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Solving the Medical Crisis for Immigration Detainees: Is the Proposed Detainee Basic Medical Care Act of 2008 the Answer?

Brianna M. Mooty†

Introduction

In May 2006, after working as a tailor in New York City for years, Boubacar Bah returned to the United States from a trip to Guinea to visit his family only to learn that the United States had denied his green card application.¹ Immigration officials immediately took Mr. Bah into detention.² Months later, Mr. Bah fell ill while detained and repeatedly requested medical attention. Officials ignored his requests until February 1, 2007, when a fellow detainee witnessed Mr. Bah collapse, strike his head on the floor, and lose consciousness.³ Mr. Bah appeared incoherent and agitated upon regaining consciousness and was taken to the medical unit.⁴ Although his behavior exhibited a “textbook symptom of intracranial bleeding,”⁵ detention center medical staff deemed Mr. Bah’s conduct to be the product of “behavior problems.”⁶ When the staff observed Mr. Bah crying and

† J.D. expected 2010, University of Minnesota Law School; B.A. 2006, Hamline University. The author would like to thank Gaetano Podgorski for his unwavering support and patience throughout her law school career; David, Jeanne, and John Mooty for inspiring her to become an attorney and for their love and encouragement throughout this process; and to the staff and editors at *LAW & INEQUALITY: A JOURNAL OF THEORY AND PRACTICE* for making this Article possible. This Article is dedicated to those in immigration detention, in the hope that reform will precede further injustices.

1. Nina Bernstein, *Few Details on Immigrants Who Died in U.S. Custody*, N.Y. TIMES, May 5, 2008, at A1.

2. *Id.* Though the complete details of Mr. Bah’s immigration status are unclear, a possible basis for Mr. Bah’s detention was a loss of status based on the denial of his green card application. This denial would trigger deportation pursuant to section 237(a)(1) of the Immigration and Nationality Act (INA), 8 U.S.C. § 1227(a)(1)(A) (2006) (making aliens who were inadmissible upon arrival removable), and would allow for detention under section 241(a)(2), 8 U.S.C. § 1231(a)(2) (2006) (ordering detention of aliens during the removal period).

3. Bernstein, *supra* note 1, at A1.

4. *Id.*

5. *Id.*

6. *Id.*

regurgitating on the floor, they ordered him to calm down, wrote him up for disobeying orders when his condition persisted, and subsequently placed him in solitary confinement.⁷ Over fourteen hours later, a nurse finally realized the gravity of his situation and contacted emergency medical services.⁸ Already in a coma, Mr. Bah was rushed to the hospital, where doctors discovered a skull fracture and multiple brain hemorrhages.⁹ Neither immigration officials nor the hospital notified his family until five days later.¹⁰ Mr. Bah died from his injuries just four months after he collapsed at the detention center.¹¹ The hospital classified his death as an “unattended accident resulting in death” and no investigation took place.¹²

While Mr. Bah’s case may sound extraordinary, his is one of eighty-seven detainee deaths that occurred in immigration detention from 2003 to 2008, according to data from Immigration and Customs Enforcement (ICE).¹³ ICE data on detainee deaths within detention facilities, however, does not fully reflect the treatment issues present in these facilities. For example, a detainee who dies after release, even if that death was the result of poor care received while in immigration detention, will not appear on the list.¹⁴

Francisco Castaneda was an El Salvadorian citizen who had been living in the United States since the early 1980s.¹⁵ U.S. officials detained him at a center in San Diego in March of 2006. Castaneda immediately informed officials of a lesion on his penis that was bleeding and producing discharge.¹⁶ Days later, a physician examined him and recommended circumcision and an

7. *Id.* Detention center medical staff did not identify the head injury or intracranial bleeding, and Mr. Bah did not receive adequate treatment until arriving at the hospital. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. ALISON SISKIN, CRS REPORT FOR CONGRESS: HEALTH CARE FOR NONCITIZENS IN IMMIGRATION DETENTION 21 (2008); Nina Bernstein, *Death of Detained Immigrant Inspires Online Game with Goal of Educating Players*, N.Y. TIMES, Oct. 4, 2008.

14. *Id.* at 22.

15. *Detention and Removal: Immigration Detainee Medical Care: Hearing Before the Subcomm. on Immigration, Citizenship, Refugees, Border Security, and International Law of the H. Comm. on the Judiciary*, 110th Cong. 17 (2007) [hereinafter *Hearing on Immigration Detainee Medical Care*] (statement of Francisco Castaneda).

16. *Id.*

immediate biopsy.¹⁷ Detention officials ignored the doctor's multiple requests that Mr. Castaneda be allowed to see a specialist, however, forcing him to languish in detention while his condition worsened.¹⁸ Eventually, an oncologist saw Mr. Castaneda and informed him that his condition might be the result of cancer and ordered a biopsy. Again, the detention center refused the treatment, calling the biopsy "elective surgery."¹⁹ Eleven months later, Mr. Castaneda's condition had progressed to a stage sufficient to necessitate his release.²⁰ Finally able to see a specialist, he was diagnosed with penile cancer which, left untreated, had spread to his lymph nodes.²¹ Mr. Castaneda testified before Congress on October 4, 2007.²² He later suffered through a penile amputation and died shortly thereafter.²³

The hearing was followed by a flood of news coverage and cries from the public calling for changes in the immigration system.²⁴ The U.S. House of Representatives responded with the

17. *Id.* at 17. In reference to Mr. Castaneda's treatment, Timothy Shack, Medical Director for the Division of Immigration Health Services stated, "I don't see this as improper care. I think this is good care It's just unfortunate that this had a bad outcome." Darryl Fears, *Illegal Immigrants Received Poor Care in Jail, Lawyers Say*, WASH. POST, June 13, 2007, at A4. Doctors agreed, however, that the proper treatment was circumcision, with a biopsy to determine if he was suffering from cancer. Mr. Castaneda did not receive either. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 244. In fact, the ICE physician's assistant that saw Mr. Castaneda "informed him that he did not have cancer *because* a biopsy had *not* been done." *Id.* at 22.

18. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 17 (statement of Francisco Castaneda).

19. *Id.* at 18.

20. *Id.* at 14–15.

21. *Id.* at 15.

22. *Id.* at 13–19 (statement of Francisco Castaneda). Mr. Castaneda stated: I have to be here today because I am not the only one who didn't get the medical care I needed. It was routine for the detainees to have to wait weeks or months to get basic care. Who knows how many tragedies can be avoided if ICE only remembers that regardless of why a person is in detention and regardless of where they will end up, they are still humans and they deserve basic care, humane medical care.

Id. at 15.

23. Mr. Castaneda had his penis amputated on February 14, 2007, and subsequently endured five aggressive rounds of chemotherapy. *Id.* at 15. Mr. Castaneda died on February 16, 2008, at the age of thirty-six, leaving behind a fourteen-year-old daughter. Nina Bernstein & Julia Preston, *Better Health Care Sought for Detained Immigrants*, N.Y. TIMES, May 7, 2008, at A18.

24. In May 2008, the *Washington Post* began a four-part series on problems with medical care provided to immigration detainees. See, e.g., Dana Priest & Amy Goldstein, *System of Neglect*, WASH. POST., May 11, 2008, available at <http://www.washingtonpost.com/wp-srv/nation/specials/immigration/index.html>. The *New York Times* also began a series covering the crisis from May to October 2008. See, e.g., Bernstein, *supra* note 1, at A1.

Detainee Basic Medical Treatment Act of 2008.²⁵ A companion bill was introduced in the Senate.²⁶ The legislation would order the Secretary of Homeland Security to create procedures for the medical treatment of immigration detainees and outline basic minimum requirements for those procedures.²⁷ According to Representative Zoe Lofgren, “[w]e are not talking about Cadillac health care here, but the government is obligated to provide basic care. Many of those in immigration custody are there for minor violations, many for administrative and paperwork-related mistakes. Their detention should not be a death sentence.”²⁸

These deaths have illuminated a number of serious issues within the current immigration detention system, highlighting the need to reform the system so that human and civil rights violations are prevented in the future. This Article begins by detailing the background and current state of immigration detention in Part I. Part II of this Article explains the existing medical standards, the proposed medical standards contained in the Detainee Basic Medical Care Act of 2008, and the legislation’s potential effects on immigration detention. In Part III, this Article concludes that the legislation, while a step in the right direction, does not go far enough to solve the current crisis. Finally, Part IV proposes elements of legislation that would adequately address the current medical problems faced by immigration detainees.

I. Immigration Detention in the United States

A. *The Basis for Immigration Detention*

The U.S. Attorney General has authority to detain foreign nationals who violate immigration law, even though such violations are not criminal.²⁹ Additionally, the Secretary of Homeland Security “possesses the authority and obligation to promulgate regulations governing immigration detention,” regardless of whether the facilities are under the Department of

25. Detainee Basic Medical Treatment Act of 2008, H.R. 5950, 110th Cong. (2008). This legislation was introduced by Representative Zoe Lofgren (D-CA).

26. Detainee Basic Medical Care Act of 2008, S. 3005, 110th Cong. (2008). This bill was introduced by Senator Robert Menendez (D-NJ), together with Senators Edward Kennedy (D-MA), Richard Durban (D-IL), Daniel Akaka (D-AK), and Joseph Lieberman (I-CT).

