

Statement on Immigration Detainee Health Care

Homer D. Venters, M.D.

Attending Physician, Bellevue/NYU Program for Survivors of Torture

Public Health Fellow, New York University

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Refugees, Border Security, and International Law

Hearing on Problems with Immigration Detainee Medical Care

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Good Afternoon. My name is Dr. Homer Venters. I am an attending physician at the Bellevue/NYU Program for Survivors of Torture as well as a Public Health Fellow with New York University. I am testifying today on behalf of the Bellevue/NYU Program for Survivors of Torture and the NYU School of Medicine Center for Health and Human Rights. I would like to thank Congresswoman Lofgren and members of the Subcommittee for inviting me to testify on immigrant detainee healthcare. My area of research as a Public Health Fellow is the medical care provided to Immigration and Customs Enforcement (ICE) detainees. Together with my colleague, Dr. Allen Keller (Director of the Torture Survivors Program and the Center for Health and Human Rights) I have conducted analysis of the ICE healthcare system, including the mortality statistics recently released by ICE and the specific provisions of the ICE health plan. My comments today focus on these two areas and I will provide recommendations for improvements of the ICE healthcare system. The central thesis of my remarks is that behind confusing and unreliable statistics concerning detainee deaths, the ICE healthcare system contains key elements that may jeopardize detainee health. Contrary to public statements by ICE, it is our conclusion that this health system, and the care it allows for detainees, is getting worse not better.

I. Misleading Mortality Statistics

I would like to begin with the recent discussion of detainee mortality reported by ICE. I am referring to the ICE fact sheet on detainee deaths dated May 2008¹ as well as the Op-Ed by Assistant Secretary Myers in the Washington Post.² In these documents, ICE relies on inappropriate use of basic epidemiologic terms and inaccurate comparisons between populations known to be radically different. The lack of standardized mortality or morbidity reported in these documents provokes grave concern for the welfare of ICE detainees and the ability of ICE to monitor the quality of its own health care system.

ICE reports falling detainee ‘mortality’ rates but their figures are based on unreliable calculations. In Fiscal Year 2006 ICE detained approximately 250,000 people while in 2007, that number rose to 310,000. Because the total number of detainee deaths dropped from 17 to 11 during those periods, ICE claims that the mortality rate fell from 6.7 to 3.5 per 100,000 detentions, a 49% decrease.³ However this conclusion neglects a very basic and essential issue, the length of detention. From 2006 to 2007, the average length of ICE detention decreased from 90 days to 37. Adjusting for risk of exposure (such as length of detention) is a fundamental practice of both medicine and epidemiology and failure to do so reflects flawed methodology. For instance, no physician would make conclusions about a patient’s risk from smoking without including how long that patient had been a smoker. Taking ICE’s same fiscal year numbers, but correctly adjusting for average length of detention, it is clear that the length-adjusted mortality actually *increased* between 2006 and 2007 from 27 to 34 per 100,000 detention-years, a 29% increase (see Table 1 for side by side comparison).⁴ Consequently, the statistics presented by ICE tend to present an unduly rosy picture of detainee mortality.

A second glaring weakness in the ICE statistics is found in their comparison between deaths of ICE detainees and those in a general prison population. Again, the lack of standardization for length of detention makes this a flawed comparison, since prisoners are typically held for a

longer period of time in a given year than are ICE detainees. For example, imagine that ICE detained 300,000 people per year for one day each and U.S. prisons detained 300,000 people each for a full year. It would be incorrect to conclude that because fewer people died in ICE custody than in prison custody, the healthcare provided to ICE detainees was somehow superior. The fact that the average ICE detainee spends so much less time in custody than the average prisoner in a given year must be factored in to provide any meaningful results.

Aside from lacking standardization over a given year, any comparison of ICE detainees to prisoner populations is dubious because prisoners are incarcerated for much longer periods of time in total than ICE detainees. Prison research has shown that mortality rates increase with time of incarceration, so even if ICE had standardized for time detained in a given year, prisoners who have accumulated years of prior detention are known to have higher rates of mortality.⁵ Also, when ICE favorably compares mortality of detainees to those of prisoners and the general population, there is no adjustment for age or disease prevalence. For example, U.S. prisoners have high rates of infectious disease, and the general U.S. population may be older, suffering from higher rates of heart disease and cancer than the ICE population. Without correct adjustment for these types of possible differences, the figures provided by ICE are unreliable.

