at Eloy Detention Center (April 30, 2013), https://www.ice.gov/news/releases/ice-detainee-passes-away-eloy-detention-center [https://perma.cc/HPS3-8VY5].

[122] LIST OF DEATHS, *supra* note 3, at 2; *see also* Press Release, U.S. Dep't of Homeland Security, Immigration & Customs Enf't, ICE Detainee Under Criminal Investigation Passes Away at Eloy Detention Center (May 2, 2013), https://www.ice.gov/news/releases/ice-detainee-under-criminal-investigation-passes-away-eloy-detention-center [https://perma.cc/S9NN-JEYM] [hereinafter Garcia-Mejia Press Release].

[123] Garcia-Mejia Press Release, *supra* note 122 ("While at Eloy, Garcia-Mejia received two routine medical screenings, but did not seek any medical or mental health treatment.").

[124] *Id.*

[125] JJ Hensley, *ICE to Probe Two Inmate Deaths at Eloy Detention Center*, ARIZ. REPUB. (May 2, 2013), http://www.azcentral.com/news/arizona/articles/20130502ice-probe-inmate-suicides-eloy.html [http://perma.cc/2V62-95XC] (quoting OFFICE OF DET. OVERSIGHT, U.S. DEP'T OF HOMELAND SEC., COMPLIANCE INSPECTION: ELOY DETENTION CENTER, ELOY, ARIZONA 3, 9, 11 (2012), https://www.ice.gov/doclib/foia/odo-compliance-inspections/eloy-dtn-ctr_eloy-AZ_july10-12_2012.pdf [https://perma.cc/DSS9-9Z84]).

[126] *See* LIST OF DEATHS, *supra* note 3, at 1–3, 6, 8, 10–12.

[127] *See id.* at 2, 6, 8, 10.

[128] *See id.* at 6.

legal resident living in Chicago for thirty-three years prior to his 2006 detention, which was based on 1979 convictions for misdemeanor battery and retail theft.[129]

The fifth Eloy suicide occurred on September 29, 2006, when thirty-two-year-old Jose Lopez-Gregorio, a Guatemalan national, hanged himself with a bed sheet.[130] Lopez-Gregorio, whom staff members described as sobbing and depressed near the end of his detention, was guilt ridden for having left his wife and children in Guatemala with insufficient food.[131] When Lopez-Gregorio placed a sick call, medical staff at Eloy ignored the call for seven days.[132] Five days before his suicide, correctional staff placed Lopez-Gregorio on suicide watch after hearing from other detainees that he had a suicide plan.[133] Later that day, a staff psychologist discontinued the suicide watch, assessing Lopez-Gregorio's risk of suicide as low, and placed him on fifteen-minute checks instead.[134] Lopez-Gregorio committed suicide on September 29, 2006.[135]

An ICE report investigating Lopez-Gregorio's death stated, "[L]imited efforts were being made to assist the detainee. The detainee did display suicidal ideologies before his death. His suicide appears to have been planned in advance and did not appear to be spontaneous."[136] The report further stated, "Any [sick call] request made by a detainee who is known to be despondent and who is on an intensive watch schedule should have been responded to with some sense of urgency."[137] The report ultimately concluded that, "Staff were viewed as caring and considerate and tried to communicate with the detainee, however, lacking critical expertise, such as that possessed by medical staff, did not foresee the outcome. The medical staff did not respond to [the] detainee['s] request in a time appropriate manner."[138] The report also suggested a root cause of the event: "Medical staff appear to

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[129] Nina Bernstein, *Officials Hid Truth of Immigrant Deaths in Jail*, N.Y. TIMES (Jan. 9, 2010), http://www.nytimes.com/2010/01/10/us/10detain.html [http://perma.cc/DD4W-KRVR] [hereinafter Bernstein, *Officials Hid Truth*]. The title of this 2010 *Times* article ("Officials Hid Truth of Immigrant Deaths in Jail") is ironic; that is, the article (presumably based on information provided by ICE) states that, "A diabetic with high blood pressure . . . [Owusu] died of a heart ailment . . . ." *Id.* In 2015, ICE revealed that Owusu's cause of death was actually "suicide by hanging," not a heart ailment. LIST OF DEATHS, *supra* note 3, at 6.

[130] LIST OF DEATHS, *supra* note 3, at l. 83; *see also* Priest & Goldstein, *supra* note 46.

[131] Suicide Autopsy, Jose Lopez-Gregorio, Alien No. 99-470-695, at 1 (Oct. 12, 2006), http://media.washingtonpost.com/wp-srv/nation/specials/immigration/documents/day3_lopezgregorio.pdf [http://perma.cc/DNQ7-BLYM] [hereinafter Lopez-Gregorio Autopsy].

[132] Lopez-Gregorio Investigation Memorandum, *supra* note 50, at 1.

[133] Lopez-Gregorio Autopsy, *supra* note 131, at 1.

[134] *Id.*

[135] *Id.*

[136] Lopez-Gregorio Investigation Memorandum, *supra* note 50, at 2.

[137] *Id.* at 1–2.

[138] *Id.* at 2.

have been overwhelmed due to a sudden loss of veteran staff and [had] no emergency plan to properly address this deficiency."[139] A sixth Eloy death, that of twenty-nine-year-old Mexican national Juan Salazar-Gomez, occurred on December 14, 2005.[140] Although ICE records publicly indicate that Salazar-Gomez died of asphyxia,[141] leading newspapers and grassroots organizations report the death as a suicide.[142]

Eloy is not the only place of detention to struggle with suicide prevention and intervention. Forty-seven-year-old Chinese national Qi Gen Guo committed suicide at the Clinton County Correctional Facility in McElhattan, Pennsylvania, on February 23, 2011, day nine of his detention.[143] Similarly, forty-four-year-old Salvadoran national Ana Romero Rivera hanged herself at Franklin County Regional Jail in Frankford, Kentucky, on August 21, 2008.[144]

Romero Rivera's case is somewhat unique in that law enforcement officials placed her in the local jail on August 7, 2008, while waiting for ICE to make custodial arrangements.[145] Although federal regulations state that individuals who are being investigated for removal may be held in local jails for a maximum of forty-eight hours (excluding weekends and holidays),[146] Romero Rivera was jailed for a total of fourteen days, ending on the day of her suicide.[147] ICE, which had planned to take custody of Romero Rivera on day fifteen, provided no reason for not taking her into custody within the required time period.[148] Of note, ICE does not count Romero Rivera as one of the 153 detainees who died in custody between

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[139] *Id.*

[140] LIST OF DEATHS, *supra* note 3, at 10.

[141] *Id.*

[142] *See, e.g.*, Kymberlie Quong Charles, *Humpday Hall of Shame: CCA Refuses Moment of Silence to Honor Employee Slain During Prison Riot*, GRASSROOTS LEADERSHIP (May 22, 2013), http://grassrootsleadership.org/blog/2013/05/humpday-hall-shame-cca-refuses-moment-silence-honor-employee-slain-during-prison-riot [http://perma.cc/FEV6-VMPL] (indicating Salazar-Gomez's death was a suicide); Justin Ferrell et al., *Deaths at Immigration Prisons*, WASH. POST (May 10, 2008), http://www.washingtonpost.com/wp-srv/nation/specials/immigration/map.html [http://perma.cc/4N7V-JTKX] (same).

[143] LIST OF DEATHS, *supra* note 3, at 4; *see also* Press Release, U.S. Immigration & Customs Enf't, ICE Detainee Passes Away at Lock Haven Hospital (Feb. 24, 2011), https://www.ice.gov/news/releases/ice-detainee-passes-away-lock-haven-hospital [https://perma.cc/D96R-LG8Y] [hereinafter Press Release, Lock Haven Hospital].

[144] *See* Steve Lannen & Valarie Honeycutt Spears, *Questions Remain in Immigrant's Jail Death*, LEXINGTON HERALD-LEADER (Nov. 20, 2008), http://www.kentucky.com/latest-news/article43983495.html [http://perma.cc/L7PZ-CJW6] (reporting that Romero was held awaiting deportation in county jail eleven days beyond the permitted forty-eight-hour hold before she was found hanging in her cell in the county jail).

[145] *Id.*

[146] 8 C.F.R. § 287.7(d) (2014).

[147] Lannen & Spears, *supra* note 144.

[148] *Id.*

October 2003 and October 2015[149] because, technically, ICE had not yet taken custody of her.[150] Therefore, the 153 number does not reflect the full scope of harm, nor does it include the numbers of individuals who died after detention due to inadequate care while in detention.

Perhaps not wanting to draw attention to the high rate of suicide in detention, ICE publicly and generically identifies the final cause of death as asphyxia, not suicide, in a number of additional deaths.[151] Deaths publicly classified by ICE as asphyxia, not suicide, include: Rogelio Canales Baca, a thirty-six-year-old Honduran national who died on July 8, 2008, at Pinal County Jail in Florence, Arizona;[152] Nery Romero, a twenty-two-year-old Salvadoran national who died on February 12, 2007, at the Bergen County Jail in Hackensack, New Jersey;[153] Antonio Martinez-Rivas, a forty-four-year-old Mexican national who died on October 4, 2006, at the Houston Contract Detention Facility in Houston, Texas;[154] Carlos Cortez-Raudel, a twenty-two-year-old Mexican national who died on October 3, 2006, at the Mira Loma Detention Center in Lancaster, California;[155] Geovanny Garcia-Mejia, a Honduran national who died on March 18, 2006, his twenty-seventh birthday, at the Newton County Correctional Center in Newton, Texas;[156] Felipe Garcia-Sanchez, a twenty-one-year-old Colombian national who died on February 13, 2006, at the Federal Detention Center in Oakdale, Louisiana;[157] Hassiba Belbachir, a twenty-seven-year-old Algerian national who died on March 17, 2005, at McHenry County Jail in Woodstock, Illinois;[158] Sung Soo Heo, a Korean national who died three days after his fifty-first birthday on February 16, 2005, at Passaic County Jail in Paterson, New Jersey;[159] Ervin Ruiz-Tabares, a twenty-four-year-old Colombian national who died on September 25, 2004,

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[149] *See* LIST OF DEATHS, *supra* note 3, at 1–15 (failing to list Romero Rivera's death as one of the 151 deaths that occurred in ICE custody between 2003 and 2015).

[150] Lannen & Spears, *supra* note 144.

[151] LIST OF DEATHS, *supra* note 3, at 1–15 (identifying each detainee's "Final Cause of Death" in the right-hand column). *But see* Joseph P. Pestaner, *End-of-Life Care: Forensic Medicine v. Palliative Medicine*, 31 J.L. MED. & ETHICS 365, 366 (2003) ("The cause of death is the injury or disease process that resulted in death and the manner of death is classified as natural, suicide, accident, homicide or undetermined.").

[152] LIST OF DEATHS, *supra* note 3, at 7; U.S. Immigration & Customs Enf't, U.S. Dep't of Homeland Security, Detention Facility Inspection Form for Pinal Adult Detention Facility 5 (Aug. 5–7, 2008), https://www.ice.gov/doclib/foia/dfra-ice-dro/pinaladultdetentionfacilityflorenceazaugust572008.pdf [https://perma.cc/RDF7-L7XQ] [hereinafter Pinal Inspection Form].

[153] LIST OF DEATHS, *supra* note 3, at 8.

[154] *Id.*

[155] *Id.*

[156] *Id.* at 9.

[157] *Id.*

[158] *Id.* at 11.

[159] *Id.*

at the Guaynabo Metropolitan Detention Center on San Juan, Puerto Rico;[160] Sebastian Mejia Vicentes, a twenty-seven-year-old Mexican national who died on August 22, 2004, at the Hampton Roads Regional Jail in Portsmouth, Virginia;[161] Cesar Rioz-Martinez, a twenty-six-year-old Mexican national who died on February 13, 2004, at the Frio County Jail in Pearsall, Texas;[162] and Argelio Leyva-Arjona, a fifty-year-old Cuban national who died on January 5, 2004, at a Federal Bureau of Prisons facility in Victorville, California.[163]

It is certainly possible for a detainee to die of asphyxia, defined as the deprivation of oxygen or the state of not being able to breathe,[164] outside the context of suicide. For example, a detainee could accidentally choke on a piece of food and asphyxiate himself. Or, one detainee could strangle another. Nevertheless, internal ICE documentation maintained separately from its public *List of Deaths* confirms that many of the deaths generically classified as asphyxia were actually suicides by hanging or other forms of self-strangulation.[165]

For example, an internal ICE Detention Facility Inspection Form used to document an August 2008 inspection of Pinal County Jail in Florence, Arizona (Pinal) states that Pinal staff found Rogelio Canales Baca hanging in his cell on July 8, 2008,[166] even though ICE's public *List of Deaths* states that Canales Baca died of asphyxia.[167] Because Pinal staff had segregated Canales Baca from the general detention center population,[168] the hanging was almost certainly a suicide, not a homicide. Indeed, ICE's own Inspection Form uses an "S" to indicate that the death was a suicide, not the result of an act of violence, an illness, or other cause.[169] Notwithstanding the suicide of Canales Baca, as well as the suicide by hanging of a second Pinal inmate on July 16, 2008, only eight days after Canales Baca's suicide,[170] ICE inspectors still gave Pinal an "acceptable" rating with respect to Pinal's

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160 *Id.* at 12.

161 *Id.*

162 *Id.* at 14.

163 *Id.*

164 *See* ANN L. BUCHOLTZ, DEATH INVESTIGATION: AN INTRODUCTION TO FORENSIC PATHOLOGY FOR THE NONSCIENTIST 279 (2015) (defining asphyxia).

165 *See infra* notes 166–173 and accompanying text (detailing conflicts within internal ICE documentation and between ICE reports and journalistic accounts relating to deaths of immigrant detainees).

166 Pinal Inspection Form, *supra* note 152, at 5 ("On July 8, 2008, at 1358 hours, Canales was found hanging in his cell.").

167 LIST OF DEATHS, *supra* note 3, at 7.

168 Pinal Inspection Form, *supra* note 152, at 5 ("[H]e told the psychiatrist that he felt safe in the segregation unit and did not want to return to General Population.").

169 *Id.* at 2.

170 *Id.* at 6.

suicide prevention and intervention efforts[171] as well as an overall rating of "acceptable."[172] Pinal did receive a "deficient" rating with respect to medical care, however.[173]

Leading journalists also have reported that many of the deaths ICE publicly and generically classifies as asphyxia were suicides by hanging or other forms of self-strangulation.[174] *The Washington Post* reported that twenty-two-year-old Mexican national Carlos Cortez-Raudel, whose October 3, 2006, death ICE publicly classified as asphyxia,[175] actually "hanged himself from a tree on the way to breakfast in a California compound."[176] *The Washington Post* further reported that twenty-seven-year-old Algerian national Hassiba Belbachir, whose March 17, 2005, death ICE publicly classified as asphyxia,[177] "strangled herself with orange jail-issue socks, which she knotted together and wrapped twice around her neck."[178]

Belbachir, as with most noncitizens, was neither a criminal nor a public safety risk. After marrying a U.S. citizen, Belbachir traveled to Chicago to live with her new husband.[179] After four weeks in Chicago, Belbachir discovered that the man she married had another wife.[180] To leave the American who deceived her, Belbachir traveled to Spain but was denied entry due to a lack of a visa.[181] She returned to the United States, requested politi-

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[171] *Id.* at 3.

[172] *Id*. at 4.

[173] *Id.* at 3.