27. See *infra* Part II (outlining, in detail, the provisions of the legislation).

28. Bernstein & Preston, *supra* note 23 (quoting a statement Rep. Lofgren gave on May 6, 2008).

29. 8 U.S.C. § 1226(a) (2006).

Homeland Security's direct control or under a contract.³⁰ Current law provides that the United States may, and in many cases must, detain immigrants who await deportation.³¹ This requirement is to prevent threats to security or public safety under the theory that most immigrants will abscond before they can be removed from the United States.³²

Immigration detention is administrative, rather than punitive, in nature.³³ A detained individual is not charged with a criminal violation, nor given a trial, and the detention is not intended as punishment.³⁴ Noncitizens convicted of committing crimes, however, are detained for their criminal charges in punitive detention, and can then be transferred immediately into immigration detention after serving their criminal sentence.³⁵ Though immigration detainees are not U.S. citizens, they enjoy certain constitutional rights.³⁶ As civil detainees, they have due

30. Steven Neeley, *Immigration Detention: The Inaction of the Bureau of Immigration and Customs Enforcement*, 60 ADMIN. L. REV. 729, 741 (2008).

31. DEPT OF HOMELAND SEC., OFFICE OF INSPECTOR GEN., OFFICE OF AUDITS, DETENTION AND REMOVAL OF ILLEGAL ALIENS: U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE) 1-2 (2006).

32. *Id.*

33. Memorandum from Laura Rótolo, ACLU of Massachusetts, to Briefing Coordinators, Special Rapporteur on Migration (Apr. 17, 2007), in DETENTION WATCH NETWORK, BRIEFING MATERIALS SUBMITTED TO THE UNITED NATIONS SPECIAL RAPPORTEUR ON THE HUMAN RIGHTS OF MIGRANTS 70, available at <http://www.detentionwatchnetwork.org/events> (follow "Briefing Materials on Detention for UN Special Rapporteur on Human Rights" hyperlink).

34. Humanitarian organizations and intergovernmental groups, such as Amnesty International and the United Nations, have expressed concern that administrative detention is a violation of international standards against arbitrary detention and deprivation of liberty, in particular Article 9 of the International Covenant on Civil and Political Rights. International Covenant on Civil and Political Rights art. 9, Dec. 16, 1966, S. Exec. Doc. E, 95-2 (1978), 999 U.N.T.S. 171. Courts in the United States, however, have upheld immigration detention as constitutional on several grounds. See *infra* Part I.B. (describing the Supreme Court's decision in *Demore v. Kim*, 538 U.S. 510 (2003), which held that mandatory detention laws do not violate an individual's Fifth Amendment due process rights).

35. 8 U.S.C. § 1226(c) (2006). See also Juliet Stumpf, *The Crimmigration Crisis: Immigrants, Crime, and Sovereign Power*, 56 AM. U. L. REV. 367 (2006) (detailing the development of the criminalization of the immigration system).

36. See *Zadvydas v. Davis*, 533 U.S. 678, 692-93 (2001) (acknowledging deportable aliens' full due process protections); *Wing v. United States*, 163 U.S. 228, 237 (1896) (indicating that aliens are constitutionally protected by the Fifth Amendment); *Jones v. Blanas*, 393 F.3d 918, 933-34 (9th Cir. 2004) (holding that the standard to be used in evaluating civil detainees' constitutional rights must be higher than convicted prisoners and pre-trial criminal detainees); see also *Augustin v. Sava*, 735 F.2d 32, 37-38 (2d Cir. 1984) (holding that inadmissible aliens have a right to adequate interpreters); *Najaf-Ali v. Meese*, 653 F. Supp. 833, 838 (N.D. Cal. 1987) (holding that inadmissible aliens have a right to present witnesses at immigration hearings).

process rights under the Fifth Amendment, which protect them “from conditions that amount to punishment without due process of law.”³⁷ Additionally, detainees are protected under the Eighth Amendment from cruel and unusual punishment.³⁸

B. History of Immigration Detention

Though detention of immigrants is not a new phenomenon, before 1996 the U.S. immigration system generally used detention only for persons considered to be security threats or flight risks.³⁹ From 1930 to 1954, as concerns for security increased, the government increased the use of detention and converted Ellis Island into a “grim” prison.⁴⁰ After Ellis Island closed, the Immigration and Naturalization Service (INS) restricted its detention program almost to the point of abandonment until the 1980s, as INS resumed the policy of detaining only those individuals who had absconded or posed a serious threat to society.⁴¹ Beginning in 1980, several factors led to another change in policy. First, civil wars and economic circumstances caused hundreds of thousands of Cubans, Haitians, and Central Americans to enter the United States.⁴² Second, as part of the “War on Drugs,” the INS began to focus on the apprehension, detention, and expulsion of those convicted of drug crimes.⁴³

These factors pushed Congress to enact legislation in 1996 that led to a sharp increase in immigration detention.⁴⁴ The Antiterrorism and Effective Death Penalty Act of 1996 (AEDPA) amended existing immigration laws to address heightened concerns related to terrorist activity.⁴⁵ Five months later, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA)⁴⁶ amended the AEDPA and added a provision to the

37. 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 (2007).

38. *Id.* at 351–52.

39. *Id.* at 348–49.

40. ACLU OF N.J., BEHIND BARS: THE FAILURE OF THE DEPARTMENT OF HOMELAND SECURITY TO ENSURE ADEQUATE TREATMENT OF IMMIGRATION DETAINEES IN NEW JERSEY 1 (2007).

41. *Id.*

42. *Id.* at 1–2.

43. *Id.* at 2.

44. *Id.*

45. Pub. L. No. 104-132, §§ 401–43, 110 Stat. 1214, 1258–81 (codified as amended in scattered sections of 8 U.S.C. (2006)).

46. Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, Div. C., 110 Stat. 3009, 3009-546 to 3009-724 (1996) (codified as

Immigration and Nationality Act (INA)⁴⁷ that required automatic mandatory detention without bail for any alien convicted of an “aggravated felony”⁴⁸ and for other noncitizens with certain criminal convictions.⁴⁹ Rather than individually assess foreign nationals for potential flight risk or danger to society, the statute requires mandatory detention of everyone who falls into certain categories.⁵⁰ The crimes within these categories include dangerous offenses, such as murder and other violent crimes,⁵¹ terrorism,⁵² and treason or espionage.⁵³ The mandatory detention requirement also includes less dangerous offenses, including any “crime involving moral turpitude”⁵⁴ with a sentence of as little as one year in prison,⁵⁵ controlled substance violations (including drug abuse or addiction),⁵⁶ certain firearm offenses,⁵⁷ theft or perjury offenses

amended in scattered sections of 8 U.S.C. and 18 U.S.C. (2006)).

47. Immigration and Nationality Act § 236, 8 U.S.C. § 1226(c)(1) (2006).

48. Illegal Immigration Reform and Immigrant Responsibility Act, Pub. L. 104-208, § 303, 110 Stat. 3009, 45 (codified as amended at 8 U.S.C. § 1226(c)(1)(B) (2006)). Congress created the term “aggravated felony” in 1988 when it passed the Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690, § 7342, 102 Stat. 4181, 4469–70, which amended the INA. It is a broad term that now encompasses a number of different crimes, listed at Immigration and Nationality Act § 101(a)(43), 8 U.S.C. § 1101(a)(43), including crimes of violence, explosive materials offenses, firearm offenses, theft offenses, child pornography, racketeering, prostitution-related charges, fraud, alien smuggling, document fraud, or conspiracy to commit one of the listed offenses.

49. Illegal Immigration Reform and Immigrant Responsibility Act § 303.

50. 8 U.S.C. § 1226(c)(1). As of this writing, a number of proposed amendments to the INA are pending in Congress: for example, a greater discretion on the part of the Attorney General to release immigrants on their own recognizance or utilize alternative detention programs, S. 1594, 111th Cong. § 4 (2009); an individualized determination of danger to national security, H.R. 264, 111th Cong. § 1102 (2009); and an increased burden on the Attorney General to demonstrate that a particular alien poses a flight risk or danger to society, H.R. 3531, 111th Cong. § 4 (2009).

51. 8 U.S.C. §§ 1226(c)(1)(B), 1227(a)(2)(A)(iii). “Aggravated felony” includes “a crime of violence . . . for which the term of imprisonment [is] at least one year.” *Id.* § 1101(a)(43)(F).

52. *Id.* § 1226(c)(1)(D). In addition, the USA PATRIOT Act of 2001, Pub. L. No. 107-56, § 412, 115 Stat. 272, 350 (codified at 8 U.S.C. § 1226a (2006)), now provides explicitly for the mandatory detention of suspected terrorists.

53. *Id.* §§ 1226(c)(1)(B), 1227(a)(2)(D).

54. *Id.* § 1182(a)(2)(A)(i)(I). “Crimes involving moral turpitude” is not statutorily defined, but the Board of Immigration Appeals has defined “moral turpitude” as “conduct that shocks the public conscience as being inherently base, vile, or depraved, and contrary to the accepted rules of morality and the duties owed between persons or to society in general.” *Matter of Frankin*, 20 I & N Dec. 867, 868 (1994). There are dozens of crimes that are included in this category, ranging from adultery to murder. See Brian C. Harms, *Redefining “Crimes of Moral Turpitude.” A Proposal to Congress*, 15 GEO. IMMIGR. L.J. 259, 264–69 (2001).