To be clear, mortality is an imprecise method for appraising healthcare in a transitional population. Because death is rare and detention is short, mortality likely under-represents problems with health care delivery among ICE detainees. Morbidity, which refers to sickness or having a disease, is a better measure of the efficacy of ICE healthcare since by ICE estimates, at least 34% of detainees suffer from chronic diseases.⁶ Consequently, complications from poorly controlled chronic disease, such as diabetes, HIV, asthma or hypertension are more sensitive health care measures. Unfortunately, ICE reports no specific information about morbidity of detainees. However, even morbidity may under-represent adverse effects of this system. As with mortality, shorter detentions will tend to produce fewer adverse events. In thinking of ICE detention as a risk factor, as ICE detention time shortens, the likelihood is that adverse events caused by this risk will occur afterwards. This may have been the case with Juan Guillermo Guerrero, 37, who was denied his seizure medicines while detained by ICE and died of complications from seizures shortly after being deported to Mexico.⁷

This discussion of ICE detainee mortality reveals two important pieces of information. First, the length-adjusted mortality for detainees has increased from 2006 to 2007. The causes or significance of this increase are unclear but it certainly is not the case that detainee mortality is dramatically falling, as ICE has asserted. Second, the reliance by ICE on unsound statistical methods that consistently present a more positive picture of detainee health should generate concerns about the ability of ICE to adequately assess and improve its own healthcare system. Our review of the ICE health plan, including recent changes, suggests that ICE detainees are receiving medical care that is increasingly limited and inconsistent with current standards of medical practice.

II. An Acute Care Health System for a Population in Need of Much More

The healthcare provided for ICE detainees is directed by a set of rules under the Detention Management Control Program of the Department of Homeland Security (DHS). This program creates procedures for ICE detention operations but does not carry the force of law. Particular

medical policies and reimbursement guidelines are determined by the Division of Immigration Health Services (DIHS), recently incorporated into DHS from the Health Resources and Services Administration of the U.S. Department of Health and Human Services. DIHS guidelines then become part of the overall set of ICE rules for detention operations.⁸ Despite acknowledging the substantial burden of chronic disease among detainees, the ICE health plan maintains a steadfast focus on an acute care model. The 1/3 of detainees with medical problems that require ongoing, skilled care for problems such as diabetes, hypertension, asthma and HIV find themselves in a medical setting geared towards addressing ankle sprains, cuts and bruises and calling 911 in case of emergency. Unfortunately, the ICE health plan is clearly not crafted to care for a population with significant chronic medical or mental health needs. The introduction of the ICE plan explains “The DIHS Medical Dental Detainee Covered Services Package primarily provides health care services for emergency care. Emergency care is defined as ‘a condition that is threatening to life, limb, hearing or sight’.”⁹

This institutional aversion to caring for detainees with chronic disease is evidenced in recent detainee deaths. One year ago, a 23 year old transgender woman, Victoria Arellano was detained by ICE.¹⁰ Ms. Arellano had AIDS and was taking a life saving medicine to prevent opportunistic infections that could quickly cause pneumonia and death were she to stop. These medicines are essential for people with AIDS and even a brief interruption risks sickness and death for a patient. Despite reporting her medical history and her medication when detained (and throughout her detention), Ms. Arellano was refused her medicine. Over the following weeks, Ms. Arellano developed a cough and fever, which should have prompted hospitalization and evaluation. Instead, Ms. Arellano was given an inappropriate antibiotic by the detention center medical staff, was still refused her needed medication, and returned to her cell. By the time Ms. Arellano’s cellmates staged a protest to draw attention to her deteriorating condition, she had become very ill and died soon thereafter, comatose and shackled to her bed. Faced with a common chronic disease, ICE medical staff withheld the correct medicines, gave inappropriate medicines and failed to seek more competent care for Ms. Arellano. The care that Ms. Arellano required would be routine in almost any medical clinic or hospital in the United States.