[174] Examples include the deaths of Korean national Sung Soo Heo, Honduran national Geovanny Garcia-Mejia, Mexican national Antonio Martinez-Rivas, Mexican national Sebastian Mejia Vicentes, Mexican national Cesar Rioz-Martinez, and Cuban national Argelio Leyva-Arjona. *See* Amy Goldstein & Dana Priest, *Five Detainees Who Took Their Lives*, WASH. POST (May 13, 2008), http://www.washingtonpost.com/wp-dyn/content/article/2008/05/12/AR2008051202694.html [http://perma.cc/K4S3-RX5L]. *The Washington Post* reported that Heo hanged himself after being transferred back to the jail from a forensic psychiatric facility. *Id.* The *Post* also reported that Martinez-Rivas hanged himself after waiting for days for an appointment with a psychiatrist, and that four days before his suicide, a staff psychologist noted in Martinez-Rivas's medical record that the detainee was talking to himself, appeared to be hallucinating, and thought the radios worn by the security staff were sending messages to him. *Id.* The *Post* further reported that Mejia Vincentes, who had a history of schizophrenia, hanged himself with a bed sheet, as did Rioz-Martinez. *Id.*; *see also* Priest & Goldstein, *supra* note 46 ("Heo . . . hanged himself from a ceiling vent in his New Jersey cell. . . . Garcia-Mejia . . . wrote notes in blood on his Texas cell floor and hanged himself from a ventilation grate while supposedly under 15-minute checks around the clock."); Cam Simpson, *More Immigration Detainee Deaths Disclosed*, WALL STREET J. (Aug. 18, 2009), http://www.wsj.com/articles/SB125055691948838827 [http://perma.cc/H6EQ-BFQA] (reporting Leyva-Arjona's death as a suicide).

[175] LIST OF DEATHS, *supra* note 3, at 8.

[176] Priest & Goldstein, *supra* note 46.

[177] LIST OF DEATHS, *supra* note 3, at 11.

[178] Priest & Goldstein, *supra* note 46.

[179] *Id*.

[180] *Id*.

[181] *Id*.

cal asylum, and was taken into ICE custody on March 8, 2005,[182] at McHenry County Jail in Woodstock, Illinois ("McHenry").[183]

Records from Belbachir's intake screening, conducted by a social worker at McHenry, document a prior suicide attempt that involved drinking soap.[184] The social worker diagnosed Belbachir with major depressive disorder, noted that she needed to see a psychiatrist for medication, and scheduled Belbachir for an appointment with a psychiatrist ten days later, on March 18, 2005, at 6:00 p.m.[185] On March 12, 2005, six days before her scheduled medical appointment, Belbachir suffered a panic attack and was placed in the jail's medical unit.[186] The following day, Belbachir told the social worker that she could hear "parasites and radio waves," that "[d]eath is dripping, drop by drop," and that she wanted to die.[187] Despite her stated desire to die and her known previous suicide attempt, Belbachir was not placed on suicide watch.[188]

On March 17, 2005, the day before her scheduled medical appointment, a guard noticed that she was lying face down on the floor of her cell at 3:40 p.m.[189] The guard, who could not see Belbachir's face, inquired of a colleague whether that was Belbachir's normal sleeping position and was told that it was.[190] When the guard returned to Belbachir's cell at approximately 4:10 p.m. to serve her dinner, he discovered that she had socks around her neck, that her face was purple, and that her mouth was bloody.[191] Belbachir had strangled herself one day and approximately two hours before her scheduled medical appointment.[192]

Equally heartbreaking is the story of Nery Romero, a twenty-two-year-old Salvadoran national who hanged himself with his bed sheets at the Bergen County Jail in Hackensack, New Jersey, on February 12, 2007.[193] Although the local sheriff's office suggested that Romero hanged himself out of fear for the gangs that awaited him in El Salvador,[194] Romero's family,

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[182] *Id.*
[183] LIST OF DEATHS, *supra* note 3, at 11.
[184] Priest & Goldstein, *supra* note 46.
[185] *Id.*
[186] *Id.*
[187] *Id.*
[188] *Id.*
[189] *Id.*
[190] *Id.*
[191] *Id.*
[192] *Id.*
[193] LIST OF DEATHS, *supra* note 3, at 8; *see also* Nina Bernstein, *One Immigrant Family's Hopes Lead to a Jail Cell Suicide*, N.Y. TIMES (Feb. 23, 2007), http://www.nytimes.com/2007/02/23/nyregion/23suicide.html?pagewanted=all&_r=0 [http://perma.cc/RC8P-CKA2] [hereinafter Bernstein, *Suicide*].
[194] Bernstein, *Suicide*, *supra* note 193 (reporting a county sheriff spokesperson's suggestion that Romero feared revenge in El Salvador).

his fellow detainees, and the attorney hired to investigate his death believe he committed suicide due to his lack of access to health care, including pain medication, in detention.[195] As background, Romero had been involved in a serious motorcycle accident that crushed one of his legs and required surgically implanted metal rods for support.[196] Following surgery, Romero was prescribed strong medication to alleviate his pain.[197] Romero's family believed that detention center officials refused to give Romero his pain medication once in detention even though the medication's instructions warned that abruptly stopping the medication can cause severe cramps, anxiety, insomnia, and other uncomfortable symptoms.[198] Federal investigators later agreed, finding that "unbearable, untreated pain had been a significant factor" in Romero's death.[199] Investigators also found that jail personnel falsified a medication log to show that Romero had been given Motrin for his pain when he had not: "The fake entry was easy to detect: When the drug was supposedly administered, Mr. Romero was already dead."[200]

The numerous stories of detainees desperate for medical attention who never receive such care illustrate the unacceptable current state of health care for immigrants in detention.

II. Health Law as a Model for Change

The previous Part identified serious concerns with immigration detainees' access to health examinations, medical treatments, infection controls, and suicide precautions.[201] Thus far, proposals to improve health care in detention have relied primarily on constitutional prohibitions against punishment without due process of law,[202] international documents establishing

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[195] *See id.* ("A closer look, though, reveals a different and more complicated picture of Nery Romero's short life and unusual death. It raises questions about his treatment in the jail, where the family and other inmates say he spent days crying out for painkillers that he never received.").

[196] *Id.*

[197] *Id.*

[198] *Id.*; *see also* MATT TAIBBI, THE DIVIDE: AMERICAN INJUSTICE IN THE AGE OF THE WEALTH GAP 219–20 & n.1 (2014) (referencing Romero's suicide and the lack of treatment he received while in detention).

[199] Bernstein, *Officials Hid Truth*, *supra* note 129; Nina Bernstein, *Officials Reportedly Obscured Truth of Migrant Deaths in Jail*, SEATTLE TIMES (Jan. 9, 2010), http://www.seattletimes.com/nation-world/officials-reportedly-obscured-truth-of-migrant-deaths-in-jail/[http://perma.cc/9P9E-CP37] [hereinafter Bernstein, *Officials Obscured Truth*].

[200] Bernstein, *Officials Hid Truth*, *supra* note 129; Bernstein, *Officials Obscured Truth*, *supra* note 199.

[201] *See supra* notes 30–200 and accompanying text.

[202] *See, e.g.*, Cahan, *supra* note 18, at 351–54 (using constitutional law to argue for improved detainee health care); SEATTLE UNIV. SCH. OF LAW INT'L HUMAN RIGHTS CLINIC, VOICES FROM DETENTION: A REPORT ON HUMAN RIGHTS VIOLATIONS AT THE NORTHWEST DETENTION CENTER IN TACOMA, WASHINGTON 50 (2008), http://www.law.seattleu.edu/documents/news/archive/2008/DRFinal.pdf [http://perma.cc/M8TS-S9NQ] [hereinafter SEATTLE CLINIC REPORT] ("Thus,

rights to health care,[203] international human rights prohibitions against cruel, inhumane, and degrading treatment,[204] and reasonable care obligations under tort law.[205] Although supportive of these proposals, this Part argues that constitutional law, international human rights law, and tort law lack the specificity, enforceability, and ex ante direction necessary, respectively, to effect comprehensive, nationwide detainee health reform.

As background, the Due Process Clause of the Fifth Amendment protects any person in custody of the United States from conditions that constitute punishment without due process of law.[206] Some detainees argue that the failure of detention officials to provide adequate health care inflicts unnecessary pain and suffering; that is, punishment without due process of law.[207] Various standards exist for evaluating such claims. Some courts require a showing that detention officials acted with "deliberate indifference" to a detainee's "serious medical need."[208] Other courts only require a showing that detention officials failed to provide "reasonable medical care" for a "serious medical need" and that such failure was not "reasonably related to a legitimate governmental objective."[209]

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if a detainee's medical needs are treated with deliberate indifference by officers or doctors, it is a violation of the detainee['s] due process.").

[203] *See, e.g.*, Skinner, *supra* note 19, at 272, 293–94 (identifying rights to physical and mental health care set forth in the Universal Declaration of Human Rights and the Covenant on Economic, Social, and Cultural Rights; concluding that the United States is in violation of its obligations to refugees under international law); SEATTLE CLINIC REPORT, *supra* note 202, at 47–48 ("Inadequate access to medical care is a violation of the [Universal Declaration of Human Rights] and the minimum standards of the UN Principles for Detained Persons.").

[204] *See, e.g.*, Hamell, *supra* note 20, at 253 (discussing international human rights' prohibitions against cruel and inhuman treatment in the context of pregnant, laboring, and delivering detainees); Skinner, *supra* note 19, at 283–84, 290–91 (discussing the prohibitions against cruel, inhumane, and degrading treatment in international human rights provisions in the context of detainees' lack of access to physical and mental health care); MIDWEST COAL. FOR HUMAN RIGHTS & LEGAL CLINIC OF THE UNIV. OF IOWA COLL. OF LAW, MIDWEST REGIONAL REPORT ON TORTURE AND CRUEL, INHUMAN AND DEGRADING TREATMENT 3 (2014), http://www.ushrnetwork.org/sites/ushrnetwork.org/files/02-general-mwc.pdf [http://perma.cc/9ZSM-WEJ7] ("The United States subjects individuals . . . to cruel, inhuman, and degrading treatment. This report focuses on the American Midwest, where . . . detained immigrants are routinely . . . denied adequate medical care.").

[205] *See, e.g.*, *Improving Carceral Conditions*, *supra* note 21, at 1491–97 (considering claims against the federal government under the Federal Tort Claims Act as a means of improving carceral conditions of immigrant detainees).

[206] *See, e.g.*, Cesar v. Achim, 542 F. Supp. 2d 897, 908 (E.D. Wis. 2008) (holding that immigration detainee stated a due process claim for denial of health care).

[207] *See, e.g.*, *Woods* Complaint, *supra* note 49, at 43 (asserting that failure to provide adequate health care to detainees is not reasonably related to any legitimate government objective and is de facto punishment without due process of law).

[208] *See, e.g.*, Chapman v. Keltner, 241 F.3d 842, 845 (7th Cir. 2001); *Cesar*, 542 F. Supp. 2d at 907.

[209] *See, e.g.*, Bell v. Wolfish, 441 U.S. 520, 539 (1979) ("[I]f a restriction or condition is not reasonably related to a legitimate goal—if it is arbitrary or purposeless—a court permissibly may

These constitutional principles have provided legal relief for some detainees. In *Woods v. Myers*, a 2007 Ninth Circuit Court of Appeals case, for example, detainees at SDCF, which is owned and operated by the for-profit Corrections Corporation of America ("CCA"), sued ICE, SDCF, and CCA, as well as individual representatives thereof, arguing that the defendants failed to provide the detainees adequate health care, that such failure was not reasonably related to any legitimate governmental objective, and that such failure constituted de facto punishment in violation of the Due Process Clause of the Fifth Amendment.[210] The defendants ultimately settled, prospectively agreeing to provide constitutionally adequate physical and mental health care to detainees at SDCF.[211]

Other than a handful of cases in which individual detainees have successfully employed constitutional principles to challenge their lack of adequate health care while in detention,[212] constitutional law has done little to effect comprehensive, nationwide detainee health reform. One reason is that constitutional standards tend towards broad ex post policies.[213] That is, after a detainee becomes sick or dies, the detainee (or his or her legal representative) retrospectively argues that the detention center's failure to provide adequate health care caused avoidable pain, suffering, deterioration of health, and/or death; that is, punishment without due process of law.[214] This constitutional standard certainly provides some guidance to judges presiding over cases in which individual detainees or groups of detainees retrospectively argue that their due process rights have been violated, but this standard does

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infer that the purpose of the governmental action is punishment that may not constitutionally be inflicted upon detainees *qua* detainees."). Similarly, the Ninth Circuit has held:

> With respect to an individual confined awaiting adjudication under civil process, a presumption of punitive conditions arises where the individual is detained under conditions identical to, similar to, or more restrictive than those under which pretrial criminal detainees are held . . . . [T]o prevail on a Fourteenth Amendment claim regarding conditions of confinement, the confined individual need not prove "deliberate indifference" on the part of government officials.

Jones v. Blanas, 393 F.3d 918, 934 (9th Cir. 2004); *see also* Hare v. City of Corinth, 36 F.3d 412, 415–16 (5th Cir. 1994) ("Thus . . . the jail officials were under a clearly established constitutional duty to provide pretrial detainees with reasonable care for serious medical needs, unless the deficiency reasonably served a legitimate governmental objective." (footnote omitted)).

[210] *Woods* Complaint, *supra* note 52, at 43.

[211] William Fisher, *ICE Ignores Health of Immigration Detainees*, PUB. REC. (Dec. 21, 2010), http://pubrecord.org/nation/8671/ignores-health-immigration-detainees/ [http://perma.cc/3QAY-UJEX].

[212] *See supra* notes 210–211 and accompanying text.

[213] *See generally* Charles D. Kostad et al., *Ex Post Liability for Harm v. Ex Ante Safety Regulation: Substitutes or Complements?* 80 AM. ECON. REV. 888, 888 (1990) (distinguishing ex ante safety regulations that affect an activity before an externality is generated and ex post policies, such as tort liability, that are designed to control externalities).

[214] *See, e.g.*, *Woods* Complaint, *supra* note 49, at 43.

little to prospectively guide detention medical staff in their future treatment of detainees. Stated slightly differently, constitutional law does little ex ante to instruct detention officials with respect to the creation and implementations of specific policies and procedures that will improve the health and safety of immigration detainees.

In addition to constitutional law, proposals to improve health care in detention also have relied on international documents establishing rights to health and prohibitions against cruel, inhuman, and degrading treatment. For example, the Universal Declaration of Human Rights provides human beings a "right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care."[215] By further example, the International Covenant on Economic, Social and Cultural Rights provides a "right of everyone to the enjoyment of the highest attainable standard of physical and mental health," including the "creation of conditions which would assure to all medical service and medical attention in the event of sickness."[216] Neither of these documents is binding or enforceable on the United States, however.[217] As such, their power to achieve broad health reform in U.S. detention centers is limited.

In addition to unenforceable international rights to health care, international human rights documents also establish negative rights against torture and other forms of poor treatment. The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("CAT"), for example, prohibits treatment that rises to the level of torture as well as other forms of cruel, inhuman, or degrading treatment ("CIDT").[218] Nevertheless, CAT narrowly defines torture as an intentional act inflicted by or with the

[215] G.A. Res. 217 (III) A, Universal Declaration of Human Rights, at 71 (Dec. 10, 1948).

[216] International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3.

[217] *See* Zöe Sodja, *Human Rights and U.S. Female Prisoners*, *in* INSIDE AND OUT: WOMEN, PRISON AND THERAPY 59 (Elaine J. Leeder ed., 2006) (stating that the Universal Declaration of Human Rights is not a treaty and therefore not binding on the United States); Andrew Clapham, Remarks, *New Thinking on Social and Economic Rights: Honoring Virginia Leary*, 104 AM. SOC'Y INT'L L. PROC. 7, 7–8 (2010) (stating that the International Covenant on Economic, Social, and Cultural Rights is not binding on the United States); Sarah Paoletti, *Deriving Support from International Law for the Right to Counsel in Civil Cases*, 15 TEMP. POL. & CIV. RTS. L. REV. 651, 654 (2006) ("[T]he Universal Declaration of Human Rights is not a treaty, and therefore arguably not binding on the United States."); AMNESTY INT'L USA HUMAN RIGHTS NETWORK, ECONOMIC, SOCIAL AND CULTURAL RIGHTS: QUESTIONS AND ANSWERS 6 (1998), http://www.amnestyusa.org/pdfs/escr_qa.pdf [http://perma.cc/E39G-9GVN] (explaining that the United States signed the Covenant in 1979 but did not ratify it and therefore is not bound by it).