55. 8 U.S.C. §§ 1226(c)(1)(C), 1227(a)(2)(A)(i).

56. *Id.* §§ 1226(c)(1)(A), 1226(c)(1)(B), 1227(a)(2)(B)(i)–(ii).

with a term of imprisonment of one year or more,⁵⁸ fraud and tax evasion,⁵⁹ and document fraud.⁶⁰

Even though immigrant detainees have constitutional rights,⁶¹ statutory mandatory detention provisions have been upheld on constitutional grounds. In *Demore v. Kim*,⁶² the Supreme Court held that mandatory detention laws, at least with respect to the detention of deportable immigrants pending their removal proceedings, do not violate an individual's Fifth Amendment due process rights.⁶³ The Court reversed the Ninth Circuit, which had held that a failure to provide a legal permanent resident who had been found deportable the opportunity for an individualized determination of flight risk or danger to the community was a violation of that person's due process rights.⁶⁴

C. *The Current State of Immigration Detention*

As a result of the 1996 statutory changes, the number of noncitizens being detained in the United States has increased rapidly.⁶⁵ From 1994 to 2001, the average daily population in immigration detention nearly quadrupled, from 5532 to 20,429.⁶⁶ Policy changes since 9/11 caused further increases.⁶⁷ Today, the average daily population ranges up to 33,000 individuals.⁶⁸ The total number of noncitizens going through the detention system was 311,213 individuals in fiscal year 2007, an increase of more than thirty percent over 2003.⁶⁹

57. *Id.* §§ 1226(c)(1)(B), 1227(a)(2)(C).

58. *Id.* §§ 1226(c)(1)(B), 1227(a)(2)(A)(iii), 1101(a)(43)(G), 1101(a)(43)(S).

59. *Id.* §§ 1226(c)(1)(B), 1227(a)(2)(A)(iii), 1101(a)(43)(M).

60. *Id.* §§ 1226(c)(1)(B), 1227(a)(2)(A)(iii), 1101(a)(43)(P).

61. *See supra* note 36.

62. 538 U.S. 510 (2003).

63. *Id.* at 531.

64. *See Kim v. Ziglar*, 276 F.3d 523, 538–39 (9th Cir. 2002) (holding that 8 U.S.C. § 1226(c) violates substantive due process, at least as applied to lawful permanent residents), *rev'd sub nom.* *Demore v. Kim*, 538 U.S. 510 (2003).

65. ACLU OF N.J., *supra* note 40, at 2.

66. ALISON SISKIN, IMMIGRATION-RELATED DETENTION: CURRENT LEGISLATIVE ISSUES 12 (2004).

67. Since its inception, ICE, and its enforcement arm, the Office of Detention and Removal Operations, have significantly stepped up programs for apprehending noncitizens who are in violation of immigration laws. For more information, see RITA ESPINOSA, DETENTION WATCH NETWORK, TRACKING ICE'S ENFORCEMENT AGENDA, <http://www.detentionwatchnetwork.org/node/280> (2007) (follow "04-18-07 DWN Enforcement Working Document--final.doc" hyperlink) (documenting immigration raids, as well as describing in detail ICE's programs on the detention and deportation of immigrants).

68. SISKIN, *supra* note 13, at 25.

69. *Id.* at 26.

As stated previously, noncitizens who have committed certain crimes are detained without bail in immigration detention after the completion of their criminal sentences.⁷⁰ More than half of all detainees are *not* criminals.⁷¹ Many are asylum-seekers⁷² and others are present without status.⁷³ Over eighty-seven percent of bed space is allocated to individuals whose detention is based on the mandatory detention provisions.⁷⁴ Those detainees not subject to mandatory detention are eligible for release on bond or parole,⁷⁵ or through other alternative programs such as ICE's Intensive Supervision Appearance Program.⁷⁶ Yet only eight percent of arrested noncitizens were released under these programs.⁷⁷

Many of the noncitizens in immigration detention are suffering from physical and/or mental health issues.⁷⁸ According

70. See *supra* notes 44–60 and accompanying text (discussing the detention of noncitizens with criminal convictions).

71. SISKIN, *supra* note 13, at 25 (noting that in fiscal year 2006, approximately forty-eight percent of the noncitizens in detention were criminal aliens).

72. The detention of asylum-seekers is heavily contested. Current U.S. law provides that asylum-seekers who are otherwise deemed inadmissible can be detained until their credible fear hearing. 8 U.S.C. § 1225(b)(1)(B)(iii)(IV) (2006). This practice arguably goes against many international agreements to which the United States is party and may cause significant psychological damage for many asylum-seekers. For a critique of the current mandatory detention policy and regulations, and a suggestion that “Congress and DHS should implement thorough and efficient credible fear interviews, define clear parole guidelines, and use humane detention alternatives,” see Kristen M. Jarvis Johnson, *Fearing the United States: Rethinking Mandatory Detention of Asylum Seekers*, 59 ADMIN. L. REV. 589, 592 (2007). See generally PHYSICIANS FOR HUMAN RIGHTS & THE BELLEVUE/NYU PROGRAM FOR SURVIVORS OF TORTURE, FROM PERSECUTION TO PRISON: THE HEALTH CONSEQUENCES OF DETENTION FOR ASYLUM SEEKERS (2003), available at <http://physiciansforhumanrights.org/library/documents/reports/report-perstoprison-2003.pdf> (reporting that detained asylum seekers suffered high rates of anxiety, depression, and post-traumatic stress disorder, and that their conditions worsened the longer they were detained).

73. SISKIN, *supra* note 13, at 3.

74. OFF. OF AUDITS, DEP'T OF HOMELAND SEC., DETENTION AND REMOVAL OF ILLEGAL ALIENS: U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE) 5–6 (2006).

75. 8 U.S.C. § 1226(a)(2) (2006).

76. Press Release, U.S. Immigration and Customs Enforcement, ICE Unveils New Alternative to Detention (June 17, 2004), available at <http://www.aila.org/content/fileviewer.aspx?docid=10854&linkid=40921> [hereinafter *Ice Unveils New Alternative*] (announcing the release of ICE's Intensive Supervision Appearance Program and describing it as an alternative to detention utilizing “electronic monitoring[,] . . . home visits, work visits and reporting by telephone . . .”).

77. U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT, ALTERNATIVES TO DETENTION (2009), <http://www.ice.gov/pi/news/factsheets/080115alternativestodetention.htm>.

78. See *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 5–6 (statement of Gary E. Mead, Assistant Director for Detention and Removal, U.S. Immigration and Customs Enforcement).

to ICE, approximately twenty-five percent of detainees have chronic health problems.⁷⁹ Though there are no statistics providing exact data, many detainees suffer from hypertension, diabetes, HIV/AIDS, and other illnesses that require ongoing treatment.⁸⁰

ICE has only eight detention facilities of its own, called Service Processing Centers (SPC).⁸¹ Detainees not housed in SPCs are housed in Bureau of Prisons (BOP) facilities, private facilities, and state and local jails.⁸² ICE buys bed space from over 300 other facilities,⁸³ using two different types of contracts: agreements with private Contract Detention Facilities or Intergovernmental Service Agreements with state and local facilities.⁸⁴ According to the Congressional Research Service, “[i]n October 2007, 65% of noncitizen detainees were detained at state and local prisons, 19% at contract facilities, 14% at SPCs owned and operated by ICE, and 2% at BOP facilities.”⁸⁵

D. Issues with the Immigration Detention System

There are many issues with the current civil detention system of individuals who violate immigration law or are otherwise removable from the United States. One category of problems involves the treatment of immigration detainees. First, medical staff provides detainees with inconsistent and inadequate treatment.⁸⁶ Few facilities provide medical check-ups on arrival or

79. *See id.*

80. *See* HUMAN RIGHTS WATCH, CHRONIC INDIFFERENCE: HIV/AIDS SERVICES FOR IMMIGRANTS DETAINED BY THE UNITED STATES, 1–2 (2007) available at <http://www.hrw.org/sites/default/files/reports/us1207web.pdf> (explaining that ICE does not keep track of the number of detainees with HIV/AIDS or adequately care for the unique needs of those individuals); *see also* *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 5–6 (statement of Gary E. Mead, Assistant Director for Detention and Removal, U.S. Immigration and Customs Enforcement) (noting that chronic problems like hypertension and diabetes are common diseases); *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 121 (testimony of Immigration Equality, Human Rights Campaign, Gay Men's Health Crisis, Stop Prisoner Rape, Urban Justice Center, National Center for Lesbian Rights, and TGI Justice Project) (noting that there is no data on how many immigration detainees are HIV-positive, but that they are among the most vulnerable detainees).

81. SISKIN, *supra* note 13, at 3.

82. *Id.*

83. *Id.* at 3.