Among the most prevalent chronic diseases from which detainees suffer may be depression and anxiety. The prevalence of these conditions is difficult to gauge in part because detainee may fear being placed in segregation should they report mental health symptoms. This fear was documented in study conducted jointly by the Bellevue/NYU Program for Survivors of Torture and Physicians for Human Rights in 2003 among asylum seekers (admittedly, a small subset of all detainees). This report found that “the mental health of asylum seekers interviewed for this study was extremely poor and worsened the longer that individuals were in detention.” In this study, symptoms of depression were present in 86% of the 70 detained asylum seekers, and anxiety was present in 77% and PTSD in 50%.¹¹ The study also documented significant difficulties for immigrant detainees accessing health services for painful and sometimes dangerous health problems. Unfortunately, recent reports by the Washington Post and New York Times demonstrate that the problems with detainee healthcare documented in 2003 are not new and have not been corrected. In fact the concerns are even greater today, given that current immigration policies continue to dramatically expand immigration detention.

The fear of arbitrary and inhumane segregation is not hypothetical and has real bearing on the health of ICE detainees. In 2007, a 52 year old man from Guinea, Boubacar Bah, fell while in ICE custody and sustained a head injury.¹² Mr. Bah was transferred to the medical unit of the detention center but when he became agitated, confused and vomited, Mr. Bah was written up for disobeying orders and transferred to segregation (a euphemistic term for solitary confinement) with approval of medical staff. The behavior that served as an excuse for disciplinary transfer to solitary confinement was in reality a sentinel sign of intracranial bleeding. The most shocking aspect of this case is that Mr. Bah was actually in the medical unit, under the care of ICE medical staff when the ill-conceived idea to place him in solitary confinement was approved. Mr. Bah's condition deteriorated steadily under the watch of ICE personnel until 14 hours after his fall, foaming at the mouth and unresponsive, he was transferred to a hospital. Mr. Bah was quickly diagnosed with a fractured skull, multiple spots of bleeding in his brain and ICE notified his family five days later of his condition. Mr. Bah died several months later without ever regaining consciousness and ICE medical staff originally reported his cause of death as 'aneurysm' without any mention of his fractured skull. While most detainees who are inappropriately placed in solitary confinement do not die, this case illustrates how very basic medical judgment can be abandoned in the detention setting. A man who had just fallen and lost consciousness, already inside the medical unit, was somehow judged to be 'disobeying orders' instead of manifesting a clearly recognizable sign of head trauma. Solitary confinement is obviously inappropriate for someone who is ill, but this case and others call into question the very practice of placing detainees in such a setting.

III. Specific Weaknesses in the ICE Health Plan Imperil Detainees

In addition to the broad institutional problems facing detainees who require medical care, there are very specific aspects of the ICE health plan that warrant concern. DIHS has altered the Covered Services Package several times in the past few years, limiting the scope of medical care for detainees. Publicly reported deaths of detainees have included cases in which persons with chronic diseases were refused access to care outside their respective detention centers.¹³ The refusal for this care comes in the form of a Treatment Authorization Request (TAR) submitted by local medical staff at a detention center and denied by DIHS. Before 2005, the Covered Services Package entitled detained with chronic medical problems to 'chronic care' visits every three months. In 2005, the Covered Services Package was changed in the following manner: "we have clarified to providers that DIHS does not mandate the frequency a detainee is seen or what testing needs to be done by the onsite physician. The responsibility will lie with the provider."¹⁴ In stark contrast to these recent changes by ICE, there is clear and convincing evidence that establishing system-wide protocols for chronic disease diagnosis and treatment (including pre-approved visits, tests and treatments) results in decreased mortality and morbidity.^{15,16,17} Because this change eliminated any notion of standard of care (such as a set protocol for treating specific diseases), and further increased the burden of securing prior approval for outside care, the net effect may have been to limit care for detainees with chronic medical problems. One tragic example is Francisco Castaneda, a 34 year old man from El Salvador, who was detained for 11 months by ICE with bleeding penile lesions. Despite numerous physicians documenting concern that his lesions were cancerous, DIHS refused the TAR for biopsy labeling the test