[218] Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment art. 2, Dec. 10, 1984, S. TREATY DOC. 100-20, 1465 U.N.T.S. 85 [hereinafter CAT] (prohibiting torture and other CIDT).

consent of a public official.[219] The element of intent, in particular, limits the acts that can constitute torture and implicate CAT's prohibitions.[220] In addition, the United States conditioned its ratification of CAT's prohibition against CIDT "only insofar as [CIDT] . . . means the cruel, unusual and inhumane treatment or punishment prohibited by the Fifth, Eighth and/or Fourteenth Amendments."[221] Enforceable international prohibitions against torture and CIDT thus circle back to the same constitutional law limitations described above.

A third proposed basis of detention reform is tort law.[222] Under principles of negligence, physicians who provide health care to detainees have a duty to act like reasonably prudent physicians under the same or similar circumstances.[223] Although a handful of detainees have successfully used tort law to obtain monetary damages for negligent diagnosis and treatment by detention medical staff,[224] it is also not clear that tort law provides suffi-

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[219] *See id.* art. 1 (defining torture to include "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for [certain] purposes . . . when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official"; clarifying that "[torture] does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions").

[220] *See, e.g.*, Gail H. Miller, *Defining Torture* 5–21 (Floersheimer Center Occasional Papers, Paper No. 3, 2005), http://cardozo.yu.edu/sites/default/files/Defining%20Torture.pdf [http://perma.cc/M3N4-BV3K]. As one scholar explained,

> In other words, were a victim to suffer severe pain at the hands of a state official, but the official did not intend to cause the severe pain, the act would not amount to torture. This might be the case if, for example, a prisoner experienced severe pain or suffering as a result of poor prison conditions but the officials did not intend the conditions to affect the prisoner so severely.

Id.

[221] CAT, *supra* note 218, at 65, ¶ 302. *See generally* MICHAEL JOHN GARCIA, THE U.N. CONVENTION AGAINST TORTURE: OVERVIEW OF U.S. IMPLEMENTATION POLICY CONCERNING THE REMOVAL OF ALIENS 2 (2004), *reprinted in* JENNIFER K. ELSEA ET AL., THE TREATMENT OF PRISONERS: LEGAL, MORAL OR CRIMINAL? 225, 225 (Ralph D. McPhee ed., 2006) ("The United States ratified the [CAT], subject to certain declarations, reservations, and understandings, including that the Convention was not self-executing, and therefore required domestic implementing legislation to take effect.").

[222] *See, e.g.*, *Improving Carceral Conditions*, *supra* note 21, at 1491–97 (proposing the classification of nonfederal prison facilities as agents of the federal government under the Federal Tort Claims Act as "the most viable approach to ameliorating the carceral conditions of federal immigrant detainees").

[223] *See, e.g.*, *Banderas* Findings, *supra* note 108, at 8 ("A physician is negligent if he or she fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances.").

[224] *See, e.g.*, *id.* at 11 (awarding a San Diego Correctional Facility detainee $250,000 for medical negligence); *Hernandez-Gonzalez* Complaint, *supra* note 63, at 7–8 (alleging that the government's failure to provide adequate health care to Medina-Martinez breached the standard of care and was negligent); Redmon, *supra* note 61 (discussing the Medina-Martinez case and noting that the parties settled for an undisclosed sum).

cient ex ante direction to detention officials regarding what they should be doing with respect to the examination, diagnosis, and treatment of detainees, so it would not lead to sufficient systemic change. In summary, constitutional law, international human rights law, and tort law provide some legal relief for injured detainees. These laws do not, however, provide specific guidance to detention staff regarding the steps necessary to maintain detainee health and safety.

Notwithstanding the limitations of constitutional law, international human rights law, and tort law, other state and federal laws do provide substantively adequate and legally enforceable health and safety standards that may serve as reference points for assessing the health care provided in detention. In particular, state laws governing involuntary commitment,[225] federal laws applicable to long-term care facilities, including Medicare-participating skilled nursing facilities and Medicaid-participating nursing facilities,[226] and federal and state behavioral health laws[227] contain detailed health and safety requirements that are designed to protect vulnerable patients in a variety of institutional contexts. As explained in more detail below, these reference laws require prompt physical and mental health examinations; the creation, formal documentation, and implementation of individualized care plans; appropriate treatment, including regular follow-up; comprehensive infection controls; and rigorous suicide precautions and monitoring. Importantly, these laws are associated with health care quality improvements in both voluntary and involuntary health care settings.[228]

A. Involuntary Commitment Laws

Each state as well as the District of Columbia has a law governing the involuntary commitment of certain individuals with severe mental illness to the inpatient hospital setting.[229] In addition, forty-five states as well as the

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[225] *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. §§ 574.034(a), 574.035(a) (West 2014) (setting forth standards for temporary and extended involuntary inpatient commitment under Texas law); *id.* §§ 574.034(b), 574.035(b) (setting forth standards for temporary and extended involuntary outpatient commitment under Texas law).

[226] *See* 42 C.F.R. pt. 483 (2014) (establishing federal requirements for long-term care facilities); *id.* § 483.1(b) ("The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a SNF [skilled nursing facility] in the Medicare program, and as a nursing facility in the Medicaid program.").

[227] *See, e.g.*, 42 C.F.R. §§ 482.60–.62 (2014) (establishing the Medicare Conditions of Participation for Psychiatric Hospitals); UTAH ADMIN. CODE r. 432-101 (2014) (regulating psychiatric hospitals in Utah).

[228] *See, e.g.*, *supra* notes 265, 299 and accompanying text.

[229] *See, e.g.*, VA. CODE. ANN. § 37.2-817(C) (West 2014) (setting forth the standard for involuntary inpatient commitment under Virginia law); TREATMENT ADVOCACY CTR., STATE STANDARDS FOR ASSISTED TREATMENT: CIVIL COMMITMENT CRITERIA FOR INPATIENT OR OUTPATIENT PSYCHIATRIC TREATMENT 2 (2014), http://www.treatmentadvocacycenter.org/storage/

District of Columbia have laws authorizing the involuntary provision of community-based, outpatient treatment.[230] Collectively, this Article refers to these two types of laws as involuntary commitment laws.[231] Although some generalizations regarding involuntary commitment laws may be made, each state uses distinct terminology and has distinct thresholds for inpatient and, if applicable, outpatient commitment.[232] As such, state law must be consulted to address particular commitment questions.

Alabama, for example, has both inpatient and outpatient commitment laws. Alabama's involuntary inpatient commitment law provides that an individual may be committed for inpatient treatment[233] if clear and convincing evidence is presented to the probate court showing that the individual: (1) has a mental illness;[234] (2) "as a result of the mental illness . . . poses a real and present threat of substantial harm to self and/or others"; (3) "will, if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently"; and (4) "is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable."[235]

Alabama's threshold for involuntary outpatient commitment is similar, except there is no requirement that the individual "pose[] a real and present threat of substantial harm to self and/or others."[236] That is, a court may order outpatient treatment[237] for an individual if clear and convincing evi-

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documents/Standards_-_The_Text-_June_2011.pdf [http://perma.cc/C7JH-ZC2K] [hereinafter STATE STANDARDS FOR ASSISTED TREATMENT] (explaining that each state has an involuntary inpatient commitment law).

[230] VA. CODE. ANN. § 37.2-817(D) (setting forth the standard for involuntary outpatient commitment under Virginia law); BAZELON CTR. FOR MENTAL HEALTH LAW, INVOLUNTARY OUTPATIENT COMMITMENT: SUMMARY OF STATE STATUTES 2–35 (2000), http://www.bazelon.org/LinkClick.aspx?fileticket=CBmFgyA4i-w%3D&tabid=324 [http://perma.cc/UX3E-6W6C] (summarizing involuntary outpatient commitment laws).

[231] *See, e.g.*, ALA. CODE. § 22-52-1.1(9) (2014) (defining involuntary commitment as "[c]ourt ordered mental health services in either an outpatient or inpatient setting").

[232] STATE STANDARDS FOR ASSISTED TREATMENT, *supra* note 229, at 2 ("Each state law is distinct from the others, utilizing its own terminology and standards.").

[233] *See* ALA. CODE. § 22-52-1.1(6) (defining inpatient treatment as "[t]reatment being provided to a person at a state mental health facility or a designated mental health facility which has been specifically designated by the department for inpatient treatment").

[234] *See id.* § 22-52-1.1(1) (defining mental illness as "[a] psychiatric disorder of thought and/or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life").

[235] *Id.* § 22-52-10.4(a). *See generally* Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, CASE W. RES. L. REV. (forthcoming 2016) (critiquing the dangerousness criterion set forth in many state involuntary commitment laws).

[236] *See infra* note 238 and accompanying text (describing Alabama's threshold standard for involuntary outpatient commitments).

[237] *See* ALA. CODE § 22-52-1.1(5) (defining outpatient treatment as "[t]reatment being provided to a person in a nonresidential setting and who is not admitted for 24-hour-a-day care").

dence is presented to the probate court showing that the individual: (1) has a mental illness; (2) "as a result of the mental illness will . . . if not treated, continue to suffer mental distress and will continue to experience deterioration of the ability to function independently"; and (3) "is unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable."[238]

Through their involuntary commitment laws, states recognize that both temporarily held[239] and fully committed individuals may have underlying physical and mental health conditions that require immediate as well as long-term treatment. As such, all states require the provision of an initial health examination within hours of an emergency hold or the filing of a formal petition for commitment to determine whether commitment may be appropriate.[240] In Texas, for example, a physician shall examine an individual who is detained on an emergency basis "as soon as possible within 12 hours after the time the person is apprehended by the peace officer or transported for emergency detention by the person's guardian."[241]

The State of Washington has similar examination requirements for individuals once they are committed. That is, individuals who receive services from the Washington State Department of Social and Health Services and are involuntarily committed must receive timely evaluations after admission to determine the nature of their health conditions as well as needed medical treatments.[242] Under Washington law, these mandatory evaluations include: (1) a physical health examination conducted within twenty-four hours of admission to a treatment facility by a licensed physician, advanced registered nurse practitioner, or physician assistant; and (2) a psychosocial evaluation by a mental health professional.[243] The psychosocial evaluation must

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[238] *Id.* § 22-52-10.2.

[239] Most involuntary commitment laws contain provisions authorizing an individual to be temporarily held on an emergency basis, usually for forty-eight or seventy-two hours, during which time a preliminary health examination is performed to determine whether commitment might be appropriate and/or during which time a person may file a formal commitment petition. *See, e.g.*, CAL. WELF. & INST. CODE § 5150(a) (West 2014) ("When a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled . . . the person [may be taken] into custody for a period of up to 72 hours . . . ."); TEX. HEALTH & SAFETY CODE § 573.021(b) (West 2014) ("A person accepted for a preliminary examination may be detained in custody for not longer than 48 hours after the time the person is presented to the facility unless a written order for protective custody is obtained."). *See generally* TREATMENT ADVOCACY CTR., EMERGENCY HOSPITALIZATION FOR EVALUATION: ASSISTED PSYCHIATRIC TREATMENT STANDARDS BY STATE 1–13 (2014), http://treatmentadvocacycenter.org/storage/documents/Emergency_Hospitalization_for_Evaluation.pdf [http://perma.cc/BL62-KN5V] (referencing each state's statutory provisions for emergency hospitalization).

[240] *See, e.g.*, *infra* notes 241–244 and accompanying text.

[241] TEX. HEALTH & SAFETY CODE § 573.021(c).

[242] WASH. ADMIN. CODE § 388-865-0541 (2014).

[243] *Id.* § 388-865-0541(2)(a)–(c).

occur within three hours of arrival if the individual is an adult or twelve hours of arrival if the individual is a child who is being placed in an inpatient facility.[244] Based on the findings of these physical and mental health examinations, as well as appropriate diagnostic testing,[245] Washington law requires the individual to be provided treatment in accordance with a detailed and formally documented plan of care.[246] The plan of care must be developed collaboratively with the individual, his or her support system, and a multidisciplinary team that includes mental health specialists.[247] Close follow up also is required. Indeed, a mental health professional must observe and evaluate each individual committed for treatment in the State of Washington once a day for the duration of the commitment.[248]

Other states' involuntary commitment laws also require prompt physical and mental health examinations, appropriate treatment in accordance with detailed, documented plans of care, and close patient follow up. In North Carolina, for example, an individual who is the subject of a commitment petition must undergo several examinations. The first examination must be conducted by a physician or psychologist "as soon as possible, and in any event within 24 hours" after the individual is taken into custody by local law enforcement.[249] If, during the first examination, the individual is preliminarily determined to meet the threshold for commitment, the individual is transported to a treatment facility and examined for a second time.[250] North Carolina requires the second examination to be conducted by a physician other than the physician who may have completed the first examination and to occur within twenty-four hours of the individual's arrival at the facility.[251] If the second examiner finds that the individual meets the threshold for inpatient or outpatient commitment, the law specifically authorizes a physician to administer the individual "reasonable and appropriate medication and treatment that are consistent with accepted medical standards."[252]

Rhode Island also clarifies that involuntarily committed individuals have a legal right to receive treatment for their health conditions.[253] That is, individuals involuntarily committed in Rhode Island have the "right to receive the care and treatment that is necessary for and appropriate to the

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[244] *Id*. § 388-865-0541(3)(a)–(b).
[245] *Id*. § 388-865-0547(1).
[246] *Id*. § 388-865-0547(2).
[247] *Id*.
[248] *Id*. § 388-865-0547(6).
[249] N.C. GEN. STAT. ANN. § 122C-263(a), (c) (West 2014).
[250] *Id*. § 122C-266(a).
[251] *Id*.
[252] *Id*. § 122C-266(d).
[253] *See infra* notes 254–257 and accompanying text (describing Rhode Island statutes pertaining to involuntary commitment).

condition for which he or she was admitted or certified and from which he or she can reasonably be expected to benefit."[254] Involuntarily committed individuals also have the right to an individualized treatment plan that shall be developed by appropriate mental health professionals, including a psychiatrist.[255] Rhode Island requires each individual's treatment plan not only to be developed, but also implemented, within five days of the individual's involuntary court certification.[256] Acceptable treatment plans must contain statements or descriptions, as appropriate, of: (1) "the nature of the specific problems and specific needs of the [individual]"; (2) "the least restrictive treatment conditions necessary to achieve the purposes of certification or admission"; (3) "intermediate and long-range treatment goals"; and (4) "the plan of treatment for achieving these intermediate and long-range goals," including rationales therefor.[257]

Finally, many involuntary commitment laws set forth a range of other health care-related statutory rights for committed individuals including, but not limited to, the right to be visited privately at reasonable times by a personal physician, the right to obtain an independent psychiatric evaluation and opinion from a psychiatrist or other mental health professional of the individual's choice, the right to have the least possible restraint consistent with the health care and treatment necessary for the individual's health condition, and the right to access a mental health advocate upon request.[258]

The right of involuntarily committed individuals to receive health care is not just statutory, but constitutional. In *Wyatt v. Stickney*, a seminal case decided in 1971 that addresses the constitutional rights of individuals involuntarily committed to a state mental hospital, the U.S. District Court for the Middle District of Alabama held that such individuals "unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental health condition."[259] The court explained that "adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed into a penitentiary where one could be held indefinitely for no convicted offense."[260] The court also stated that a lack of funding for staff or facilities cannot be used as an excuse for a lack of adequate health care: "The failure to provide suitable and adequate treatment to the mentally

[254] R.I. GEN. LAWS § 40.1-5-9(a) (2014).
[255] *Id.*
[256] *Id.*
[257] *Id.* § 40.1-5-9(a)(1)–(4).
[258] *See, e.g.*, *id.* § 40.1-5-5(f)(5), (8), (12)–(13).
[259] Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).
[260] *Id.*

ill cannot be justified by lack of staff or facilities."[261] The court concluded by emphasizing involuntary health care providers' legal and moral obligations to their court-ordered patients:

> There can be no legal (or moral) justification for the State of Alabama's failing to afford treatment—and adequate treatment from a medical standpoint—to the several thousand patients who have been who have been civilly committed . . . . To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic purposes and then fail to provide adequate treatment violates the very fundamental of due process.[262]

In *Wyatt*, the court ultimately ordered the defendant hospital to prepare a specific plan for providing "appropriate and adequate treatment to patients."[263] Circuit courts across the country have agreed with the constitutional rights first identified in *Wyatt*, calling them the "*Wyatt* standards."[264] Researchers also have associated the *Wyatt* standards with health care quality improvements in Alabama's mental hospitals.[265]

In summary, state involuntary commitment laws contain stringent and enforceable standards regarding health examinations, plans of care, and initial treatment as well as follow-up care. Individuals who are involuntarily committed also have constitutional rights to adequate, or reasonable, health care.