84. Cahan, *supra* note 37, at 349.

85. SISKIN, *supra* note 13, at 3.

86. *See* *Problems with Immigration Detainee Medical Care: Hearing Before the Subcomm. on Immigration, Citizenship, Refugees, Border Security, and*

within fourteen days, as required by ICE's own standards for detainee medical care.⁸⁷ The care available is often limited to urgent medical care.⁸⁸ There are also many instances where translation and interpretation services are not available, which may prevent staff from administering correct treatment.⁸⁹ Furthermore, the quality of personnel employed at these facilities is questionable. There are documented instances of nurses or doctors laughing at detainees for "faking" illnesses that were later proven to be legitimate and life-threatening.⁹⁰ Finally, while there are standards for the treatment of the detainees,⁹¹ these standards are non-binding and routinely ignored.⁹² The lack of clarity as to what standards apply to the different kinds of facilities

International Law of the H. Comm. on the Judiciary, 110th Cong. 89 (2008) (statement of Mary Meg McCarthy, Director, National Immigrant Justice Center) (citing her organization's receipt of "a constant stream of complaints about the denial of adequate medical care").

87. U.S. IMMIGR. AND CUSTOMS ENFORCEMENT, DEP'T OF HOMELAND SEC., DET. OPERATIONS MANUAL, INS DETENTION STANDARD: MEDICAL CARE, available at <http://www.ice.gov/pi/dro/opsmanual/> (follow "Medical Care" hyperlink) (last visited Oct. 9, 2009) (establishing national standards governing the care of aliens in detention); see SISKIN, *supra* note 13, at 14–17 (outlining three governmental reports on compliance with these standards). The Government Accountability Office audited twenty-three facilities, noting that three failed to adhere to the standards, "including failing to administer the mandatory physical exams within fourteen days of admission and failure to administer medical screening immediately after admission." *Id.* at 15–16. The Office of the Inspector General study found non-compliance at four of the five facilities audited, "including failure to provide timely initial medical care." *Id.* at 16.

88. According to Representative Zoe Lofgren, the [Department of Immigration Health Services] Medical Dental Detainee Covered Services Package specifically states that medical care in ICE detention facilities is to be provided primarily for emergency care. Care for, and I quote, "accidental or traumatic injuries incurred while in the [sic] custody and acute illnesses is not required, but simply reviewed for appropriate care. Care for other illnesses, including pre-existing illnesses that are serious but not life-threatening, is also not automatic but simply reviewable for appropriate care."

Hearing on Immigration Detainee Medical Care, *supra* note 15, at 2 (statement of Rep. Zoe Lofgren).

89. See *id.* at 83 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center) (discussing the unique difficulties faced by ICE detainees due to language barriers).

90. See *id.* at 95 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center) (noting that officers "too readily assume the detainees are faking their illness"); see also *id.* at 44 (statement of Edwidge Danticat) (discussing a particularly disturbing case in which her uncle's medications for hypertension and an inflamed prostate were taken away, a medic accused him of faking his illness, and he had to wait twenty-four hours to see a doctor, before ultimately dying unattended in detention).

91. See *infra* Part II.A. (discussing the current ICE detention standards).

92. See SISKIN, *supra* note 13, at 14–17.

exacerbates these problems.⁹³

A second category of issues results from the policies dictating which foreign nationals should be detained, and in which facilities. The rise in numbers of detained individuals, mainly attributed to the expansion of mandatory detention, has put a strain on the current system.⁹⁴ A Department of Homeland Security report acknowledges that the amount of bed space and the number of personnel are declining, despite an increase in the numbers of detainees.⁹⁵ A related problem is that often the facilities housing immigration detainees are criminal detention centers, inappropriate for administrative detainees.⁹⁶ In many instances, immigration detainees are placed with general prison populations, rather than placed in separate areas, and have severe restrictions on their freedom of movement, rights to communicate with families and receive visits, and limited access to outdoor recreational activities.⁹⁷ Further, prison personnel do not know which detainees are criminal and which are civil immigration detainees, and do not receive training on how to deal with foreign

93. See *infra* Part II.A. (discussing the ICE, American Correctional Association, and National Commission on Correctional Health Care standards). The contracts that ICE enters into with local and county jails do not clearly specify what standards of care apply to the detainees housed in those facilities. See Neeley, *supra* note 30, at 738–39. The lack of clarity as to which standards apply to the different facilities also makes it difficult for detainees and their families to report complaints. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 162–67 (statement of The Legal Aid Society).

94. See OFF. OF AUDITS, *supra* note 74, at 1. The report identifies a number of problems resulting from inadequate funding, including an increase in the number of legally-detainable aliens being released. *Id.* ICE also must compensate for its budget shortfalls by placing strict limitations on the recruitment and training of its employees, as well as the expansion of new programs. *Id.* at 11.

95. *Id.* at 1–2. The report noted that “the number of illegal aliens apprehended increased from 231,077 in [fiscal year] 2002 to 275,680 in [fiscal year] 2004, a 19 percent increase. During the same period, however, authorized personnel and funded bed space levels declined by 3 percent and 6 percent, respectively.” *Id.* at 1.

96. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 91–93 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center) (describing complaints of unhealthy, unsafe conditions including filthy jails and overcrowding).

97. See WOMEN’S COMM’N FOR REFUGEE WOMEN AND CHILDREN & LUTHERAN IMMIGRATION AND REFUGEE SERV., LOCKING UP FAMILY VALUES: THE DETENTION OF IMMIGRANT FAMILIES 11–14 (2007) available at <http://www.womenscommission.org/pdf/famdeten.pdf> [hereinafter THE DETENTION OF IMMIGRANT FAMILIES]; see also *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 95–97 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center). “Officers frequently view ICE detainees as criminals, even when they have no criminal history. . . . Moreover, ICE detainees who are not serving criminal sentences are nonetheless handcuffed and/or shackled when transported to outside hospitals for medical care and even when in their hospital ward.” *Id.* at 95.

detainees.⁹⁸ Detention facilities often do not have arrangements for culturally-appropriate food,⁹⁹ or for the practice of non-Christian religions.¹⁰⁰ Many of the county and local facilities are not designed to house people for long periods of time and many do not have any outdoor spaces or educational or recreational activities for child detainees.¹⁰¹ Most county jails are designed for an average stay of four days—the average length of ICE detention at the Ramsey County jail in Minnesota, however, is 100 days, and at least six people in 2007 were detained there for over 300 days, and one for over 400 days.¹⁰² This problem is not limited to Minnesota, as more than 7000 noncitizens were in detention for more than six months in fiscal year 2006 across the United States.¹⁰³

There are also a number of issues surrounding the administration of the immigration detention system. First, there is a complete lack of transparency.¹⁰⁴ For example, detainee medical records are often inaccessible, even to the detainee.¹⁰⁵ In some cases, detainees or their families have to hire attorneys and

98. See THE DETENTION OF IMMIGRANT FAMILIES, *supra* note 97, at 11–14 (discussing the many problems faced by detained immigrants including inadequate facilities, physical settings, accommodations, medical care, mental healthcare, education, recreation, access to counsel, and other topics, with a focus on family detention facilities); see also *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 83 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center) (explaining the difficulties that result when the medical staff at a facility cannot speak the language of detainees).

99. See THE DETENTION OF IMMIGRANT FAMILIES, *supra* note 97, at 19 (describing how the menus at these facilities are composed mostly of American style food).

100. *Id.* at 18 (describing how a Pakistani detainee was not allowed to shave in accordance with his religious practices).

101. See *id.* at 25–28.

102. Michele Garnett McKenzie, Staff Briefing on Medical Treatment at Immigration Detention Centers (July 9, 2007) http://www.immigrantlawcentermn.org/homepage/news/news_attachments/michele_mckenzie_briefing_07_2007.pdf.

103. SISKIN, *supra* note 13, at 4.

104. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 167 (statement of The Legal Aid Society) (reporting on the lack of transparency in contracting, oversight, and access to information regarding detention operations).

105. See *id.* at 159 (statement of Judy London, Directing Attorney of Public Counsel's Immigrants' Rights Project) ("Despite repeated phone calls and letters from [the detainee's] counsel over a two month period, DHS refused to provide [the detainee] with the requested medical care and refused to provide [the detainee's] attorneys with his medical records, making an adequate review of his medical condition impossible." (emphasis omitted)). The attorneys in this case finally received the medical records and the detainee received the requested care, but this response only happened after another detainee tragically died at the facility and the information surrounding that death was made public. *Id.* at 160.

sue to obtain their records.¹⁰⁶ One family requested the medical records of a relative who had died in immigration detention under questionable circumstances.¹⁰⁷ After many months, the family finally received reports, but the reports contained thirty-one pages of redacted information for “privacy,” even though the family had requested the reports and the individual was deceased.¹⁰⁸ Second, there is very little oversight of the current system. A Government Accountability Office (GAO) report investigating ICE’s compliance with the GAO’s medical standards in ICE detention facilities cited serious flaws in ICE’s current inspection system.¹⁰⁹ Significantly, ICE is only required to inspect its facilities annually and often fails to meet even that very low standard.¹¹⁰ Furthermore, there is little oversight by external actors such as the Red Cross, the United Nations, or other governmental and non-governmental organizations.¹¹¹

II. Medical Treatment for Immigration Detainees

A. Absence of Current Laws on Medical Treatment for Detainees

There are no laws requiring medical treatment for detainees.¹¹² ICE’s office of Detention and Removal Operations, however, presents a series of non-binding standards outlining the appropriate treatment and care of detainees.¹¹³ The office of Detention and Removal Operations also partners with the U.S. Public Health Service’s Division of Immigration Health Services (Health Services) to provide and arrange for health care to ICE’s detainees.¹¹⁴ Detention facilities must be in compliance with

106. *See id.* at 46 (statement of Edwidge Danticat).