‘elective’. After being released from detention, Mr. Castaneda was finally able to receive appropriate evaluation and treatment. But by then it was too late and Mr. Castaneda died shortly after beginning treatment for metastatic penile cancer.¹⁸

Another potential threat to detainee medical care is the requirement of the Covered Services Package that mandates that detention center medical providers include non-medical criteria in any potential referral for outside care. The Covered Services Package allows non-emergent care with the following explanation: “Other medical conditions which the physician believes, if left untreated during the period of ICE/BP custody, would cause deterioration of the detainee’s health or uncontrolled suffering affecting his/her deportation status will be assessed and evaluated for care.”¹⁹ With these conditions, ICE simultaneously demands that a care provider estimate the length of detention for a detainee and assess whether or not deterioration of the condition might impact deportation. Both of these non-medical criteria potentially limit the care provided to detainees and likely create ethical (and potentially legal) jeopardy for ICE providers. In contrast, the U.S. Marshals Service relies on medical necessity alone in establishing criteria for outside referral.²⁰

A third problem with the care allowed under the Covered Services Package pertains to health screening. Originally (prior to the 2005 changes), the plan approved basic health screening tests such as mammograms and pap smears only after one year in detention. This guideline was substandard because many detainees likely had little or no prior health screening and would have benefited from indicated health screening tests (as is the standard at Rikers Island Jail in New York City, where average length of stay is shorter than average ICE detention).²¹ But even this substandard coverage was further reduced in 2005 when the Covered Services Package substituted diagnostic criteria for what they continued to call screening tests. The new guidelines stated: “screening for disease processes (e.g., breast, cervical, prostatic, colorectal cancer) are considered on a case by case basis, subject to clinical findings...In other words, clinical findings must support the need for the requested screening. This change will remove the impression that these tests are automatically approved for a detainee who is in custody for over 12 months.”²² Screening tests are by definition, applied to the entire *non-symptomatic* portion of a population. For example, in discussing Pap smears, the U.S. Preventative Services Task Force recommends screening for cervical cancer in women who have been sexually active and have a cervix.²³ There is no reference to symptoms or clinical suspicion in this, or any other screening recommendation and to wait until clinical suspicion or symptoms appear completely undermines the ‘screening’ aspect of the test. This difference is enormously important because while ICE continues to call these tests ‘screening’, they are in fact forcing tens of thousands of people to forgo some of the most beneficial and cost-effective measures of modern medicine. By waiting until detainees show symptoms or arouse clinical suspicion of a disease, ICE deprives detainees of the accepted medical practice of early detection and treatment in favor of letting diseases such as cervical, breast and prostate cancer develop to the point of symptoms.

A final but critical problem with the ICE health plan involves changes in how each Treatment Authorization Request (TAR) is processed. Prior to changes in 2005, detention center medical staff could submit a TAR and if it was rejected by DIHS, they could appeal this refusal. These appeals were reviewed by a team of 3 DIHS physicians. This formal appeal process was scrapped in 2005 in favor of a ‘grievance’ process that eliminated the physician review component. In addition, in 2007 ICE changed the guidelines for refusing TAR’s so that DIHS nurses could reject a TAR without any input from the DIHS medical director. Such oversight by

the medical director was required for rejection of TAR's prior to this change. The net effect of these two changes is that physicians in detention centers may have their TAR's rejected by off-site nurses and they have lost the ability to appeal such decisions to a group of physicians.

IV. Recommendations

We recommend several specific changes to the DIHS Medical Dental Detainee Covered Services Package as well as to the larger health infrastructure if ICE. Without these changes, we are concerned that all detainees held by ICE face an unacceptably low standard of medical care that will adversely affect their health.