Why might these statutory and constitutional rights serve as a reference point for assessing the health care, or lack thereof, provided to immigration detainees? Several reasons exist. First, involuntary commitment and immigration detention are both government-authorized forms of civil confinement. Involuntary commitment is a state-authorized, civil measure designed to ensure the health, safety, and welfare of individuals who have a mental illness and might be a danger to themselves or others and/or who meet other criteria.[266] Indeed, state legislatures frequently title their involun-

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[261] *Id*.

[262] *Id*. at 785.

[263] *Id*. at 785–86.

[264] *See, e.g.*, Wyatt v. Rogers, 92 F.3d 1074, 1077 (11th Cir. 1996) (referencing the "*Wyatt* standards"); Walters v. W. St. Hosp., 864 F.2d 695, 700 (10th Cir. 1988) (citing *Wyatt* for its constitutional right to adequate treatment); Deborah J. Belcher, *Wyatt v. Stickney*, ENCYCLOPEDIA OF ALA. (Aug. 6, 2009), http://www.encyclopediaofalabama.org/article/h-2375 [http://perma.cc/RB6Q-73ZM] ("These standards, later referred to as the *Wyatt* Standards, rested on three principles: individualized treatment plans, qualified staff in numbers sufficient to administer adequate treatment, and humane psychological and least restrictive environments.").

[265] *See, e.g.*, Philip J. Leaf, Wyatt v. Stickney*: Assessing the Impact in Alabama*, 28 HOSP. & COMMUNITY PSYCHIATRY 351, 351 (1977) ("[The *Wyatt* standards] may have contributed significantly to the improvements that have occurred in mental health care in Alabama after *Wyatt*.").

[266] *See, e.g.*, W. VA. CODE ANN. § 27-5-4(k)(1)(A)–(B) (West 2014) (allowing an individual's involuntary commitment if the circuit court or mental hygiene commissioner makes a finding that

tary commitment laws "civil commitment" laws[267] and carefully distinguish these civil commitment laws from their criminal counterparts, even to the point of prohibiting evidence obtained during a civil commitment from being used in a criminal conviction.[268]

Immigration detention also is a civil, not criminal, form of detention.[269] The U.S. Supreme Court has repeatedly stated that unlawful presence in the United States does not itself constitute a federal crime, although it can trigger the civil remedy of removal,[270] that immigration detention is a form of civil, not criminal, detention,[271] and that deportation proceedings are purely civil actions that are not designed to punish past transgressions.[272]

In addition, both involuntary commitment and immigration detention have as one of their stated purposes the protection of the public. Indeed, one of the thresholds for involuntary inpatient commitment in every state is the

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the individual has a mental illness or addiction and, because of that mental illness or addiction, is likely to cause serious harm to self or others if allowed to remain at liberty, among other requirements).

[267] *See, e.g.*, CAL. WELF. & INST. CODE § 5585 (West 2014) (California Act titled the "Children's Civil Commitment and Mental Health Treatment Act"); MINN. STAT. ch. 253B (2014) (Minnesota Statutes chapter titled "Civil Commitment").

[268] *See, e.g.*, NEV. REV. STAT. ANN. § 458.340 (West 2014) ("The determination of alcoholism or drug addiction and civil commitment . . . shall not be deemed a criminal conviction."); *id.* § 458A.250 ("The determination of problem gambling and civil commitment . . . shall not be deemed a criminal conviction."); V.I. CODE ANN. tit. 19, § 664 (2014) ("The determination of narcotic addiction and the subsequent civil commitment . . . shall not be deemed a criminal conviction. The results of any tests or procedures . . . may only be used in a [civil commitment] proceeding [and] not be used . . . in any criminal proceeding . . . .").

[269] *See, e.g.*, Kristen C. Ochoa et al., *Disparities in Justice and Care, Persons with Severe Mental Illness in the U.S. Immigration Detention System*, 38 J. AM. ACAD. PSYCHIATRY & L. 392, 393 (2010). As one group of scholars explains,

> 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. 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.

Id. (footnotes omitted).

[270] *See, e.g.*, Arizona v. United States, 132 S. Ct. 2492, 2505 (2012) (citing Immigration & Naturalization Serv. v. Lopez-Mendoza, 468 U.S. 1032, 1038 (1984), for the principle that "[i]t is not a crime for a removable alien to remain present in the United States").

[271] *See, e.g.*, Zadvydas v. Davis, 533 U.S. 678, 690 (2001) ("The proceedings at issue here are civil, not criminal, and we assume that they are non-punitive in purpose and effect."). *But see* César Cuauhtémoc García Hernández, *Immigration Detention as Punishment*, 61 UCLA L. REV. 1346, 1353 (2014) ("Despite the consistent description of immigration confinement as civil, the Court has never explicitly rationalized this determination.").

[272] *See, e.g.*, *Lopez-Mendoza*, 468 U.S. at 1038–39 ("A deportation proceeding is a purely civil action to determine eligibility to remain in this country . . . . [A] deportation hearing is intended to provide a streamlined determination of eligibility to remain in this country, nothing more. The purpose of deportation is not to punish past transgressions . . . .").

potential danger to others of an individual with severe mental illness.[273] Likewise, the federal courts and ICE have repeatedly stated that one purpose of immigration detention is to protect the public.[274] In its 2003 opinion in *Demore v. Kim*, the U.S. Supreme Court examined in detail the government's two principal justifications for mandatory detention, including protection of the public from allegedly dangerous aliens.[275] The Director of ICE also stated in 2011 that individuals who pose a "risk to public safety" are a top priority in terms of immigration apprehension, detention, and removal.[276] In its 2003 opinion in *Sylvain v. Attorney General of the United States*, the U.S. Court of Appeals for the Third Circuit further explained that, "The [mandatory detention] statute promotes the public interest by keeping the most dangerous aliens off the streets . . . . The sooner they detain dangerous aliens, the safer the public will be."[277]

In addition to their shared civil nature and goal of protecting the public, involuntary commitment and immigration detention have other similarities. For example, individuals in both groups are unable to access the health care they need, although for very different reasons. On the commitment side, the inability of individuals who need to be committed to access health care is reflected in the standard for involuntary commitment in each state. Alabama requires the subject of a commitment petition to be "unable to make a rational and informed decision as to whether or not treatment for mental illness would be desirable."[278] Idaho similarly requires the subject to "lack insight into his need for treatment and [be] unable or unwilling to

[273] *See, e.g.*, DEL. CODE ANN. tit. 16, § 5011(a) (2014) ("An individual shall be involuntarily committed for inpatient treatment only if . . . (1) The individual is a person with a mental condition; (2) Based upon manifest indications, the individual is . . . [d]angerous to others . . . ."); N.H. REV. STAT. ANN. 135-C:34 (2014) ("The standard to be used . . . in determining whether a person should be . . . treat[ed] . . . on an involuntary basis shall be whether the person is in such mental condition as a result of mental illness as to create a potentially serious likelihood of danger . . . to others."); STATE STANDARDS FOR ASSISTED TREATMENT, *supra* note 229, at 2–89 (referencing each state's involuntary inpatient commitment standard, almost all of which allow commitment when an individual with a mental illness is a danger to others and meets certain other criteria); Gordon, *supra* note 235, at 13 (explaining that states began, in the 1950s, to shift away from a "need for treatment" standard to a "dangerousness to self or others" standard).

[274] *See infra* notes 275–277 and accompanying text.

[275] Demore v. Kim, 538 U.S. 510, 518–22 (2003) (discussing the justifications of flight risk and danger to community); *id.* at 531 (Kennedy, J., concurring) ("[T]he justification for 8 U.S.C. § 1226(c) is based upon the Government's concerns over the risks of flight and danger to the community . . . .").

[276] *See, e.g.*, Memorandum from John Morton, Dir., U.S. Immigration & Customs Enf't, to All ICE Employees 1 (Mar. 2, 2011) (including within the first priority "[a]liens who pose a . . . risk to public safety").

[277] Sylvain v. Att'y Gen. of the U.S., 714 F.3d 150, 159 (3d Cir. 2003).

[278] ALA. CODE § 22-52-10.2(iii) (one of three criteria for involuntary outpatient commitment); *id.* § 22-52-10.4(a)(iv) (one of four criteria for involuntary inpatient commitment).

comply with treatment."[279] Florida also requires the subject to have "refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment" or to be "unable to determine for himself or herself whether placement is necessary."[280] And, once committed, these individuals have no way to access health care outside the hospitals or other treatment facilities into which they have been court ordered.

On the detention side, the stories shared in Part I illustrate that detainees, including detainees whose health conditions were successfully managed prior to detention, frequently rely on detention center staff to access health care or continue their treatments once detained. Remember, for example, Nery Romero, the twenty-two-year-old Salvadoran national whose pain for his shattered broken leg had been medically managed prior to detention but whose pain medications were discontinued upon detention.[281] Federal investigators later found Romero's untreated pain to be a factor in his suicide.[282] Other individuals' medically necessary treatments also have been discontinued upon detention. At Irwin County Detention Center, a new detainee with only three months of chemotherapy remaining in her plan of care was unable to continue her life-saving treatments.[283] At the time of intake, Irwin staff did administer the detainee a test for tuberculosis, but the detainee was unable to see a physician for over one week even after sharing her cancer diagnosis and requesting treatment.[284] When the detainee finally was seen, the physician gave her over-the-counter pain medication but would not order a radiological examination to monitor the progress of her cancer or continue her chemotherapy treatments.[285]

These examples show that individuals, once detained, lose their ability to obtain adequate health care if their detention centers fail to provide such care. In the criminal setting, the U.S. Supreme Court has used this reason to identify a violation of the Eighth Amendment to the U.S. Constitution in cases involving a prison's deliberate indifference to an inmate's serious medical needs: "[The] government [has an] obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do

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[279] IDAHO CODE ANN. § 66-317(11)(c) (2014); *id.* § 66-329(11).

[280] FLA. STAT. ANN. § 394.467(1)(a)(1)(a)–(b) (West 2014).

[281] Bernstein, *Suicide*, *supra* note 193; *see supra* notes 30–200 (presenting accounts of individuals who suffered from preventable illnesses yet were unable to receive treatment while in detention).

[282] Bernstein, *Officials Hid Truth*, *supra* note 129; Bernstein, *Officials Obscured Truth*, *supra* note 202.

[283] IRWIN COUNTY DETENTION CENTER REPORT, *supra* note 88, at 3.

[284] *Id.*

[285] *Id.*

so, those needs will not be met."[286] The Court further explained, "This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed."[287]

In the context of civil immigration detention, detainees also have a right to necessary medical care, but this right derives from the Due Process Clause of the Fifth Amendment, not the Eighth Amendment.[288] When immigration officials have denied detainees medically necessary treatments they were receiving prior to detention, detainees' due process claims may be allowed to proceed in court.[289]

B. Long-Term Care Requirements

In addition to state involuntary commitment laws, a second possible reference point for assessing the quality of health care provided to immigration detainees is a federal rule applicable to long-term care facilities, including Medicare-participating skilled nursing facilities and Medicaid-participating nursing facilities.[290]

As background, Medicare-participating skilled nursing facilities ("SNFs") are institutions that: (1) primarily provide to Medicare beneficiaries and other individuals skilled nursing care or rehabilitation services; (2) do not primarily care for and treat mental disorders; and (3) must adhere to stringent require-

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[286] *See* Estelle v. Gamble, 429 U.S. 97, 103–04 (1976) ("[D]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' . . . proscribed by the Eighth Amendment." (citation omitted)); *see also* U.S. CONST. amend. VIII ("Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.").

[287] *Estelle*, 429 U.S. at 104. Some state statutes affirmatively require criminal defendants adjudicated guilty but mentally ill to be provided mental health care. *See, e.g.*, ALASKA STAT. ANN. § 12.47.050(b) (West 2014). Alaska, for example, requires its Department of Corrections to "provide mental health treatment to a defendant found guilty but mentally ill . . . until the defendant no longer suffers from a mental disease or defect that causes the defendant to be dangerous to the public peace or safety." *Id.*

[288] *See, e.g.*, Adekoya v. Holder, 751 F. Supp. 2d 688, 694–95 & n.4 ("Because [the plaintiff] was in civil immigration detention rather than criminal detention, his deliberate indifference claims should be analyzed under the Fifth Amendment's Due Process clause rather than the Eighth Amendment's 'cruel and unusual punishment' clause."); *see also* U.S. CONST. amend. V ("No person shall be . . . deprived of life, liberty, or property, without due process of law . . . .").

[289] *See, e.g.*, *Cesar*, 542 F. Supp. 2d at 906–08 (holding that detainee stated a Fifth Amendment due process claim against detention official for denial of medical care when: (1) detainee was successfully managing a number of medical conditions, including hypertension, depression, diabetes, arthritis, back pain, acid reflux, and Grave's disease, with prescription medications prior to detention; and (2) officials would not give the detainee these medications in detention).

[290] *See* 42 C.F.R. § 483.1(b) (2015).

ments designed to ensure the health and safety of residents.[291] For example, SNFs must care for their residents in a way that will at least maintain, if not enhance, the quality of life of each resident.[292] By further example, SNFs "must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[293]

SNFs are legally distinct from Medicaid-participating nursing facilities ("NFs"), which are institutions that: (1) primarily provide to Medicaid beneficiaries and other individuals skilled nursing care, rehabilitation services or, on a regular basis, health-related care and services above the level of room-and-board services that can only be made available through an institutional facility; (2) do not primarily care for and treat mental disorders; and (3) must adhere to stringent requirements designed to ensure the health and safety of residents.[294] One of these requirements is that the NF must care for its residents in a way that will at least maintain, if not enhance, the quality of life of each resident.[295] A second requirement is that the NF "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[296]

Collectively referred to as long-term care ("LTC") facilities, SNFs and NFs are jointly regulated by the Centers for Medicare and Medicaid Services ("CMS") through federal regulations first promulgated in the late 1980s and early 1990s during a period of federal LTC reform.[297] Following the promul-

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[291] *See* 42 U.S.C. § 1395i-3(a)(1)–(3) (2012).

[292] *Id.* § 1395i-3(b)(1)(A).