107. *Id.* at 69 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center).

108. *Id.* (noting that it took lawyers months in many cases to access records on their clients’ behalf and that “[t]he process for requesting records is different at each facility where immigrants are detained, but is consistently riddled with bureaucratic red tape.”).

109. *See* U.S. GOV’T ACCOUNTABILITY OFFICE, ALIEN DETENTION STANDARDS: OBSERVATIONS ON THE ADHERENCE TO ICE’S MEDICAL STANDARDS IN DETENTION FACILITIES (2008), available at <http://www.gao.gov/new.items/d08869t.pdf>.

110. *Id.* at 2–4.

111. *See id.* at 6–7 (discussing that the limited amount of oversight comes primarily from detainee complaints to the American Bar Association and the United Nations High Commissioner for Refugees). Each of these organizations files the complaints with the Department of Homeland Security. *Id.*

112. Cahan, *supra* note 37, at 345–46.

113. U.S. IMMIGR. AND CUSTOMS ENFORCEMENT, *supra* note 87.

114. *Hearing on Immigration Detainee Medical Care, supra* note 15, at 5

applicable health care standards, including those from the American Correctional Association, the National Commission on Correctional Health Care, and ICE.¹¹⁵

ICE standards require a minimum of two medical examinations for each detainee: an initial health screening immediately upon arrival, including a determination of appropriate treatment for the detainee, and a follow-up screening and physical examination within fourteen days of arrival.¹¹⁶ Additionally, facilities are required to provide language translation services to all detainees.¹¹⁷ Finally, facilities are required to give all detainees access to “sick call”¹¹⁸ and other services.¹¹⁹ All “request slips,” the forms used by detainees to request medical care, are required to be processed in a timely manner.¹²⁰

While these standards appear to provide the framework for sufficient medical care to immigration detainees, they are rarely

(statement of Gary E. Mead, Assistant Director for Detention and Removal, U.S. Immigration and Customs Enforcement).

115. *Id.* The American Counseling Association (ACA) and the National Conference on Health Care Consumerism “accredit national, state, and local detention facilities that meet existing detention standards For facilities seeking accreditation, ACA conducts onsite inspections every three years. According to ACA policy, facilities are required to document compliance with the standards for each month over the three-year period.” OFF. OF AUDITS, DEP’T OF HOMELAND SEC., ICE POLICIES RELATED TO DETAINEE DEATHS AND THE OVERSIGHT OF IMMIGRATION DETENTION FACILITIES 3 (2008). For more information on ACA detention standards, see the ACA website, <http://www.aca.org/standards/faq.asp> (last visited Oct. 9, 2009). There is some question as to whether the ACA standards are appropriate for immigration detention facilities. As Cheryl Little notes, the ACA standards

were designed for a criminal population and do not take into account that detainees in ICE custody are there on the basis of civil violations only and are not serving criminal sentences or awaiting trial. They have special needs that are not applicable to those accused or convicted of criminal violations.

Hearing on Immigration Detainee Medical Care, *supra* note 15, at 98 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center).

116. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 6 (statement of Gary E. Mead, Assistant Director for Detention and Removal, U.S. Immigration and Customs Enforcement).

117. *Id.* at 7 (statement of Gary E. Mead, Assistant Director for Detention and Removal, U.S. Immigration and Customs Enforcement).

118. “Sick call” is the opportunity to request health care services provided by a physician or other qualified medical officer in a clinical setting. *Id.* at 7–8. According to Mead, “[t]he sick call process allows detainees to access non-emergent medical services, and all facilities are required to have regularly scheduled times when medical personnel will be available to see detainees who have requested services.” *Id.*

119. *Id.*

120. *Id.* at 7.

followed by the facilities housing immigration detainees.¹²¹ An Office of the Inspector General investigation showed that four of the five ICE facilities audited were not following ICE standards.¹²² Even by the Division of Immigration Health Services' own numbers, they provided intake screenings to just forty percent of the detainees reported to have gone through the detention system during fiscal year 2007.¹²³ As demonstrated by the stories of Mr. Bah and Mr. Castaneda,¹²⁴ the many other individuals who have died in custody,¹²⁵ and the scores of others who suffer from inadequate care, this is not enough.

B. Proposed Legislation: Detainee Basic Medical Treatment Act of 2008

Legislators presented the Detainee Basic Medical Treatment Act of 2008 in the House,¹²⁶ with sister legislation in the Senate.¹²⁷ This legislation marks a significant change in the way medical staff administer treatment to detainees. The Act requires staff to conduct initial examinations, explore continuing care, provide an administrative appeals process for rejected treatment, and regularly report all detainee deaths.

1. Medical Treatment of Detainees

The Act requires the Secretary of Homeland Security "to establish procedures for the timely and effective delivery of medical and mental health care to all immigration detainees in custody . . ."¹²⁸ These procedures must cover "primary care, emergency care, chronic care, prenatal care, dental care, eye care, mental health care, medical dietary needs, and other medically necessary specialized care."¹²⁹ The Act specifically compels facilities to provide an initial medical screening upon the arrival of a detainee, and a second examination within fourteen days after

121. See SISKIN, *supra* note 13, at 16.

122. *Id.*

123. The Department of Immigration Health Services reported providing 138,000 intake screenings in fiscal year 2007. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 6 (statement of Gary E. Mead, Assistant Director for Detention and Removal, U.S. Immigration and Customs Enforcement). ICE detained a total of 311,213 individuals during that same year. SISKIN, *supra* note 13, at 26 fig.1.

124. See *supra* Introduction.

125. See SISKIN, *supra* note 13 and accompanying text.

126. *Id.* at 23.

127. See *id.*

128. H.R. 5950, 110th Cong. (2008).

129. *Id.* § 2(a).

the individual's arrival at the detention center.¹³⁰ Additionally, the Act requires the continuation of all prescribed medications, and that all detainees be informed of available services for continuing care.¹³¹

2. General Provisions on Detention and Facilities

The Act applies to all facilities that house immigration detainees for more than seventy-two hours, regardless of whether a facility is subject to a contract or other agreement.¹³² Any detainee with a serious medical or mental health condition receives priority consideration for release on parole, bond, or alternative detention program.¹³³ The Act requires those who are not initially released through these programs to be periodically reevaluated.¹³⁴

3. Transparency and Oversight

The Act requires facilities to make all medical records available to detainees, as well as to the receiving facility if a detainee is transferred.¹³⁵ Moreover, the Act provides an administrative appeals process for denied medical treatment, requiring a final determination on the matter within thirty days.¹³⁶ The appeals process requires the Secretary of Homeland Security to respond "promptly to any request by an on-site medical provider for authorization to provide medical or mental health care to an immigration detainee."¹³⁷ If the Secretary denies or fails to grant the request, he or she must provide a written explanation as to why the treatment was not approved.¹³⁸ Both the detainee and the medical provider have an opportunity to appeal that denial or failure to grant medical care. An impartial board, to include health care professionals in the field, must make a written

130. *Id.* § 2(b)(1)–(2).

131. *Id.* § 2(b)(3)–(2)(c).

132. *Id.* § 3(1).

133. *Id.* § 2(b)(4). "Parole," in immigration law, gives the noncitizen temporary permission to enter and live in the United States, though a parolee's status may expire and the parolee may be forced to leave. SISKIN, *supra* note 13, at 2 n.8.

134. H.R. 5950, § 2(b)(4).

135. *Id.* § 2(d).

136. *Id.* § 2(e).

137. *Id.* § 2(e)(1). A detention center has an "on-site medical provider" when there is a medical facility located within the detention facility itself. *See* SISKIN, *supra* note 13, at 7–8. Only fifteen of the more than 300 DIHS immigration detention facilities have on-site providers, as most local or county jails are completely unequipped to have such resources. *See id.* at 8.

138. H.R. 5950, § 2(e)(2).

decision on the appeal within thirty days.¹³⁹

Finally, facilities must report all deaths to the Office of the Inspector General for the Department of Homeland Security and the Department of Justice within forty-eight hours.¹⁴⁰ The facilities must also provide the Committees on the Judiciary of both the House and Senate with annual reports including detailed information regarding the deaths of all detainees during the previous fiscal year.¹⁴¹

III. Evaluating the Sufficiency of the Proposed Legislation

The Detainee Basic Medical Care Act of 2008 is bare-bones legislation. While any legislation codifying medical standards in these facilities would be a step in the right direction, the Act has a number of issues that prevent it from sufficiently solving the medical crisis for noncitizens in immigration detention. The purpose of the Act is to assure the “timely and effective delivery of medical and mental health care”¹⁴² for all immigration detainees. Doctors and humanitarian organizations, outraged at the quality of service currently provided in these facilities, support this purpose.¹⁴³ The Act as currently written, however, is unlikely to achieve that purpose because its provisions repeat many of the policies from the ICE Detention Operations Manual¹⁴⁴ without including specific language to fix identified problems. The Act also fails to incorporate a number of provisions that are lacking in the Detention Operations Manual.