1. The DIHS Medical Dental Detainee Covered Services Package must be altered in the following ways:
 - A. Care for chronic disease must be routinely available and reflect accepted medical standards for the care of HIV, diabetes, hypertension and other common chronic diseases. Part of these improvements must include pre-approval for standard, foreseeable care (including visits, diagnostic tests and treatment).
 - B. Health screening tests must be made available based on prevailing medical standards and any mention of 'clinical suspicion' or 'symptoms' must be eliminated from criteria for these tests.
 - C. Non-medical criteria must be eliminated from the process of detention center medical staff seeking a TAR for detainees. Specifically, the mandate that ICE providers balance a deteriorating condition and uncontrolled suffering against the ability to deport the detainee or estimate a detainee's length of detention must be eliminated from the health plan.
 - D. TARs generated by physicians should not be rejected by off-site nurses without review by a physician. Any TAR rejected by DIHS should be open to a genuine appeal, including review by physicians
2. ICE should be mandated to report vital health statistics (including deaths, disease prevalence & complications, accidents and forcible medical actions against detainees) to a body outside DHS with expertise in public health and epidemiology.
3. Detainees with serious medical ailments requiring high levels of care should be routinely considered for parole. The correctional setting is an inefficient and inhumane venue for persons with medical problems requiring high levels of ongoing medical care.
4. Healthcare for ICE detainees must be guaranteed and defined as a matter of law. Many of the deaths reported among ICE detainees involve poor adherence to existing ICE guidelines. Greater accountability is needed to ensure compliance in healthcare standards across the wide spectrum of detention centers.

These improvements will require substantial effort, including financial investment. Currently, ICE argues that the number of medical visits, procedures and overall medical budget (\$100 million) demonstrate a high degree of care for detainees. But these details tell us nothing about key factors in care delivery, including delays in treatment and the nature of visits. Several detainee deaths involved delays in care and the explosive increase in immigration detainees has outpaced increases in medical spending. Moreover, \$100 million may be a low health care budget for a system that detains 300,000 people per year. By comparison, Rikers Island Jail in New York City detains roughly half the people annually and on any given day that ICE detains, but has spent over \$100 million annually on healthcare for over a decade for a population that is generally detained for less time than ICE detainees. Without transparency from ICE on basic health outcomes or costs, ICE's raw expenditures tell us little about the efficacy of this system of care.

We believe that the most basic principles of decency and sound medical practice demand that an adequate standard of health care for detainees be legally mandated aggressively enforced and that basic health outcomes among detainees be reported for evaluation outside ICE. Unfortunately, the present response of ICE to the overwhelming evidence of inhumane healthcare for detainees shows that officials are more concerned with public relations than confronting the grim medical reality suffered daily by immigrants in detention.

Table 1.

Year (fiscal)	Number of Annual Detentions (by fiscal year)	Average Detention (days)	Detention-years*	Deaths (fiscal year)	Crude Mortality** (deaths/100,000 detentions)	Length-adjusted Mortality (deaths/100,000 detention-years)
2006	254,383	90	62725	17	6.9	27.1
2007	311,213	37	31548	11	3.5(49% decrease)	34.9(29% increase)

* From number of detentions multiplied by average detention length, divided by 365

**Mortality figures reported by ICE

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4. If one were to use the calendar year deaths for 2006 and 2007 (16 and 7), then the length-adjusted mortality does fall slightly from 25 to 22 per 100,000 detention-years. However, this calculation is unreliable since it mixes fiscal and calendar year numbers at a time of rapid changes in numbers and length of detentions. Length of detention numbers were unavailable for years other than 2006 and 2007.
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4 If one were to use the calendar year deaths for 2006 and 2007 (16 and 7), then the length-adjusted mortality does fall slightly from 25 to 22 per 100,000 detention-years. However, this calculation is unreliable since it mixes fiscal and calendar year numbers at a time of rapid changes in numbers and length of detentions. Length of detention numbers were unavailable for years other than 2006 and 2007.

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8 (Government Accountability Office 2007)

9 (Human Rights Watch 2007)

10 (Human Rights Watch 2007)

11 (Physicians for Human Rights/Bellevue/NYU Program for Survivors of Torture 2003)

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