[293] *Id.* § 1395i-3(b)(2).

[294] 42 U.S.C. § 1396r(a)(1)–(3) (2012). Although SNFs and NFs have different legal definitions, 95% of LTC facilities in the United States are certified as both SNFs and NFs; "[t]hat is, they provide both the Medicare SNF benefit, and the Medicaid NF benefit." *See* Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 80 Fed. Reg. 42,168, 42,177 (proposed July 16, 2015) (to be codified at 42 C.F.R. pt. 483) [hereinafter LTC Proposed Rule].

[295] 42 U.S.C. § 1396r(b)(1)(A) (2012).

[296] *Id.* § 1396r(b)(2).

[297] A number of studies published in the mid-1980s reported the widespread abuse, neglect, and inadequate medical treatment of residents in LTC facilities. *See, e.g.*, INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES 21 (1986), https://iom.nationalacademies.org/Reports/1986/Improving-the-Quality-of-Care-in-Nursing-Homes.aspx [http://perma.cc/L8Q9-S5D6] ("Quality of care and quality of life in many nursing homes are not satisfactory."). In response, the Institute of Medicine ("IOM") recommended to Congress a "major reorientation" of the regulation of LTC facilities in order to improve the health, safety, and welfare of LTC residents. *Id.* at 22. The IOM's recommendations included an overhaul of the federal regulations governing the quality of care provided by LTC facilities, stringent surveillance of LTC facilities, and rigorous enforcement policies and procedures. *Id.* Congress agreed with the IOM's recommendations, passing in 1987 the Nursing Home Reform Act ("NHRA"). Nursing Home Reform Act, Pub. L. No. 100-203, §§ 4201–18, 101 Stat. 1330-175, 1330-179, 1330-182 (1987) (codified as amended at 42 U.S.C. §§ 1395i-3(a)–(h), 1396r(a)–(h)). In 1989 and 1991, the Federal Department of Health and Human Services promulgated final regulations implementing the NHRA. *See* Medicare and Medicaid; Requirements for Long Term Care Facilities, 54 Fed. Reg. 5316 (Feb. 2, 1989) (codified as amended at 42 C.F.R. pt. 483);

gation of these regulations (collectively, the LTC requirements),[298] researchers reported quality improvements in LTC facilities across the country, suggesting that such improvements were due to the requirements' stringent quality and staffing provisions.[299] As discussed in more detail below, the LTC requirements may serve as a useful reference point for assessing possible detention health reform.[300]

As background, the LTC requirements establish minimum standards designed to ensure the health and safety of each individual, called a resident, admitted to an LTC facility.[301] Promptly upon admission to an LTC facility,[302] for example, each resident must be comprehensively assessed with respect to cognition, communication, vision, mood and behavior, psychosocial well-being, physical functioning, continence, disease diagnosis, dental and nutritional status, skin condition, activity pursuit, and medications.[303] Recognizing the importance of these assessments for identifying each resident's health care needs and establishing a plan of care, the Secretary of the U.S. Department of Health and Human Services has the authority to impose civil money penalties on individuals who knowingly and willfully fail to conduct an assessment or who make a material and false statement as part of an assessment.[304]

Following each assessment, LTC facilities are required to develop a comprehensive care plan for each resident that includes measurable goals and objectives designed to meet the resident's physical and mental health care needs.[305] Each care plan must identify, among other goals and objectives, the services the resident needs in order to "attain or maintain" his or

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see also Medicare and Medicaid; Requirements for Long Term Care Facilities, 56 Fed. Reg. 48,867 (Sept. 26, 1991) (codified as amended at 42 C.F.R. pt. 483) (revising final regulations). The LTC requirements promulgated through these two regulations, along with the NHRA, are known as "federal LTC reform."

[298] *See* 42 C.F.R. pt. 483. On July 16, 2015, CMS issued a notice of proposed rulemaking that would modify some of the LTC requirements. LTC Proposed Rule, 80 Fed. Reg. at 42,168. Because CMS has not yet issued a final rulemaking, this Article references the LTC requirements currently codified at 42 C.F.R. pt. 483.

[299] *See, e.g.*, Xinzhi Zhang & David C. Grabowski, *Nursing Home Staffing and Quality Under the Nursing Home Reform Act*, 44 GERONTOLOGIST 13, 13 (2004) ("Following the [Nursing Home Reform Act], quality improvements were found in nursing homes nationwide, and these results suggest that part of this improvement was due to the quality and staffing regulations within the NHRA.").

[300] *See infra* notes 301–323 and accompanying text.

[301] *See, e.g.*, *infra* notes 302–323 and accompanying text.

[302] 42 U.S.C. § 1395i-3(b)(3)(C)(i)(I) ("[S]uch an assessment must be conducted . . . promptly upon . . . admission . . . .").

[303] 42 C.F.R. § 483.20(b)(1).

[304] *Id.* § 483.20(j)(1)(i)–(ii).

[305] *Id.* § 483.20(k)(1).

her "highest practicable" physical and mental well-being.[306] The care plan, which must be periodically reviewed and revised, shall be prepared by an interdisciplinary team that includes the resident's attending physician, a registered nurse with responsibility to the resident, and other caregivers in disciplines relevant to the resident's needs.[307]

In accordance with the care plan, the LTC facility must provide care and services that will: (1) maintain or improve each resident's ability to perform activities of daily living including bathing, ambulating, toileting, eating, and communicating;[308] (2) maintain each resident's vision and hearing;[309] (3) avoid the development of pressure sores;[310] (4) avoid catheterization;[311] (5) maintain range of motion;[312] (6) correct existing mental or psychosocial adjustment difficulties;[313] (7) prevent decreased social interaction and increased withdrawn, angry, or depressive behaviors;[314] (8) maintain a safe environment free of accidents;[315] and (9) maintain acceptable nutrition and hydration, body weight, and protein levels.[316]

LTC facilities also must provide or arrange for medical, nursing, dietary, rehabilitation, dental, pharmacy, and other health services that will, again, "attain or maintain the highest practicable" physical and mental well-being of each resident.[317] For example, LTC facilities must ensure that each resident is under the care of an attending physician, that a second physician is available to supervise the medical care of a resident whose attending physician is unavailable, that each resident is visited by a physician at least once every thirty days, and that during those visits, the physician reviews each resident's plan of care, including medications and treatments.[318] LTC facilities also must provide a sufficient number of licensed nurses available on a twenty-four-hour basis[319] as well as registered nurses available eight

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[306] *Id.*
[307] *Id.* § 483.20(k)(1)–(2).
[308] *Id.* § 483.25(a)(1)–(2).
[309] *Id.* § 483.25(b).
[310] *Id.* § 483.25(c).
[311] *Id.* § 483.25(d).
[312] *Id.* § 483.25(e).
[313] *Id.* § 483.25(f)(1).
[314] *Id.* § 483.25(f)(2).
[315] *Id.* § 483.25(h).
[316] *Id.* § 483.25(i)–(j).
[317] *See, e.g.*, *id.* § 483.30 (nursing staff requirements); *id.* § 483.35(a) (dietary services requirements); *id.* § 483.40 (physician supervision requirements); *id.* § 483.45 (specialized rehabilitation requirements, including physical therapy, occupational therapy, and speech-language pathology requirements); *id.* § 483.55 (dental service requirements); *id.* § 483.60 (pharmacy requirements).
[318] *Id.* § 483.40(a)–(c).
[319] *Id.* § 483.30(a).

hours a day, seven days a week.[320] In addition, LTC facilities with 121 or more licensed beds must hire a full-time social worker to provide medically related social services.[321]

Finally, LTC facilities must create and implement a comprehensive infection control program designed to help prevent the development and spread of infectious diseases.[322] This program must identify the procedures by which the LTC facility: (1) identifies, manages, and treats infections in the facility; (2) determines which measures, such as segregation, should be applied to residents who have infectious diseases; (3) maintains records of infectious diseases acquired in the facility and responses thereto; (4) actually segregates residents who acquire infectious diseases; (5) prohibits employees with infectious diseases and skin lesions from contacting residents and their food; (6) requires staff to wash their hands following contact with each resident in accordance with accepted hand washing standards and techniques; and (7) handles bed and other linens in a manner that will stop the transmission of infections.[323]

Why might these LTC requirements serve as a reference point for assessing the health care provided in the context of immigration detention? First, LTC facilities and immigration detention centers have similar lengths of stay. Unlike general, acute care hospitals, which have short (4.5-day) average lengths of stay,[324] SNF and NF residents stay in their facilities a long time. The average length of stay is twenty-seven days for Medicare SNFs and two years for Medicaid NFs.[325] Due to their long-term nature as well as old, unfavorable reports of little actual nursing or other health care provided therein, many LTC facilities were, prior to federal LTC reform, unfavorably

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[320] *Id.* § 483.30(b).

[321] *Id.* § 483.15(g)(2).

[322] *Id.* § 483.65.

[323] *Id.* § 483.65(a)–(c).

[324] AUDREY J. WEISS & ANNE ELIXHAUSER, HEALTHCARE COST & UTILIZATION PROJECT, OVERVIEW OF HOSPITAL STAYS IN THE UNITED STATES, STATISTICAL BRIEF 1 (2014), http://www.hcup-us.ahrq.gov/reports/statbriefs/sb180-Hospitalizations-United-States-2012.pdf [http://perma.cc/VT5X-JP55] ("In 2012, there were 36.5 million hospital stays in the United States, with an average length of stay of 4.5 days . . . ."); *see also* NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL & PREVENTION, NAT'L HOSP. DISCHARGE SURVEY: 2010, NUMBER & RATE OF HOSP. DISCHARGES 2 (2010), http://www.cdc.gov/nchs/data/nhds/1general/2010gen1_agesexalos.pdf [http://perma.cc/URX7-25V5] (using 2010 data, identifying the average length of stay as 4.8 days for both sexes, 5.2 days for males, and 4.5 days for females).

[325] OFFICE OF DISABILITY, AGING, & LONG-TERM CARE POLICY, U.S. DEP'T OF HEALTH & HUMAN SERVS., POST-ACUTE AND LONG-TERM CARE: A PRIMER ON SERVICES, EXPENDITURES, AND PAYMENT METHODS 1 tbl.1 (2010), http://aspe.hhs.gov/sites/default/files/pdf/76146/paltc.pdf [http://perma.cc/J7W6-E4AV]; *see* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 198 tbl.8-7 (2014), http://medpac.gov/documents/reports/mar14_entirereport.pdf [http://perma.cc/AB4P-BAV8] (providing average lengths of stay for freestanding Medicare SNFs in the top and bottom quartiles).

referred to as "holding facilities," "pre-hospitalization holding facilities," "well-intended residences for the incurably under-attended to," "warehouses for death," "places of abandonment," and "dumping ground[s] for death."[326] Even though long-term care has vastly improved since federal LTC reform, the unfavorable names remain.[327]

Like LTC facilities, immigration detention centers also have long average lengths of stay. Asylum seekers, for example, spend an average of twenty-seven days in detention.[328] Data are inconsistent for other noncitizens, with some reports identifying a thirty-day average length of stay and others identifying an eighty-one-day average length of stay.[329] The detention stories shared in Part I of this Article illustrate the long-term nature of many detentions.[330] For example, forty-four-year-old Salvadoran national Raul Ernesto Morales-Ramos was detained for almost five years; that is, from 2010 until his death from intestinal cancer in 2015.[331] Fernando Dominguez Valdivia spent one hundred days in ICE custody before he died of multiple organ failure.[332] Tiombe Kimana Carlos also was in ICE custody for a long time. She was detained for more than two-and-a-half years before she hanged herself.[333] Due to their long-term nature as well as their poor conditions, many immigration detention centers share the unfavorable names giv-

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[326] *See, e.g.*, Peter Children, Opinion, *Nursing Homes Are "Warehouses for Death,"* NORTH IOWA TODAY (July 4, 2012), http://northiowatoday.com/2012/07/04/op-ed-nursing-homes-are-warehouses-for-death-by-peter-children/ [http://perma.cc/PE6H-2UJF] ("These warehouses for death are a blight on this country . . . . [T]hey are places of abandonment[,] a dumping ground for loved ones . . . . If you put your parents in one of these holding pens then God should strike you down."); Thomas Day, *About Nursing Homes*, NAT'L CARE PLAN. COUNCIL (July 12, 2015 7:35 AM), https://bsl.app.box.com/s/zacdviats3ve6eek4x5f7403ow5qze5n [https://perma.cc/BZ25-F8YM] (referring to nursing homes as holding facilities); Paula Span, *Where Are the Nurses?*, N.Y. TIMES: NEW OLD AGE BLOG (Aug. 13, 2014, 11:20 AM), http://newoldage.blogs.nytimes.com/2014/08/13/where-are-the-nurses/?_r=0\ [http://perma.cc/6ZZ9-VTP6] ("[W]e probably should refer to these facilities as something besides nursing homes: 'pre-hospitalization holding facilities,' perhaps, or 'well-intended residences for the incurably under-attended to.' You can probably come up with a few even-less-flattering names yourselves.").

[327] *See supra* note 326 and accompanying text.

[328] *See* Mark Noferi, *Immigration Detention: Behind the Record Numbers*, CTR. FOR MIGRATION STUD. (Feb. 13, 2014), http://cmsny.org/immigration-detention-behind-the-record-numbers/ [http://perma.cc/L7X5-TKRK].

[329] *Id*.

[330] *See supra* notes 30–200 (providing stories of detainees who spent extensive amounts of time in detention).

[331] Linthicum, *supra* note 1.

[332] *See* Yáñez, *supra* note 3.

[333] Michael Matza, *Sad Tale of Mental Illness and U.S. Detention*, PHILLY.COM (Nov. 15, 2013), http://articles.philly.com/2013-11-15/news/44078208_1_immigration-detainees-detainee-deaths-u-s-immigration [http://perma.cc/7AK5-KXRY].

en to LTC facilities prior to federal LTC reform: "warehouses for the mentally ill," "holding pens," "animal cages," and "dumping grounds."[334]

Top detention officials, including Dennis Slate, the former ICE Chief of Psychology, also have noted the similarities between LTC facilities and detention centers. In a confidential internal email, Slate stated, "[The immigration detention system was] set up for quick stays [but] turned into a de facto long-term care center for the most troublesome patients, those whose countries of origin often refused to take them."[335] Attorneys representing detainees allegedly denied adequate health care also liken immigration detention and long-term care: "Health care for immigration detainees around the country . . . is premised on the often-false notion that detention is short-term. In truth, many detainees spend months or years awaiting a final determination of their immigration case, and are forced to suffer needlessly as a result . . . ."[336]

In addition to the average lengths of stay, LTC facilities and immigration detention centers share other characteristics as well. For example, although neither SNFs nor NFs were intended to primarily care for and treat mental disorders,[337] many residents of LTC facilities do have mental ill-

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[334] *See, e.g.*, Editorial, *Death by Detention*, N.Y. TIMES, (May 6, 2008), http://www.nytimes.com/2008/05/06/opinion/06tue1.html [http://perma.cc/ZKX9-L9ZL] (referring to detention centers as "vast holding pen[s]"); Molly Hennessy-Fiske & Cindy Carcamo, *Overcrowded, Unsanitary Conditions Seen at Immigration Detention Centers*, L.A. TIMES (June 18, 2014, 7:24 PM), http://www.latimes.com/nation/nationnow/la-na-nn-texas-immigrant-children-20140618-story.html [http://perma.cc/X2RZ-S43R] (noting that a detention center for migrant children in Nogales, Arizona, is a former warehouse); Michael Kiefer, *Immigrant Kids Detained in Warehouses of Humanity*, USA TODAY (June 18, 2014, 3:42 PM), http://www.usatoday.com/story/news/nation/2014/06/18/immigrant-children-detention-centers/10798643/ [http://perma.cc/BF54-GECR] ("The scene looks like a warehouse . . . . The entire facility has the feel of the livestock areas at a state fair. Inside it smells of feet, sweat and straw."); Luke Turf, *Activist Likens Holding Pen for Illegal Immigrants to Guantanamo Cages*, TUCSON CITIZEN (Apr. 1, 2004), http://tucsoncitizen.com/morgue2/2004/04/01/105568-activist-likens-holding-pen-for-illegal-immigrants-to-guantanamo-cages/ [http://perma.cc/S5V4-WKH2] (likening noncitizen field processing shelters to holding pens and animal cages); Steve Williams, Opinion, *Dumping Ground, or Revenue Center?*, DAILY PRESS (July 11, 2014 8:30 AM), http://www.vvdailypress.com/article/20140711/Opinion/140719975 [http://perma.cc/J33M-LTYA] (reporting a local politician's reference to a detention center as a "dumping ground").