A. Medical Treatment of Detainees

As described in Part II.B., the Act sets forth a minimum requirement that each immigration detainee must receive a comprehensive medical and mental health intake screening upon arrival, as well as an examination and assessment no later than fourteen days after arrival.¹⁴⁵ These provisions are not new—they only codify the existing policies from the Detention Operations

139. *Id.* § 2(e)(3)–(4).

140. *Id.* § 2(g).

141. *Id.*

142. *Id.* § 2(a).

143. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 68 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center); *id.* at 61 (statement of Allen S. Keller, M.D., Associate Professor of Medicine, New York University School of Medicine); *id.* at 53 (statement of Tom Jawetz, Detention Staff Attorney, ACLU National Prison Project).

144. U.S. IMMIGR. AND CUSTOMS ENFORCEMENT, *supra* note 87.

145. H.R. 5950, § 2(b)(1)–(2).

Manual.¹⁴⁶ While the timing of the screening and examination are appropriate, the provision is vague as to who will perform these examinations. The provisions require a “qualified health care professional”¹⁴⁷ to perform these screenings and examinations, which could be interpreted to allow a nurse or Managed Care Coordinator, rather than a physician, to conduct the examinations. Because misdiagnoses have resulted in deaths,¹⁴⁸ it is important that the staff providing these screenings be well-trained with strong medical backgrounds.

The Act also does not require that there be on-site medical staff.¹⁴⁹ The few facilities that have had on-site Health Services medical personnel have provided better care than other facilities, especially county jails, which are not designed for long-term care.¹⁵⁰ Currently, when any off-site medical care is requested, Health Services must approve that care regardless of where the noncitizen is detained.¹⁵¹ The approvals emanate from nurses—not physicians—in Washington, D.C. who only review the files and have no contact with detainees.¹⁵² In addition to ensuring impersonal health treatment, waiting for bureaucratic approval significantly slows the administration of care. For detainees who have serious medical problems, a delay of even hours could have a significant impact. Thus, ensuring that each facility has on-site medical personnel would provide better access to care for all detainees.

The Act also requires that each detainee taking prescribed medications be allowed to continue those medications, “on schedule and without interruption,” unless a medical professional decides upon an alternative course of treatment.¹⁵³ While this is an extremely important provision, especially for the diabetic and HIV/AIDS populations, it does not necessarily cover all individuals

146. U.S. IMMIGR. AND CUSTOMS ENFORCEMENT, *supra* note 87, at 3.

147. H.R. 5950, § 2(b)(1)–(2).

148. *See, e.g.*, Nina Bernstein, *Federal Report Recommends Improvements in Reporting Deaths of Immigrant Detainees*, N.Y. TIMES, July 3, 2008, at A20 (describing the cases of two detainees who died after ICE staff overlooked their symptoms).

149. H.R. 5950, § 2.

150. SISKIN, *supra* note 13, at 8. Health Services provides on-site care at just fifteen of over 300 facilities, “while in the others, mostly for detainees in local prisons and jails, health care is provided by contract workers who are not affiliated with [Health Services].” *Id.*

151. *Id.* at 9.

152. *Hearing on Immigration Detainee Medical Care, supra* note 15, at 119 (statement of Rep. Zoe Lofgren, Chairwoman, Subcomm. on Immigration, Citizenship, Refugees, Border Security, and International Law).

153. H.R. 5950, § 2(b)(3).

who need new prescriptions while in detention.¹⁵⁴ In addition, some local or county facilities have been forced to purchase over-the-counter medications, limiting the quality of medications available to the detainee.¹⁵⁵ This practice violates Detention Operations Manual standards, which require that facilities have access to on-site or local pharmacies to get medications for their detainees.¹⁵⁶ The Act needs to clearly state that the detainees must have access to both currently-prescribed medications and newly-prescribed medications, and that those medications be prescription quality, not over-the-counter.

Furthermore, the “continuity of care” provisions do not explicitly state that treatment must adequately address all medical and mental health issues discovered in the screenings and examinations.¹⁵⁷ The current Health Services Medical Dental Detainee Covered Services Package specifically limits coverage primarily to emergency care, defined as “a condition that is threatening to life, limb, hearing or sight.”¹⁵⁸ This definition requires that all non-emergency care receive preauthorization.¹⁵⁹ The Act vaguely states that detainees shall receive all “medically necessary treatment,” without defining what that term means or what care would be included.¹⁶⁰ This lack of specificity could permit Health Services to continue limiting care to its own definition of “emergency care,” forcing detainees to continue waiting weeks or months for basic care.¹⁶¹ It also allows Health

154. H.R. 5950, § 2(c)(4) (stating that “prescribed medications and medically necessary treatment are provided to immigration detainees on schedule and without interruption.”) It does not, however, clearly indicate whether the provision would cover newly-prescribed medications. *Id.* Because detainees have been denied medications on countless occasions in the past, clarity in this provision is imperative. See, e.g., *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 90–91 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center); *id.* at 121–38 (statement of Immigration Equality, et al.) (detailing stories of HIV-positive detainees who suffered medical consequences as a result of being denied their medications).

155. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 99 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center).

156. U.S. IMMIGR. AND CUSTOMS ENFORCEMENT, *supra* note 87, at 2.

157. H.R. 5950, § 2(c).

158. U.S. Dep’t of Homeland Sec., DIHS Medical Dental Detainee Covered Services Package, available at <http://www.inshealth.org> (follow “Managed Care” tab; then follow “Benefits Package” hyperlink) (last visited Nov. 11, 2009).

159. SISKIN, *supra* note 13, at 10–11.

160. H.R. 5950, § 2(c)(4).

161. See SISKIN, *supra* note 13, at 13. “According to a 2007 GAO report, officials at several detention facilities reported difficulties obtaining approval for outside medical and mental health care.” *Id.* (citing U.S. GOV’T ACCOUNTABILITY OFFICE, ALIEN DETENTION STANDARDS: TELEPHONE ACCESS PROBLEMS WERE PERVASIVE AT

Services to characterize diagnostic tests, such as biopsies, as “elective surgeries” causing other detainees to suffer as Mr. Castaneda did.¹⁶²

The Act’s failure to define “medically necessary treatment” means it is silent about care for “pre-existing conditions,” such as HIV/AIDS, diabetes, and pregnancy. The Act also does not address regular gynecological care and mammograms for women, which have been issues for many female detainees.¹⁶³ For example, one woman detained in Florida brought her symptoms to the attention of medical staff on December 18, 2003.¹⁶⁴ Though she had classic symptoms of an ectopic pregnancy, a painful and potentially fatal condition, she was simply given Tylenol.¹⁶⁵ Even when she began to bleed profusely, the staff did not take her seriously.¹⁶⁶ Weeks later, when she was finally allowed to see a doctor, she was immediately taken to the hospital for surgery.¹⁶⁷ For the Act to ensure that detainees receive adequate care, the legislature should fill these gaps in the provision’s language by adding a clearer definition of what “medically necessary treatment” includes.

B. General Provisions on Detention and Facilities

Importantly, the Act includes a provision requiring that ICE give detainees with medical problems preference for alternatives to detention, such as release on parole, bond, or other alternative programs.¹⁶⁸ While the U.S. government has begun alternative programs,¹⁶⁹ it has not implemented these programs on a wide

DETENTION FACILITIES; OTHER DEFICIENCIES DID NOT SHOW A PATTERN OF NONCOMPLIANCE 18 (2007)).

162. *Id.* at 12.

163. See *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 99 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center); see also SOUTHWEST INST. FOR RESEARCH ON WOMEN, ET AL., UNSEEN PRISONERS: A REPORT ON WOMEN IN IMMIGRATION DETENTION FACILITIES IN ARIZONA (2009), available at <http://sirow.arizona.edu/files/UnseenPrisoners.pdf> (providing an in-depth examination of the problems faced by female detainees and recommendations for policy changes to address those problems).

164. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 69 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center).

165. *Id.*

166. *Id.*

167. *Id.* at 70.

168. H.R. 5950, 110th Cong. § 2(b)(4) (2008).

169. DHS began the Intensive Supervision Appearance Program in 2004, at eight pilot sites (Baltimore, Philadelphia, Miami, St. Paul, Denver, Kansas City, San Francisco, and Portland), with up to 200 noncitizen participants at each site. Ice Unveils New Alternative, *supra* note 76. The program uses tools such as

scale.¹⁷⁰ The main issue with this provision in the Act is that the release must be “subject to the [current] immigration laws.”¹⁷¹ This requirement means that ICE will continue to operate within the current laws, which require mandatory detention for many noncitizens.¹⁷² Nearly every humanitarian group or non-governmental organization that has provided recommendations on this matter stresses the importance of using these alternative programs.¹⁷³ Thus, a revision of the mandatory detention procedures is a necessary component of any legislation regarding the treatment of immigration detainees.