[335] Priest & Goldstein, *supra* note 46.

[336] *Woods* Complaint, *supra* note 49, at 1, 11. In reality,

> Because immigration detention is perceived to be short-term, medical personnel and persons charged with authorizing treatment delay or deny treatment in the hope that detainees will be removed from the United States or released from detention sooner, rather than later. This perception is often incorrect, as detainees with serious medical needs may spend months or years in detention pursuing their right to remain in the United States or seek refuge here.

Id.

[337] *See* 42 U.S.C. § 1395i-3(a)(1) (defining a SNF as an institution that, among other requirements, "is not primarily for the care and treatment of mental diseases"); *id.* § 1396r(a)(1) (defining

ness.[338] More than 500,000 individuals with mental illness reside in LTC facilities on any particular day, leading some to classify LTC facilities as "de facto mental institution[s]."[339] Indeed, studies estimate the prevalence of LTC facility residents with a primary diagnosis of mental illness at 18.7% for residents sixty-five to seventy-four years old and 23.5% for residents eighty-five years of age and older.[340]

Immigration detainees also have high rates of mental illness. The federal government conservatively estimated in one confidential memorandum that 15% of detainees have severe mental illness.[341] Estimates of mental illness from other studies are significantly higher. One study of detainees seeking asylum found that 86% of those surveyed exhibited symptoms of clinical depression, 75% manifested anxiety-related symptoms, and 50% exhibited symptoms of post-traumatic stress disorder.[342] These estimates are not surprising given the extreme vulnerability of detainees due to their history of torture and trauma, which may include human trafficking, sexual violence, political oppression, psychosocial trauma, and acculturative stress.[343] Without proper diagnosis and treatment, detention can exacerbate preexisting vulnerabilities and contribute to severe mental illness.[344] To respond to the high rates of mental illness among residents, the LTC requirements contain numerous protective provisions, including mandatory assessments of residents' mood and behavior patterns,[345] the creation and implementation of comprehensive care plans that include measurable goals and objectives designed to meet residents' mental health care needs,[346] and the provision of treatment that will correct existing mental and psychosocial adjustment difficulties,[347] prevent decreased social interaction, and prevent in-

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an NF as an institution that, among other requirements, "is not primarily for the care and treatment of mental diseases").

[338] *See* LTC Proposed Rule, 80 Fed. Reg. at 42,174 ("[LTC facilities] are . . . caring for a significant number of residents who require behavioral health services.").

[339] David C. Grabowski et al., *Mental Illness in Nursing Homes: Variations Across States*, 28 HEALTH AFFAIRS 689, 689 (2009).

[340] WILLIAM C. REEVES ET AL., CTRS. FOR DISEASE CONTROL & PREVENTION, MENTAL ILLNESS SURVEILLANCE AMONG ADULTS IN THE UNITED STATES 29 tbl.21 (2011), http://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm [http://perma.cc/WHH2-VVJQ].

[341] Ochoa et al., *supra* note 269, at 393; Priest & Goldstein, *supra* note 46.

[342] PHYSICIANS FOR HUMAN RIGHTS & BELLEVUE/NYU PROGRAM FOR SURVIVORS OF TORTURE, FROM PERSECUTION TO PRISON: THE HEALTH CONSEQUENCES OF DETENTION ON ASYLUM SEEKERS 2 (2003), http://www.survivorsoftorture.org/files/pdf/perstoprison2003.pdf [http://perma.cc/23A2-5VWE].

[343] *See, e.g.*, Foster, *supra* note 15, at 154.

[344] *See, e.g.*, *Robbins* Brief, *supra* note 16, at 2.

[345] 42 C.F.R. § 483.20(b)(1).

[346] *Id.* § 483.20(k)(1).

[347] *Id.* § 483.25(f)(1).

creased withdrawn, angry, and depressive behaviors.[348] As discussed in more detail in Part III, these protections may serve as a backdrop against which the lack of mental health care in immigration detention might be assessed.[349]

C. Behavioral Health Laws

Because of the high rates of mental illness among immigration detainees, a third possible reference point includes federal regulations governing Medicare-participating psychiatric hospitals (called Medicare Conditions of Participation)[350] and state laws regulating inpatient psychiatric hospitals and outpatient mental health centers[351] (collectively, behavioral health laws). Because many provisions set forth in behavioral health laws are similar to those set forth in involuntary commitment laws and LTC requirements, a quick summary of only the most stringent provisions is provided below.

Prompt health examinations and comprehensive care plans are central to most behavioral health laws.[352] The Medicare Conditions of Participation, for example, require patients admitted to psychiatric hospitals to receive a comprehensive health examination within twenty-four hours of admission or registration.[353] State behavioral health laws contain similar requirements. Colorado, for example, requires patients admitted to a hospital for psychiatric care to receive an initial assessment for immediate safety needs within four hours of admission, a nursing assessment and care to maintain the patient's health and safety within eight hours of admission, and a comprehensive psychiatric examination within twenty-four hours of admission.[354] In Massachusetts, individuals admitted to facilities licensed by, contracted for, or operated by the Massachusetts Department of Mental Health also must receive prompt examinations, including a mental status examination "[u]pon admission" as well as a complete psychiatric and physical examination "within 24 hours of admission."[355]

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[348] *Id.* § 483.25(f)(2).

[349] *See infra* notes 372–443 (arguing that regulations of LTC facilities could be used to promulgate legally enforceable regulations that would improve the health and safety of immigration detainees).

[350] The Medicare Conditions of Participation for Psychiatric Hospitals are codified at 42 C.F.R. §§ 482.60–.62.

[351] *See, e.g.*, R.I. GEN. LAWS § 40.1-5-1 (Rhode Island's "Mental Health Law" that regulates state hospitals, public psychiatric inpatient facilities, general and special hospitals that offer behavioral health services, and community mental health facilities); 6 COLO. CODE REGS. § 1011-1:XVIII (2014) (Colorado regulations governing psychiatric hospitals).

[352] *See infra* notes 353–360 and accompanying text.

[353] 42 C.F.R. § 482.24(c)(4)(i)(A).

[354] 6 COLO. CODE REGS. § 1011-1:IV-26.102(1)(a)–(c).

[355] 104 MASS. CODE REGS. § 27.05(3) (2014).

The Medicare Conditions of Participation also require each psychiatric hospital patient to receive a comprehensive, individualized, treatment plan that documents the patient's diagnosis, short-term and long-range goals, treatments ordered, and responsibilities of health care team members, among other important data.[356] A physician who is responsible for the patient's care as well as other health professionals who treat the patient must record progress notes at least weekly for the patient's first two months in the psychiatric hospital.[357] Recommendations for treatment plan revisions and accurate evaluations of the patient's progress are an essential part of these progress notes.[358] State law is similar. Colorado, for example, requires patients admitted to a hospital for psychiatric services to receive treatment in accordance with an individualized care plan that is initiated by an interdisciplinary care team within twenty-four hours of admission.[359] The interdisciplinary team is required to finish the care plan within seventy-two hours of admission and review the plan once a week during the patient's first month as an inpatient.[360]

Behavioral health laws also contain strict staffing requirements. The Medicare Conditions of Participation, for example, require psychiatric hospitals to have "adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning."[361] The Medicare Conditions of Participation also contain minimum staffing requirements for certain professionals. For example, a registered (not just licensed) nurse must be available at each psychiatric hospital twenty-four hours a day.[362] State law is similar. Colorado, for example, requires hospitals that provide psychiatric services to have a physician director of such services who is a board-certified in psychiatry and neurology,[363] a registered nurse available in the psychiatric unit twenty-four hours per day, seven days per week,[364] and a sufficient number of other health professionals to evaluate each patient's mental health care needs, implement each patient's individualized care plan, and ensure the safety of other patients and staff members.[365]

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[356] 42 C.F.R. § 482.61(c)(1).
[357] *Id.* § 482.61(d).
[358] *Id.*
[359] 6 COLO. CODE REGS. § 1011-1:IV-26.102(2)(a).
[360] *Id.* § 1011-1:IV-26.102(2)(b).
[361] 42 C.F.R. § 482.62.
[362] *Id.* § 482.62(d)(2).
[363] 6 COLO. CODE REGS. § 1011-1:IV-26.101(2).
[364] *Id.* § 1011-1:IV-26.101(3)(b).
[365] *Id.* § 1011-1:IV-26.101(7).

In addition, behavioral health laws contain stringent infection control requirements.[366] The Medicare Conditions of Participation, for example, require a "sanitary environment to avoid sources and transmission of infections and communicable diseases" and an "active program for the prevention, control, and investigation of infections and communicable diseases."[367] As part of that program, an infection control officer must develop a system for "identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel."[368] In addition, each hospital's chief executive officer, medical staff, and director of nursing services have legal responsibility for ensuring that any infections found by the infection control officer are appropriately managed through the hospital's quality assessment and improvement program and for implementing corrective action plans that identify the root causes of infections and prevent them from reoccurring.[369]

Finally, behavioral health laws contain detailed suicide prevention requirements. Oregon, for example, requires its Medicaid-participating behavioral health providers to adopt and implement written suicide prevention policies describing how they will respond to the potential for patient suicide. Among other elements, these policies must address the performance of suicide risk assessments on the day of patient intake, documentation of suicidal ideation and other forms of self-harm, communication of findings regarding suicidal ideation and self-harm to all staff, implementation of suicide and self-harm precautions, comprehensive staff training on suicide and self-harm prevention and risk assessment, and implementation of post-suicide or self-harm intervention plans.[370]

III. THE GRAPES OF WRATH: IMPROVING THE HEALTH AND SAFETY OF IMMIGRATION DETAINEES

The previous Part identifies the limitations of constitutional law, international human rights law, and tort law with respect to producing comprehensive health and safety reform in the context of immigration detention.[371] The federal government has attempted to respond to these limitations by publishing specific, ex ante guidelines that address the provision of health care in detention. The former Immigration and Naturalization Service

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[366] *See* 42 C.F.R. § 482.60(b) (stating that psychiatric hospitals must comply with the Conditions of Participation set forth at 42 C.F.R. §§ 482.25–.57); *id.* § 482.42 (setting forth the Condition of Participation for infection control).

[367] *Id.* § 482.42.

[368] *Id.* § 482.42(a).

[369] *Id.* § 482.42(b).

[370] OR. ADMIN. R. 410-170-0030(11)(a)(H) (2014).

[371] *See supra* notes 201–370 and accompanying text.

("INS") issued the first set of National Detention Standards in 2000 ("2000 NDS"),[372] ICE issued a second set of Performance-Based National Detention Standards in 2008 ("2008 PBNDS"),[373] and ICE issued a third set of Performance-Based National Detention Standards in 2011 ("2011 PBNDS").[374] These standards, however, share the same limitations as many international human rights documents; that is, they are not legally enforceable in court and injured detainees have no cause of action or other recourse under them.[375]

Even if they were enforceable, the federal government's most recent—and stringent—guidelines, the 2011 PBNDS, do not apply to all detention centers. Some detention centers only comply with the less stringent 2000 NDS or 2008 PBNDS because their contracts with ICE do not specify that they have to comply with the 2011 PBNDS.[376] Baker County Jail, Polk County Detention Facility, Pinal County Jail, and Tri-County Detention Center, for example, are still only contractually obligated to follow the former INS's 2000 NDS.[377] Likewise, Stewart Detention Center and Theo Lacy Detention Center are only contractually obligated to follow the 2008 PBNDS.[378]

Finally, even if all detention centers in United States were required to comply with the 2011 PBNDS, the guidelines set forth in these standards are substantively inadequate. Using the reference laws as evidence of contemporary health and safety standards, the remainder of this Part identifies the shortcomings of the 2011 PBNDS and makes eight specific recommendations that, if promulgated by the U.S Department of Homeland Security ("DHS") into legally enforceable regulations, would improve immigration detainees' access to physical and mental health care.

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[372] 2000 NDS, *supra* note 10.

[373] 2008 PBNDS, *supra* note 10.

[374] 2011 PBNDS, *supra* note 10.

[375] *See, e.g.*, HUMAN RIGHTS WATCH, DETAINED AND DISMISSED, WOMEN'S STRUGGLE TO OBTAIN HEALTH CARE IN UNITED STATES IMMIGRATION DETENTION 17 (2009), https://www.hrw.org/report/2009/03/17/detained-and-dismissed/womens-struggles-obtain-health-care-united-states [https://perma.cc/KUR7-W5JC] ("ICE has internal enforcement mechanism for its detention standards, but . . . the standards . . . are not legally enforceable.").

[376] *See, e.g.*, *infra* notes 377–378.

[377] BAKER COUNTY JAIL REPORT, *supra* note 38, at 3 (stating that the "2000 INS National Detention Standards" apply to Baker County Jail); PINAL COUNTY JAIL REPORT, *supra* note 89, at 2 (stating that the jail "[o]perates under 2000 National Detention Standards"); POLK COUNTY DETENTION FACILITY REPORT, *supra* note 90, at 3 ("According to ICE, the 2000 National Detention Standards apply."); TRI-COUNTY DETENTION CENTER REPORT, *supra* note 93, at 2 (stating that the "2000 National Detention Standards" apply to Tri-County).

[378] STEWART DETENTION CENTER REPORT, *supra* note 61, at 3 ("According to ICE, the 2008 Performance Based National Detention Standards apply."); THEO LACY DETENTION CENTER REPORT, *supra* note 41, at 5 (noting that the Orange County Sheriff's Department is contractually obligated to follow the 2008 PBNDS).

The first recommendation relates to the timeliness of detainee health examinations. The 2011 PBNDS provide that detainees shall receive a "comprehensive health assessment, including a physical examination and a mental health screening . . . no later than 14 days after entering into ICE custody or arrival at [a detention center]."[379] ICE's own internal documentation, shared in Part I,[380] shows that, notwithstanding this two-week guideline, many detainees do not receive these examinations until day sixteen,[381] day twenty-one,[382] or later, if at all.[383] Many detainee deaths occur earlier than these dates. Chinese national Qi Gen Guo committed suicide at the Clinton County Correctional Facility on day nine of his detention, for example.[384] Salvadoran national Ana Romero Rivera hanged herself at Franklin County Regional Jail on day fourteen of her detention.[385]

Compare, however, the illustrative involuntary commitment laws of North Carolina, Texas, and Washington, discussed in Part II,[386] which demonstrate that the standard for prompt physical and mental health examinations in the context of civil commitment is in the range of twelve to twenty-four hours following emergency detention, the filing of a petition for involuntary treatment, and/or admission to a facility for the provision of involuntary treatment.[387] Some state involuntary commitment laws require the mental portion of these health examinations to occur within a shorter time frame.[388] In Washington, for example, mental health examinations must occur within three hours of arrival at a court-ordered treatment facility if the individual is an adult, or within twelve hours of arrival if the individual is a child who is being placed in an inpatient facility.[389]

Like involuntary commitment laws, the LTC requirements also require residents to be comprehensively examined promptly upon admission to a

[379] 2011 PBNDS, *supra* note 10, at 278 (Standard 4.3(II)(15)).

[380] *See supra* notes 30–200 (providing ICE documentation of delays in provision of medical examinations within the context of individual detainee accounts).

[381] *See* Carlos Investigation Memorandum, *supra* note 8, at 5 (noting that York County Jail detainee Tiombe Kimana Carlos was not physically examined until day sixteen of her detention).

[382] *See supra* notes 50, 54 and accompanying text (noting that Jose Lopez-Gregorio, who eventually committed suicide, did not receive physical examination until twenty-first day of detention).

[383] *See supra* notes 55, 59 and accompanying text (noting the absence of physical exam or medical appointment prior to Mario Francisco Chavez-Torres's death from a brain aneurysm).

[384] LIST OF DEATHS, *supra* note 3, at 4; *see also* Press Release, Lock Haven Hospital, *supra* note 143.

[385] *See* Lannen & Spears, *supra* note 144.

[386] *See supra* notes 241–252 and accompanying text (providing examples of state requirements for prompt medical examinations).

[387] *See supra* notes 241–252 and accompanying text.

[388] *See infra* note 389 and accompanying text.

[389] WASH. ADMIN. CODE § 388-865-0541(3) (2014).

SNF or an NF.[390] Some behavioral health laws also require physical and mental health examinations as soon as four hours but no later than twenty-four hours following admission to an inpatient psychiatric hospital or treatment at a community mental health facility.[391]

Under 8 U.S.C. § 1103(a)(2), the Secretary of DHS has the authority to issue legally enforceable federal regulations establishing the standard of care for individuals in ICE custody.[392] This Article recommends that DHS promulgate a new regulation requiring each detainee to receive a comprehensive physical and mental health examination as soon as possible but no later than twenty-four hours following detention, which is the outside limit for health examinations under the reference laws. The individuals who are qualified to perform these examinations, the systems and functions that must be assessed during these examinations, and the formal documentation requirements relating to these examinations should be determined by DHS through a notice of proposed rulemaking that solicits commentary from the public, including members of the health care industry, immigrant rights organizations, human rights organizations, and other interested parties.

The second recommendation relates to plans of care. The 2011 PBNDS only provide for written plans of care for detainees who "require[] close, chronic or convalescent medical supervision."[393] Many individuals enter detention with minor health conditions that may not appear to meet these subjective thresholds but that quickly progress to life-threatening, acute conditions without medical treatment. The story of Martin Hernandez Banderas, who suffered a minor foot bruise that later turned into an infected ulcer that eventually turned gangrenous and required six weeks of inpatient treatment and several surgeries, is just one example.[394]

In comparison, all three sets of reference laws require the creation, formal documentation, implementation, and periodic revision of comprehensive plans of care that identify, among other things, the health care services an individual needs to attain or maintain reasonable health and well-being.[395] This Article thus recommends that DHS promulgate a new regula-

[390] *See supra* note 303 and accompanying text (requiring comprehensive assessments in multiple health areas shortly after admission).

[391] This can depend on whether the relevant health law is state law or federal law and on whether the relevant law applies to inpatient or outpatient settings. *See supra* notes 352–355 and accompanying text.

[392] 8 U.S.C. § 1103(a)(3) (2014).

[393] 2011 PBNDS, *supra* note 14, at 278 (Standard 4.3(II)(8)).

[394] *See supra* notes 106–110 and accompanying text (detailing the story of Martin Hernandez Banderas).

[395] *See, e.g.*, *supra* notes 246–248, 255–257, 305–307, and 356–360 and accompanying text (evaluating legal requirements for creation and implementation of individual health plans for individuals committed to mental health facilities).

tion requiring each detainee who has any physical or mental health condition identified during the initial health examination, or for which medically necessary health care services are requested by the detainee at any point during detention, to have a care plan created, documented, implemented, and periodically revised by the detention facility. Through a notice of proposed rulemaking, DHS should solicit commentary from the public regarding the health professionals who shall be permitted to create or participate in the creation of the care plan, the required elements of the care plan, documentation requirements relating to the care plan, and time frames for initiation, completion, implementation, and periodic revision of the care plan.

The third recommendation relates to treatment. This is one area where the 2011 PBNDS, at first glance, appear adequate. For example, Standard 4.3(II)(1) of the 2011 PBNDS provides, "Detainees shall have access to a continuum of health services, including . . . prevention, health education, diagnosis and treatment."[396] Standard 4.3(II)(2) requires a "mental health staffing component" to be "on call to respond to the needs of the detainee population 24 hours a day, seven days a week."[397] Standard 4.3(II)(4) requires that detainees "be able to request health services on a daily basis and . . . receive timely follow-up."[398] Standard 4.3(II)(9) provides that, "Twenty-four hour emergency medical and mental health services shall be available to all detainees."[399] Standard 4.3(II)(12) provides that, "Detainees with chronic conditions shall receive care and treatment, as needed, that includes monitoring of medications, diagnostic testing and chronic care clinics."[400] A number of additional standards, expected outcomes, and expected practices provide guidance regarding the treatment of detainees.[401]

Some of these standards could be improved, including by incorporating specific time frames, in hours or days, where the 2011 PBNDS only require a "timely" response. The problem, as Part I illustrates,[402] is that these standards are neither followed nor enforced. This Article recommends that DHS promulgate a third regulation giving detainees the legally enforceable right to receive adequate, or reasonable, medical care that is necessary and appropriate for their health conditions and from which they can reasonably be expected to benefit.[403] Like the treatment standard set forth in the refer-

[396] 2011 PBNDS, *supra* note 10, at 277 (Standard 4.3(II)(1)).

[397] *Id*. (Standard 4.3(II)(2)).

[398] *Id*. at 278 (Standard 4.3(II)(4)).

[399] *Id*. (Standard 4.3(II)(9)).

[400] *Id*. (Standard 4.3(II)(12)).

[401] *Id*. at 277–308 (Standards 4.3–4.4).

[402] *See supra* notes 30–200 (offering examples of detainees not receiving appropriate or necessary care, despite the requirements of 2011 PBNDS).

[403] *Cf.* Wyatt v. Stickney, 325 F. Supp. 781, 784 (M.D. Ala. 1971) ("[Involuntarily committed individuals] unquestionably have a constitutional right to receive such individual treatment as will

ence laws,[404] as well as the standard announced by the handful of courts that have addressed the tort law obligations of detention medical staff vis-à-vis immigration detainees,[405] the regulation should specify that treatment in detention must be "consistent with accepted medical standards." Through a notice of proposed rulemaking, DHS should solicit commentary on implementation details including detainee means for requesting treatment, time frames within which treatment must be provided or initiated, and means for accessing medically necessary treatment not available at the detention center.

It may be argued that the primary purpose of immigration detention is to detain, not to treat; therefore, detention centers should not be required to provide health care consistent with accepted medical standards. In response, this Article contends that health care is unlike other goods and services because substandard care can be injurious or deadly. For example, Francisco Castaneda's squamous cell carcinoma produced early, telltale symptoms including a white-and-yellow raised lesion that was bleeding and discharging pus.[406] The San Diego Correctional Facility refused to arrange for the medically accepted, standard diagnostic test; that is, a biopsy or excision and histologic confirmation.[407] The federal government later agreed that this

give each of them a realistic opportunity to be cured or to improve his or her mental health condition."), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

[404] *See, e.g.*, N.C. GEN. STAT. ANN. § 122C-266(d) (West 2014) (announcing the standard as "reasonable and appropriate medication and treatment that are consistent with accepted medical standards").

[405] *See, e.g.*, *Banderas* Findings, *supra* note 108, at 8 (stating, in the context of an immigration detainee's negligence lawsuit against a medical staff member at San Diego Correctional Facility, that "[a] physician is negligent if he or she fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances"). The *Banderas* court further stated,

> The Court finds Plaintiff has proven a case of medical negligence. Dr. Hui failed to use the level of skill, knowledge, and care in diagnosis and treatment that a reasonably careful physician would have used in similar circumstances. The care was substandard . . . . This substandard care injured Plaintiff and caused him to suffer damages. Dr. Hui's acts of negligence were within the scope of her employment for the United States, and thus the United States is liable for her negligent actions under the FTCA.

Id. at 10.

[406] *See supra* notes 65–71 and accompanying text (providing further detail of untreated cancer symptoms).

[407] *See* Alexander Stratigos et al., *Diagnosis and Treatment of Invasive Squamous Cell Carcinoma of the Skin: European Consensus-Based Interdisciplinary Guideline*, 51 EUR. J. CANCER 1989, 1990 (2015) ("A biopsy or excision and histologic confirmation should be performed in all clinically suspicious lesions in order to facilitate the prognostic classification and correct management of [the carcinoma]."); *supra* notes 65–78 (describing failings of detention center related to diagnosis and treatment).

substandard care was the cause in fact as well as the proximate cause of Castaneda's death.[408]

By further example, consider the tuberculosis death of Mexican Jose Javier Hernandez-Valencia, shared in Part I, section B.[409] The national and international standard for treatment of tuberculosis includes an initial, two-month treatment phase using the drugs isoniazid, rifampicin, pyrazinamide, and ethambutol, as well as a second, four-month treatment phase using the drugs isoniazid and rifampicin.[410] Houston Contract Detention Facility's deviation from this medically accepted standard contributed to Hernandez-Valencia's death.

By final example, Algerian national Hassiba Belbachir disclosed to a social worker at McHenry County Jail a prior suicide attempt, a current desire to die, and a present thought that "[d]eath is dripping, drop by drop."[411] As described in Part I, section C, McHenry County Jail neither placed Belbachir on suicide watch nor expedited her medical appointment although standard suicide risk algorithms actually direct immediate hospitalization.[412] Federal officials later found that McHenry County Jail's substandard care contributed to Belbachir's death.

These three examples illustrate how health care differs from other goods and services because substandard health care can be deadly. This Article therefore argues for the application of the "medically accepted standard of care" in immigration detention; that is, not health care above the standard of care, just health care consistent with nationally recognized standards of adequate health care. In situations in which a detention center does not have the

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[408] Hui v. Castaneda, 559 U.S. 799, 804 n.3 (2010) ("[T]he government filed a formal notice admitting liability with respect to respondents' claims for negligence under the [Federal Tort Claims Act].").

[409] *See supra* notes 101–104 and accompanying text (detailing Hernandez-Valencia's death by tuberculosis).

[410] *See, e.g.*, THE TUBERCULOSIS COAL. FOR TECH. ASSISTANCE, INTERNATIONAL STANDARDS FOR TUBERCULOSIS CARE: DIAGNOSIS, TREATMENT, PUBLIC HEALTH 5 (2006), http://www.who.int/tb/publications/2006/istc_report.pdf?ua=1 [http://perma.cc/YRP4-PMRJ]. The report states that,

> The basic principles of care for persons with, or suspected of having, tuberculosis are the same worldwide: a diagnosis should be established promptly and accurately; standardized treatment regimens of proven efficacy should be used with appropriate treatment support and supervision; the response to treatment should be monitored; and the essential public health responsibilities must be carried out.

Id.

[411] *See supra* notes 177–192 and accompanying text (providing details and evidentiary support of Hassiba Belbachir's disclosure of suicidal ideation).

[412] *See, e.g.*, Michael F. Gliatto & Anil K. Rai, *Evaluation and Treatment of Patients with Suicidal Ideation*, 59 AM. FAMILY PHYSICIAN 1500 fig.1 (1999) (providing an algorithm for the evaluation of suicidal patients).

staff or facilities to provide such care, the detention center has an obligation to transfer the detainee to an appropriate provider of care.[413] In some cases, there may be a question as to what the standard of care is, and in situations in which there is more than one accepted standard of care, or there is a "respectable minority" standard of care, a reasoned decision by detention staff to adhere to one of the accepted standards, or the "respectable minority" standard, would be acceptable.[414] Because most detention injuries and deaths result from a refusal of detention staff to provide any health care, not the provision of arguably adequate health care, it is anticipated that disputes involving the standard of care will be relatively infrequent.

This Article's recommended treatment regulation is consistent with legal principles identified in other contexts, including the criminal justice context. For example, the primary purpose of jails and prisons is to detain and incarcerate suspected and convicted criminals, not to treat.[415] Nevertheless, the moment a state or local government, or the Federal Bureau of Prisons, takes a suspect into custody, courts have held that the relevant government assumes a legal obligation to provide adequate, or reasonable, health care to that individual.[416]

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[413] *See* Jacoby v. State, 434 So. 2d 570, 573–74 (La. Ct. App. 1983) ("[C]onfining authorities, such as the sheriff . . . have a legal obligation to provide medical treatment for prisoners. If these medical services are not available on the premises, it is the duty of the confining authority to transfer a sick prisoner to a medical facility for appropriate treatment." (citations omitted)).

[414] *See, e.g.*, Meghan C. O'Connor, *The Physician-Patient Relationship and the Professional Standard of Care: Reevaluating Medical Negligence Principles to Achieve the Goals of Tort Reform*, 46 TORT TRIAL & INS. PRAC. L.J. 109, 116–27 (2010) (discussing the standard of care, including the "respectable minority" standard).

[415] *Cf. Jacoby*, 434 So. 2d at 577 ("The principal purpose of [Southeast Louisiana Hospital] is to provide appropriate medical treatment for mental illness and, thus, is different from that of a prison . . . .").

[416] *See, e.g.*, Carson v. United States, No. 13-cv-02962-CMA-KLM, 2014 WL 3563021, at *6 (D. Colo. 2014) ("Prison officials have a legal duty to 'ensure that inmates receive adequate . . . medical care . . . .'"); Saint Barnabas Med. Ctr. v. County of Essex, 543 A.2d 34, 43 (N.J. 1988) ("The County's legal duty was to provide for Williams' health care while he was a prisoner . . . ."). As one district court described it,

> [T]he Defendant concededly had a legal duty of care, as prison officials have a duty to provide appropriate medical care to prisoners. While this duty can reach the level of a constitutional claim in so far as appropriate medical care for prisoners is mandated by the Eighth Amendment, for purposes of an FTCA claim . . . the standard of duty owed is that of "reasonable care."

Butler v. Does, No. 9:08-2760-HFF-BM, 2010 WL 4929572, at *6 (D.S.C. 2010). Another court explained:

> [C]onfining authorities, such as the sheriff . . . have a legal obligation to provide medical treatment for prisoners. If these medical services are not available on the premises, it is the duty of the confining authority to transfer a sick prisoner to a medical facility for appropriate treatment. The standard of care imposed upon the confin-

Finally, it must be noted that ICE has no legal obligation to provide health care to individuals in the community at large,[417] including aliens who have been released on recognizance, community support, or bond.[418] ICE could choose one of these safe, effective, and humane alternatives to detention to enforce federal immigration law,[419] relieving itself of the responsibility to provide adequate health care to detainees. The moment ICE decides to take an individual into custody, however, ICE assumes a legal duty to provide adequate, or reasonable, health care to that individual.[420] From that point forward, both acts (including the negligent examination, diagnosis, or treatment of a detainee) as well as omissions (including the failure to examine, diagnose, or treat a detainee, or to transfer a detainee to an outside medical facility when medically necessary) can violate legal duties.[421]

In addition to recommendations relating to prompt health examinations, individualized plans of care, and treatment in accordance with medically accepted standards, this Article makes a fourth recommendation; that is, a staffing recommendation. The 2011 PBNDS provide that, "Health care services shall be provided by a sufficient number of appropriately trained

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> ing authority in providing for the medical needs of inmates is that those services be adequate and reasonable.