Even with a revision of the mandatory detention procedures, there are still serious problems with the facilities in which the immigration detainees are housed.¹⁷⁴ The Act does not include a provision for monitoring facilities or for any kind of performance assessment to ensure that standards are adequate. As ICE has assessed many facilities with glaring problems in medical treatment as “acceptable,” such provisions are necessary to ensure that detainees are not placed in facilities known to violate the Act’s requirements.¹⁷⁵

Furthermore, there is no provision that explicitly prevents staff from retaliating against detainees who complain about treatment on their own behalf, or on behalf of other detainees—a practice that has been widely reported.¹⁷⁶ There is also no

curfews and electronic monitoring to intensely supervise noncitizens released into the community to ensure their appearance at their immigration hearings and compliance with immigration judges’ orders. *Id.* Levels of restrictions decrease as the participants demonstrate compliance. *Id.* The program is only available to those who are not subject to mandatory detention and the participants must volunteer for the program. *Id.*

170. *Id.*

171. H.R. 5950, § 2(b)(4).

172. U.S. IMMIGR. AND CUSTOMS ENFORCEMENT, *supra* note 87, at 1–2.

173. See *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 67 (statement of Allen S. Keller, M.D., Associate Professor of Medicine, New York University School of Medicine). In addition to the Florida Immigrant Advocacy Center, the ACLU, the Bellevue/NYU Program for Torture Survivors, Lutheran Immigrant and Refugee Services, the Women’s Commission for Refugee Women and Children, and Human Rights Watch, ninety-two other organizations expressed their strong support for the use of alternatives to detention, as well as a number of other important provisions that are discussed in this Article. *Id.* at 153–58 (statement of Human Rights Watch).

174. See SISKIN, *supra* note 13, at 19–23 (outlining health care procedures at facilities for detained asylum seekers).

175. See OFF. OF AUDITS, *supra* note 115, at 22–23.

176. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 56–57 (statement of Tom Jawetz, Detention Staff Attorney, ACLU National Prison Project); see also *id.* at 99 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center). In order to protect detainees from retaliatory action,

provision prohibiting ICE from putting detainees suffering from medical ailments in solitary confinement. As with Mr. Bah, such an action is inhumane and prevents adequate monitoring of a medical condition.¹⁷⁷ To adequately address such situations, ICE must make their policies more transparent.¹⁷⁸

C. *Transparency and Oversight*

The Act's administrative appeals process will ensure that any denied medical treatment is reviewed by an impartial board of medical providers.¹⁷⁹ This process is a marked change from current Health Services policy, in which the Managed Care Review Committee, comprised of the Health Services Medical Director, consultants, and Managed Care Coordinators, conduct reviews.¹⁸⁰ Outside of this appeals process for denied treatment, however, there are no processes for complaints.

The Act requires ICE to report deaths to the Offices of the Inspector General for the DHS and the Department of Justice within forty-eight hours,¹⁸¹ and to prepare annual reports to the Committees on the Judiciary for both houses of Congress.¹⁸² While important, this provision, does not detail what information on the detainee or the death is required in the report. The current list of deaths that ICE has reported contained errors in the spelling of detainees' names, as well as inaccurate or missing alien numbers that prevented verification.¹⁸³

The Act should require the noncitizen's full name, date of birth, and alien number, as well as detailed information regarding the date the detainee entered the facility and all information regarding the detainee's death. The Act should also contain provisions to ensure the reported cause of death is not vague or

the Act should include a whistleblower-type provision prohibiting transfers, punishment, and any retaliatory action against detainees for requesting medical care or for complaining about the quality of care given.

177. See *supra* notes 1–5 and accompanying text.

178. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 131 (statement of Immigration Equality, et al.) (recommending the establishment of an ombudsman to oversee grievances filed by detainees against staff).

179. See *supra* notes 136–139 and accompanying text.

180. SISKIN, *supra* note 13, at 12.

181. H.R. 5950, 110th Cong. § 2(g) (2008).

182. *Id.*

183. See *Immigration Agency's List of Deaths in Custody*, N.Y. TIMES, May 5, 2008, [http://www.nytimes.com/2008/05/05/nyregion/05detain-list.html?scp=1&sq=immigration agency's list of deaths in custody&st=cse](http://www.nytimes.com/2008/05/05/nyregion/05detain-list.html?scp=1&sq=immigration%20agency's%20list%20of%20deaths%20in%20custody&st=cse). (“But errors and omissions on the list made it difficult for The Times to confirm the identities of many whose deaths had not previously come to public attention, to find out why they died, or to locate relatives.”).

misleading, as it was for some detainees on ICE's recently-released list.¹⁸⁴ For example, one El Salvadoran detainee hung himself in his cell after begging unsuccessfully for days for his prescribed pain medications from his leg surgery.¹⁸⁵ In cases such as this, simply reporting the death as a suicide without releasing detailed information on the surrounding circumstances leading up to the death would mislead Congress. Many humanitarian organizations are calling for public release of information on the deaths of all detainees.¹⁸⁶ Reporting this information on ICE's website or through another public avenue would ensure public oversight.

Significantly, there is no enforcement mechanism within the Act. Separate legislation on the provision of emergency medical care in other contexts includes civil monetary penalties—against both the facility and physician—for negligently violating certain requirements, as well as civil enforcement provisions granting a private right of action.¹⁸⁷ Such provisions would strengthen the Act by holding facilities and physicians financially accountable for their actions.

Finally, there is no provision requiring investigation into cases where detainees have died in detention facilities. According to current ICE standards, Health Services conducts an independent review of all in-custody deaths.¹⁸⁸ These investigations never happen in many cases, like Mr. Bah's,¹⁸⁹ demonstrating a need for codification of this investigatory duty.

IV. Components of Ideal Legislation

There is clearly a need to change the Detainee Basic Medical Care Act legislation to better address problems in the administration of immigration detention health care. ICE is working to make changes to their standards, such as making the

184. *Id.* (“[T]he list includes cryptic causes of death like ‘unresponsive’ and ‘undetermined.’ The list does not mention the immigrants’ nationalities or where they lived in the United States. Some names and birth dates appear garbled.”).

185. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 164 (statement of The Legal Aid Society).

186. *See* THE DETENTION OF IMMIGRANT FAMILIES, *supra* note 97, at 9 (discussing the current lack of oversight and accountability for standards of care and custody in immigration detention).

187. *See, e.g.*, 42 U.S.C. § 1395dd(d)(1)–(2) (2006) (creating enforcement provisions regarding the examination and treatment for emergency medical conditions and women in labor).

188. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 7 (statement of Gary E. Mead, Assistant Director for Detention and Removal, U.S. Immigration and Customs Enforcement).

189. *See supra* notes 1–5 and accompanying text.

board who reviews denied claims impartial¹⁹⁰ and implementing a new performance-based program to put more pressure on facilities to follow the non-mandatory medical standards.¹⁹¹ Because of these steps, it is possible that the Secretary of the Department of Health Services will only modify the existing medical provisions with slight alterations to fit the minimum requirements under the Act. Therefore, it is especially important that Congress be explicit in listing required minimum considerations to provide adequate health care for immigration detainees. Without such clarity from the legislature, there is no guarantee that facilities will address identified problems with the Detention Operations Manual standards. The goal is not “Cadillac health care,” but rather that the United States provides a level of care to ensure that detainees’ health does not deteriorate, lead to unnecessary pain and suffering, or result in preventable deaths.

A. *Necessary Components of Legislation*

To adequately administer health care to immigration detainees, there are a number of provisions that should be added or modified in the Act.

1. Medical Treatment of Detainees

First, the Act should clearly state that a physician, not a nurse or physician’s assistant, must perform the initial screening and comprehensive examination. The Act must also clearly state that on-site medical staff be available. This provision would limit the amount of off-site medical treatment requiring preauthorization, and thus would hasten access to care. This change would not represent a marked difference from existing ICE standards which, in theory, require that all detainees have access to “sick call.”¹⁹² Ensuring that available staff be properly trained, however, would increase the quality of care given to detainees.

Additionally, the Act needs to specify that detainees will have access to both previously-prescribed and newly-prescribed medications while in detention. It must also state that neither local or county facilities, nor individual detainees, will have to purchase over-the-counter drugs at marked-up prices. Rather, detainees in all facilities should have access to the same

190. SISKIN, *supra* note 13, at 12.

191. U.S. Immigration and Customs Enforcement, ICE Performance Based National Detention Standards (Nov. 20, 2008), www.ice.gov/pi/news/factsheets/detention_standards.htm.

192. *See supra* note 118.

prescription-quality medications.

Any “continuity of care” provisions must explicitly state that treatment shall adequately address all medical and mental health issues discovered during screenings and examinations. This requirement would expand the current Health Services Medical Detainee Covered Services Package, which limits care to emergencies, to cover all treatment.¹⁹³ The Act need only include a definition of all “medically necessary treatment”¹⁹⁴ to ensure that all discovered medical conditions are treated, including “pre-existing conditions” such as HIV/AIDS and diabetes, as well as regular gynecological care and mammograms for women.