Jacoby, 434 So. 2d at 573–74 (citations omitted).

[417] *See, e.g.*, Joseph M. Healy, *Legal Obligations of Genetic Counselors*, *in* GENETICS AND THE LAW II 69, 73 (Aubrey Milunsky & George J. Annas eds., 2d ed. 1979) ("There is no general right to health care in the United States."); RICHARD K. RIEGELMAN, PUBLIC HEALTH 101: HEALTHY PEOPLE—HEALTHY POPULATIONS 73 (2010) ("[A] right to health care in the United States has not been generally established.").

[418] *See* IMMIGRANT RIGHTS CLINIC, RUTGERS SCH. OF LAW-NEWARK, FREED BUT NOT FREE: A REPORT EXAMINING THE CURRENT USE OF ALTERNATIVES TO DETENTION 10 (2012), http://www.law.newark.rutgers.edu/files/FreedbutnotFree.pdf [http://perma.cc/JZ69-T6R4] [hereinafter RUTGERS CLINIC REPORT] (identifying release on recognizance, community support, or bond as alternative to detention ("ATD") programs and stating "ATD programs allow ICE officials to meet their law enforcement objectives, while avoiding the pitfalls and human costs associated with detention in secure facilities").

[419] *See* RUTHIE EPSTEIN, ALTERNATIVES TO IMMIGRATION DETENTION: LESS COSTLY AND MORE HUMANE THAN FEDERAL LOCK-UP 1 (2014) (identifying release on recognizance, community support, or bond as safe, effective, and humane alternatives to detention).

[420] *See Banderas* Findings, *supra* note 108, at 8 (stating, in the context of a lawsuit by a detainee against a physician staff member at San Diego Correctional Facility based on the physician's failure to provide adequate health care, "A physician is negligent if he or she fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances."); *cf.* Borrego v. City of El Paso, 964 S.W.2d 954, 958 (Tex. Ct. App. 1998) ("[O]nce a government health-care provider begins to treat a patient, the duty of care owed to the patient is no different from the duty of care owed by any medical professional.").

[421] *See supra* note 420 and accompanying text; *cf.* Brown v. Pa. Dep't of Health Emergency Med. Svcs. Training Inst., 318 F.3d 473, 477 (3d Cir. 2003) ("It is a basic tenet of tort law that although an individual generally has no duty to rescue, once voluntarily undertaken, a rescue must not be performed negligently.").

and qualified personnel."[422] The word "sufficient" allows for subjective interpretations regarding appropriate staff-to-detainee ratios. The reference laws discussed in Part II[423] show a trend towards specific staff-to-patient ratios, including particular types of staff members. The LTC requirements, for example, require LTC facilities with 121 or more licensed beds to hire a full-time social worker to provide medically related social services.[424] The Medicare Conditions of Participation, by further example, require a registered (not just licensed) nurse to be available at each psychiatric hospital twenty-four hours a day.[425] Similarly, Colorado law requires hospitals that provide psychiatric services to have a physician director of psychiatric services who is a board-certified in psychiatry and neurology[426] as well as a registered nurse available in the psychiatric unit twenty-four hours per day, seven days per week.[427] This Article recommends that DHS promulgate a regulation establishing minimum medical, nursing, and other health professional staffing ratios. Through a notice of proposed rulemaking, DHS should solicit commentary regarding appropriate staff as well as staffing ratios.

The fifth and sixth recommendations relate to infection control and suicide prevention. The 2011 PBNDS contain some guidelines regarding infection control,[428] including a requirement for written plans that address the management of infectious and communicable diseases.[429] The 2011 PBNDS also contain some guidelines regarding suicide prevention,[430] including a requirement for a written suicide prevention and intervention program.[431] The problem, as illustrated in Part I, is that these guidelines are neither followed nor enforced.[432] This Article recommends that DHS promulgate two additional regulations requiring the implementation of active programs for the prevention, intervention, and control of infections and suicide, respectively. Through a notice of proposed rulemaking, DHS should solicit commentary on the elements of these programs, the individuals responsible for implementing these programs, staff training requirements, and, when infections and suicides occur, root-cause analyses and corrective action plans.

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[422] 2011 PBNDS, *supra* note 10, at 279 (Standard 4.3(II)(21)).

[423] *See supra* notes 201–370 (examining reference laws from various states and considering requirements related to health care provisions for residents in LTC facilities).

[424] *See supra* note 321 and accompanying text (explaining the federal regulation requiring a full-time social worker for LTC facilities with 121 beds or more).

[425] 42 C.F.R. § 482.62(d)(2) (2014).

[426] 6 COLO. CODE REGS. § 1011-1:IV-26.101(2) (2014).

[427] *Id*. § 1011-1:IV-26.101(3)(b).

[428] 2011 PBNDS, *supra* note 10, at 282–85 (Standard 4.3(V)(C)).

[429] *Id*. at 282 (Standard 4.3(V)(C)(1)).

[430] *Id*. at 314–19 (Standard 4.6).

[431] *Id*. at 315 (Standard 4.6(V)).

[432] *See supra* notes 30–200 (demonstrating the lack of enforcement of 2011 PBNDS guidelines through stories of individual detainees who were denied necessary health care).

The seventh recommendation relates to detainee complaints and investigations. The 2011 PBNDS contain some guidelines regarding detainee grievances,[433] including provisions allowing detainees to "file formal grievances, including medical grievances, and [to] receive written responses, including the basis for the decision, in a timely manner."[434] As written, the 2011 PBNDS also require medical staff to respond to medical grievances within five working days.[435] The stories detailed in Part I illustrate that these guidelines are neither followed nor enforced and that detainees wait weeks or months for responses to their medical grievances.[436] DHS should promulgate a legally enforceable regulation establishing a formal complaint and investigation process. Through a notice of proposed rulemaking, DHS should solicit commentary on the elements of this process, the means for making detainees aware of their right to file complaints through this process, the time frames within which detention officials must initiate and conclude investigations of complaints, the time frame within which detention officials must respond to complaints, and internal appeal rights and external complaint rights of detainees, including the right to complain directly to the federal government.[437]

The eighth recommendation relates to penalties for detention center non-compliance with the regulations outlined above. In the health care industry, health care facilities that contract with the Federal Department of Health and Human Services to provide health care services to government beneficiaries are subject to a range of penalties for non-compliance, including exclusion from the Medicare and Medicaid programs—resulting in termination of the ability to receive reimbursements for treating government program patients—as well as civil money penalties that accrue on a daily basis, significant criminal fines, incarceration, and potential false claims liability.[438] Of these, exclusion from the Medicare and Medicaid Programs, known as the "financial death sentence," is particularly effective due to providers' heavy reliance on Medicare and Medicaid dollars.[439] The federal

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[433] 2011 PBNDS, *supra* note 10, at 392–400 (Standard 6.2).

[434] *Id.* at 392 (Standard 6.2(II)(3)).

[435] *Id.* at 398 (Standard 6.2(V)(C)(4)).

[436] *See supra* notes 30–200.

[437] *See, e.g.*, *How to File a Complaint*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/ocr/privacy/hipaa/complaints/ [http://perma.cc/3TVL-ECHT] (detailing how patients who believe their confidentiality rights have been violated can file a complaint with the Office of Civil Rights).

[438] *See, e.g.*, Tovino, *supra* note 11 (manuscript at 44 nn.276–82) (outlining penalties that may be imposed on Medicare-participating hospitals that violate the Medicare Conditions of Participation).

[439] *See, e.g.*, Randall R. Fearnow & Jaya F. White, *Permissive Exclusion: OIG Proposes Rule Creating More Problems, Not Solutions for Long Term Care Providers*, 17(2) LTC-SIR ADVISOR 7, 9 (2014), http://www.quarles.com/content/uploads/2014/11/AHLA-article-published-LTC_Oct

civil money penalty regulation that imposes steep penalties (ranging from $3050 to $10,000 per day, per uncorrected violation) for situations that cause, or are likely to cause, serious injury, harm, impairment, or death to a patient,[440] also serves as an effective compliance tool. The False Claims Act, a federal law that allows the Office of Inspector General to impose steep civil penalties on health care providers that submit claims for reimbursement to the Medicare program for substandard health care provided to Medicare beneficiaries, also provides a useful compliance incentive.[441]

This Article recommends a similar range of penalties for detention centers that fail to comply with the regulations proposed above, regardless of whether the detention center is owned by ICE, operated by the Federal Bureau of Prisons, run by a state or local sheriff's office or jail, or managed by a for-profit corrections or detention company. Through a notice of proposed rulemaking, DHS should solicit commentary on the types of civil, criminal, and administrative penalties that may be imposed on noncompliant detention centers, the level of intent required for the imposition of such penalties, the procedures for imposing such penalties, and the appeal and other due process rights of detention centers. Given that a majority of immigration detention beds are located in detention centers owned and operated by private, for-profit corporations organized for the purpose of maximizing profits,[442] the threat of civil monetary penalties, criminal fines,

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14-R-Fearnow-J-White-pdf.pdf [http://perma.cc/Z3J2-QK3C] ("Failure to comply, which may result in an exclusion, could be a virtual death sentence for most SNFs, which depend heavily on Medicare and Medicaid for their livelihood."); GWINNETT HEALTH SYS., CODE OF CONDUCT AND PRINCIPLES OF ETHICAL BUSINESS PRACTICES 9 (2015), http://www.gwinnettmedicalcenter.org/media/file/Code%20of%20Conduct%202015.pdf [http://perma.cc/AFG7-6RJG] ("Some refer to exclusions as a 'financial death sentence' because excluded persons and entities may not receive payment for treating any Medicare and Medicaid beneficiaries.").

[440] *See* 42 C.F.R. § 488.438(a)(1)(i) (2014) (outlining the civil monetary penalties that may be imposed for deficiencies constituting immediate jeopardy); *id.* § 489.3 (defining immediate jeopardy as a situation in which a health care provider's noncompliance with one or more Conditions of Participation "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident"); CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL app. Q at 2–8 (2014), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf [https://perma.cc/Q5AH-VBMG] (outlining situations that constitute immediate jeopardy).

[441] *See, e.g.*, United States *ex rel.* Aranda v. Cmty. Psychiatric Ctrs., 945 F. Supp. 1485, 1487, 1489 (W.D. Okla. 1996) (holding psychiatric hospital that failed to provide patients with a reasonably safe environment and then billed Medicare for its services submitted "false claims" within the meaning of the Federal False Claims Act); Lourdes Martinez & Nora A. Colangelo, *Substandard Quality of Care Used as a Basis for False Claims Act and Criminal Liability in Nursing Homes*, 7 HEALTH L. NEWSLETTER (2002) (reviewing the use of substandard quality of care as a basis for Federal False Claims Act liability in the LTC context).

[442] *See, e.g.*, BETHANY CARSON & ELEANA DIAZ, GRASSROOTS LEADERSHIP, PAYOFF: HOW CONGRESS ENSURES PRIVATE PRISON PROFIT WITH AN IMMIGRANT DETENTION QUOTA 3 (2015), http://grassrootsleadership.org/sites/default/files/reports/quota_report_final_digital.pdf [http://perma.cc/6XTW-B889] (reporting that 62% percent of immigration detainee beds are located in private,

and DHS contractor exclusion ought to be more effective than ICE's current unenforceable guidelines.

DHS has several options for promulgating these regulations. A subsection within an existing regulation codified at subchapter B of DHS's immigration regulations, 8 C.F.R. § 235.3(e), offers one option. As currently written, this subsection only requires the "availability of emergency care" in detention centers that are not operated by ICE.[443] DHS could delete the current content of 8 C.F.R. § 235.3(e) and insert the eight regulations described above. DHS could also add the proposed regulations to a reserved, or newly created, Part within Title 8 of the Code of Federal Regulations. In either case, the regulations may be structured as follows:

8 C.F.R. § [ ]

(a) Basis and Scope
(b) Definitions
(c) Physical and Mental Health Examinations
(d) Comprehensive, Written Plans of Care
(e) Timely, Adequate Treatment
(f) Minimum Staffing
(g) Infection Control
(h) Suicide Prevention
(i) Complaints and Investigations
(j) Penalties for Non-Compliance

CONCLUSION

This Article has carefully examined immigration detainees' lack of access to physical and mental health care, leading to the three primary conclusions. First, U.S. Immigration and Customs Enforcement's current detention standards are legally unenforceable and substantively inadequate. Second, current proposals to improve detainee health and safety are based on constitutional law, international human rights law, and tort law, which lack the specificity, enforceability, and ex ante perspective necessary to effect comprehensive detainee health reform. Third, involuntary commitment laws, long-term care requirements, and behavioral health laws provide a lens through which the lack of access to health care in detention might be as-

for-profit detention centers); NAT'L IMMIGRATION FORUM, THE MATH OF IMMIGRATION DETENTION: RUNAWAY COSTS FOR IMMIGRATION DETENTION DO NOT ADD UP TO SENSIBLE POLICIES 7 (2013), https://immigrationforum.org/wp-content/uploads/2014/10/Math-of-Immigation-Detention-August-2013-FINAL.pdf [https://perma.cc/42GF-RED9] (reporting that Corrections Corporation of America and the GEO Group, Inc., the two largest detention contractors, reported annual revenues of $1.8 billion and $1.5 billion, respectively, in fiscal year 2012).

[443] 8 C.F.R. § 235.3(e) (2014).

sessed and through which the unenforceable standards guiding detention centers might be improved. This Article makes eight recommendations that, if promulgated by the U.S. Department of Homeland Security into legally enforceable regulations, would improve the health and safety of immigration detainees.

Undoubtedly, these regulations will cause federal, state, and local prisons and jails, private detention centers that contract with ICE, and ICE's own detention centers to incur significant compliance costs. These regulations also may reduce the number of preventable deaths in detention, an important balancing consideration. In the context of involuntary civil commitment, courts do not allow a lack of resources to excuse a public or private facility's failure to provide adequate health care.[444] The same rule should apply to immigration detention. Once the government takes an individual into custody, the government has a legal obligation to provide adequate physical and mental health care consistent with the standard of care to that individual.[445] Absent adequate health care, immigration detention centers are little more than warehouses for illness and death.

ICE has no legal obligation to provide health care to individuals in the community at large,[446] including aliens who have been released on recognizance, community support, or bond.[447] These alternatives to detention are effective, inexpensive, and humane.[448] Perhaps the administrative burdens to DHS associated with promulgating the regulations recommended by this Article, as well as the compliance costs to detention centers that necessarily will follow, will be the final push ICE needs to adopt community release and other safe alternatives to detention.

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[444] *See, e.g.*, *Wyatt v. Stickney*, 325 F. Supp. at 784 ("The failure to provide suitable and adequate treatment to the mentally ill cannot be justified by lack of staff or facilities."); *see also* Rosalie Berger Levinson, *Wherefore Art Thou* Romeo*: Revitalizing* Youngberg*'s Protection of Liberty for the Civilly Committed*, 54 B.C. L. REV. 535, 558 n.163 (2013) (noting that although fiscal constraints may affect conditions in mental health institutions, courts still require institutions to provide adequate mental health treatment or medical care).

[445] *See supra* notes 416–420 (approving notion that the government exercising custody over an individual requires provision of adequate medical care to that individual).

[446] *See, e.g.*, Healy, *supra* note 417, at 73 ("There is no general right to health care in the United States."); RIEGELMAN, *supra* note 417, at 73 ("[A] right to health care in the United States has not been generally established.").

[447] *See* RUTGERS CLINIC REPORT, *supra* note 418, at 10 (identifying release on recognizance, community support, or bond as ATD programs, stating that "ATD programs allow ICE officials to meet their law enforcement objectives, while avoiding the pitfalls and human costs associated with detention in secure facilities").

[448] EPSTEIN, *supra* note 415, at 1.