2. General Provisions on Detention and Facilities

The mandatory detention provisions of the INA must be revised to allow facilities to make individual assessments of flight risks and security threats for each noncitizen. Noncitizens should be allowed to participate in alternatives to detention, supervised release, or release on their own recognizance, unless they are found to be a flight risk or security threat. Policymakers have introduced a number of amendments to the Immigration and Nationality Act that are currently pending in Congress that would encourage the use of alternatives to detention.¹⁹⁵ Though comprehensive immigration reform is necessary, changing current laws to give immigration judges discretion to impose alternative programs instead of detention, especially for detainees who may have medical problems, is a crucial first step.¹⁹⁶

Additionally, the policy of housing immigration detainees with criminal detainees must be changed so that officials treat immigration detainees respectfully and appropriately, with the higher level of rights accorded to them as civil detainees.¹⁹⁷ The staff at these facilities must be trained on the specific needs of immigration detainees, and the facilities must take steps to address the cultural differences of those being held there.¹⁹⁸

The Act must explicitly prohibit retaliatory action against

193. SISKIN, *supra* note 14, at 10–11.

194. H.R. 5950, 110th Cong. § 2(c)(4) (2008).

195. *See* Immigration and Nationality Act § 236, 8 U.S.C. § 1226(c)(1) (2006).

196. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 172 (statement of Lutheran Immigration and Refugee Service and Bishops of the Evangelical Lutheran Church in America).

197. *See* Jones v. Blanas, 393 F.3d 918, 934 (9th Cir. 2004) (holding that immigration detainees be accorded a higher level of respect and treatment than criminal detainees).

198. *See supra* notes 94–103 and accompanying text.

detainees who complain about treatment on their own behalf, or on behalf of other detainees.¹⁹⁹ Furthermore, the Act must require ICE to clearly outline their policies on solitary confinement and ensure that such detention is not used for detainees who are suffering from medical problems.

3. Transparency and Oversight

The Act must go farther than just the impartial review of all denied claims.²⁰⁰ It must require creation of other processes for complaints by clearly stating which division of the U.S. government is responsible for the oversight of immigration detention. Additionally, it must create a separate appeals process for reporting complaints.

The legislation must specify clear reporting requirements for information such as the detainee's name, date of birth, alien number, and all other information required to unmistakably identify the person, and all the circumstances of that person's death. A stronger enforcement mechanism that would hold facilities financially accountable for their acts is also needed. The Act must provide guidelines for monitoring the facilities or for performance assessment to ensure that standards are adequate. It must also codify a requirement of an independent review of all in-custody deaths.²⁰¹

B. Barriers to Health Care Legislation for Immigration Detainees

There are many barriers to achieving adequate health care legislation for detainees. It is especially difficult to discuss the need for comprehensive care for noncitizens in immigration detention when forty-six million U.S. citizens have no health insurance and face a number of obstacles to receiving health care.²⁰² Further, in the face of the current economic crisis, the ability of the government to fund such programs is a barrier to implementation of legislation on health care for immigrant detainees. Finally, national security concerns must be incorporated into any legislation on immigration detention to

199. See *supra* note 176.

200. See *supra* Part II.B.3.

201. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 7 (statement of Gary E. Mead, Assistant Director for Detention and Removal, U.S. Immigration and Customs Enforcement).

202. See CARMEN DENAVAS-WALT, ET AL., INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007 19 (2008), <http://www.census.gov/prod/2008pubs/p60-235.pdf>.

ensure the safety of all persons living in the United States.

1. Cost of Administering Physical and Mental Health Care

The cost of administering health care to noncitizens in immigration detention is a valid concern. While ICE's office of Detention and Removal Operations faced funding cuts between fiscal years 2003 and 2007,²⁰³ the total amount spent on medical care for immigration detainees increased by eighty-three percent, from fifty million dollars to ninety-two million dollars.²⁰⁴ The government, however, has spent two-thirds of this money on program operations, with the amount spent on medical claims actually decreasing from fiscal years 2004 to 2005 and staying nearly stagnant from fiscal years 2005 to 2007.²⁰⁵

The most effective way to diminish the costs of immigration detention is to reform the current detention system to first use alternatives to detention, and to use detention only when a noncitizen is a threat to the community or a flight risk. According to the American Immigration Lawyers Association, the cost of detaining a noncitizen averages about ninety-five dollars per person, per day, while the cost of an alternative program is twelve dollars per person, per day.²⁰⁶ Noncitizens released through these alternative programs still have an estimated ninety-three to ninety-eight percent appearance rate in subsequent immigration proceedings.²⁰⁷ Additionally, more than half of those detained in immigration detention do not have criminal backgrounds.²⁰⁸ Many detainees are heavily involved in their communities and pose no safety or flight risk.²⁰⁹ Detention incurs unnecessary costs that could easily be avoided by using alternative programs.²¹⁰

203. OFF. OF AUDITS, *supra* note 74, at 11.

204. SISKIN, *supra* note 13, at 18.

205. *Id.* Program operations refer to the operational costs for the program area, while medical claims are services rendered by off-site health care providers. *Id.* The amount spent on medical claims was just over forty million dollars in fiscal year 2004, but dropped to around thirty million dollars in fiscal year 2005, where it has remained relatively stagnant. *Id.*

206. See AMERICAN IMMIGRATION LAWYERS ASSOCIATION, ALTERNATIVES TO DETENTION, available at http://www.bibdaily.com/pdfs/AILA_alternatives_to_detention.pdf.

207. *Id.*

208. SISKIN, *supra* note 13, at 4.

209. See AMERICAN IMMIGRATION LAWYERS ASSOCIATION, *supra* note 206.

210. *Id.* Community-based alternatives to detention programs utilize less restrictive means. *Id.* Many of these programs provide "case management services, legal orientation for participants and facilitate access to counsel [and] have been shown to substantially increase program compliance without the

Furthermore, policy makers should be reticent to approve detention of asylum seekers, as many of these individuals are torture survivors and have suffered arbitrary detention in their home countries.²¹¹ The same experiences that are often the bedrock of asylum claims put these asylum-seekers at a significant risk of suffering post-traumatic stress and other mental health issues. These issues are amplified when they are placed in detention while awaiting their credible fear hearing or the outcome of their asylum claim.²¹² It is especially important that officials put these individuals into alternative programs, rather than subject them to mandatory detention under the current law.²¹³

Another way to diminish the costs of providing healthcare to noncitizens in detention is to create a procedure to allow those with existing health insurance to use their personal policies. While a number of detainees are likely to be uninsured, many detainees have complained that they have medical coverage and would have been able to receive significantly better care had they been allowed to use their personal insurance plans.²¹⁴

A complete economic analysis outlining the potential funding sources for the Act is outside the scope of this Article. However, there are many ways policymakers can overhaul the current system to maximize the benefit of money spent on these programs. The most significant benefit can be realized by reducing the number of noncitizens who are detained by using alternative programs.²¹⁵

2. National Security Concerns

The strain placed on the current detention system negatively affects ICE's ability to combat terrorism.²¹⁶ The significant amount of resources allocated to mandatory detention programs limits ICE's ability to detain high risk and high priority noncitizens believed by the Department of Homeland Security to

extensive use of electronic monitoring." *Id.*

211. See PHYSICIANS FOR HUMAN RIGHTS & THE BELLEVUE/NYU PROGRAM FOR SURVIVORS OF TORTURE, *supra* note 72.

212. *Id.*

213. See Johnson, *supra* note 72, at 618–19.

214. *Hearing on Immigration Detainee Medical Care*, *supra* note 15, at 73 (statement of Cheryl Little, Executive Director, Florida Immigrant Advocacy Center).

215. See AMERICAN IMMIGRATION LAWYERS ASSOCIATION, *supra* note 206.

216. See OFF. OF AUDITS, *supra* note 74, at 4–6.

pose national security or public safety risks.²¹⁷ Furthermore, ICE's office of Detention and Removal Operations states that its efforts to apprehend terrorists or nationals suspected to be from countries supporting terrorism are threatened by the decrease in the amount of bed-space and the number of personnel.²¹⁸

To adequately address all national security concerns pertaining to immigration, there must be comprehensive immigration reform.²¹⁹ That reform must begin with significant changes in the mandatory detention program that would allow the Department of Homeland Security to detain only those noncitizens with serious criminal backgrounds or those with high risks of absconding, and use alternatives to detention for those who do not. Regardless, the economic and security concerns related to immigration detention do not diminish the U.S. government's obligation to protect the basic human rights of those whom they hold in custody.

Conclusion

Changes in immigration law and policy following the 1996 addition of the IIRIRA and post-9/11 detention policies have had an enormous impact on noncitizens and their families, and have resulted in a health-care crisis in immigration detention facilities. Overburdened facilities are unable to meet the basic health demands of the tens of thousands of detainees they hold each day. The U.S. government must be held accountable for its lack of adequate policies to guarantee basic care. Existing medical policies must be improved and codified, with clear legislation detailing exactly what is required of detention center personnel. The government must also reexamine current immigration laws on detention and recognize the adverse effects they have had on medical care in detention facilities. Adjusting detention policies to allow for alternative programs for all noncitizens who do not pose either a security risk or a flight risk would ease the burden on these facilities, reduce overcrowding, and diminish the total costs to U.S. taxpayers. It would also allow facilities to provide a level of medical care consistent with the detainees' constitutional and human rights. All immigration detainees have an irrefutable right

217. *Id.* at 5–6.

218. *See id.* at 4.

219. For more information on comprehensive immigration reform and on current proposals in Congress, see the National Immigration Law Center's website on Comprehensive Immigration Reform, <http://www.nilc.org/immlawpolicy/CIR/index.htm> (last visited Nov. 3, 2009).

to basic health care that must be satisfied at all times and without exception.

