December 2, 2022

Ada I. Rivera, MD
Deputy Assistant Director for Clinical Services/Medical Director
ICE Health Service Corps
Enforcement Removal Operations
U.S. Immigration and Customs Enforcement
500 12th Street, SW
Washington, DC 20536

Via Electronic Mail

RE: Acute Medical and Mental Health Crisis in Torrance County Detention Facility

Dear Dr. Rivera:

The American Civil Liberties Union of New Mexico (ACLU-NM), Innovation Law Lab, New Mexico Immigrant Law Center, Las Americas Immigrant Advocacy Center, Justice For Our Neighbors (JFON) El Paso and Santa Fe Dreamers Project write to request that your office take immediate action regarding the acute and ongoing medical and mental health crisis that individuals detained in the custody of U.S. Immigration and Customs Enforcement (ICE) are subjected to in the Torrance County Detention Facility (TCDF) in Estancia, New Mexico, which is operated by CoreCivic. The ICE Health Service Corps (IHSC) has a vital role to play in protecting life and ensuring safety for asylum-seekers who remain detained in this dangerous facility.

Although TCDF is not an IHSC-staffed facility—the healthcare providers there are CoreCivic personnel—it is of vital importance that IHSC robustly exercise its authority to monitor and recommend appropriate action regarding the inadequate medical and mental healthcare provided by this ICE subcontractor. Indeed, the Intergovernmental Service Agreement (IGSA) itself provides that IHSC must have reasonable access to the facility and detained individuals' medical records, including for the purpose of conducting a quality improvement/quality of care review.

We are attaching for your review a report prepared by Humanitarian Outreach for Migrant Emotional Health (HOME), whose licensed professionals' findings regarding the

conditions of confinement in TCDF shock the conscience. At the request of Innovation Law Lab, Las Americas Immigrant Advocacy Center, and other direct legal service providers, beginning in October 2021 HOME clinicians conducted interviews with individuals detained in TCDF and reviewed medical and mental health records. They found:

- Grievous shortfalls in the TCDF suicide prevention protocols and practices as compared to evidence-based best practices;
- Fear among asylum-seekers detained in the TCDF of disclosing suicidal thoughts to TCDF healthcare staff due to the risk of being placed in solitary confinement; and
- Serious and disturbing inadequacies in the TCDF mental healthcare records.

The asylum-seekers who remain detained in TCDF today have been stripped of their dignity, deprived of their support networks, and subjected to degrading conditions that have caused many to actively consider self-harm and/or suicide. Some have been in and out of suicide watch repeatedly. They recognize how being placed in isolation causes their mental health to deteriorate even more rapidly. TCDF healthcare providers have exhorted them to "think positively" rather than providing appropriate care. These asylum-seekers have seen ICE release their friends from custody, while they remain detained without justification. Every one of them has a pathway to relief from deportation and each is eligible for release from ICE custody.

The current medical and mental health crisis in TCDF should not be a surprise to ICE given the facility's track record. The ICE Office of Professional Responsibility (OPR) Office of Detention Oversight (ODO) conducted an inspection of TCDF in late October 2022. Its preliminary findings included failures by facility personnel to document required monitoring of individuals on suicide watch. Just prior to that, in September 2022, the DHS Office of Inspector General disclosed findings on TCDF including: medical staff shortages impacted the level of care asylum-seekers received for suicide watch; healthcare personnel were not familiar with basic guidelines for standards of care; and the facility routinely falsified medical records regarding the administration of medication.[1] To highlight just one example of the chronic and unresolved staffing issues at TCDF, as of July 2022 the facility had been trying to fill a vacant licensed practical nurse (LPN) position for more than 27 months. Three other LPN positions had been vacant for more than 16 months. The ODO inspection report issued in May 2022 documented as a "repeat deficiency" the clinical medical authority's failure to review detained people's health assessments to determine the priority for treatment.[2] As early as January 2021, when ICE rejected CoreCivic's response to the agency's December 2020 Contract Discrepancy Report (CDR), ICE highlighted that the chief medical officer, another doctor, and a nurse practitioner were providing only part time medical service at TCDF because they were "floating" between facilities, in violation of CoreCivic's contractual obligations. ICE's continued use of TCDF in the face of this mounting evidence speaks volumes.

[1] U.S. Dep't of Homeland Sec. Ofc. of Inspector Gen., OIG-22-75, *Violations of ICE Detention Standards at Torrance County Detention Facility* (Sept. 28, 2022), https://www.oig.dhs.gov/sites/default/files/assets/2022-09/OIG-22-75-Sep22.pdf.

[2] U.S. Dep't of Homeland Sec. Imm. & Customs Enf., *Office of Detention Oversight Unannounced Compliance Inspection: Torrance County Detention Facility, May 3-5, 2022*, at 8, https://www.ice.gov/doclib/foia/odo-compliance-inspections/torranceCoDetFacEstanciaNM_May3-5_2022.pdf.

There are currently only 11 asylum-seekers detained in ICE custody in TCDF, while the facility is holding open—and ICE is paying for—empty beds for the detention of up to 505 individuals under the guaranteed minimum set forth in the IGSA.[3] Since the death of Kesley Vial following his fatal suicide attempt while in ICE custody in TCDF on August 17, 2022, ICE has refrained from transferring additional individuals into TCDF. We have reason to believe that ICE is considering resuming new transfers into the facility in the coming weeks. Your office's urgent intervention is needed to block any such action.

Given these concerns and the gravity of these issues, and in light of the recent findings by the HOME clinicians detailed here, our organizations recommend the following:

- IHSC should conduct an urgent investigation on the quality of medical and mental health services in TCDF;
- IHSC should issue a recommendation to ICE leadership endorsing the immediate release from ICE custody of all individuals who remain detained in the facility; and
- IHSC should issue a recommendation to ICE leadership in favor of the termination of the Intergovernmental Service Agreement between ICE and Torrance County.

Thank you for your prompt attention to this matter. For any questions or additional information please contact Rebecca Sheff at rsheff@aclu-nm.org.

Sincerely,

Rebecca Sheff
Senior Staff Attorney
ACLU of New Mexico

Sophia Genovese
Senior Attorney
New Mexico Immigrant Law Center

Ian Philabaum
Co-director, Anticarceral Legal Organizing
Innovation Law Lab

Zoe Bowman
Supervising Attorney, Detained Deportation Defense Team
Las Americas Immigrant Advocacy Center

Jannette Mondragón
Staff Attorney
JFON El Paso

Emma O'Sullivan
Executive Director
Santa Fe Dreamers Project

[3] Joshua Bowling, "Immigration Invoice," SEARCHLIGHT NEW MEXICO (Nov. 23, 2022), https://searchlightnm.org/immigration-invoice/.

cc: DHS Office of Inspector General
DHS Office of Civil Rights and Civil Liberties
DHS Office of the Immigration Detention Ombudsman
ICE/OAQ Contracting Officer (TCDF)
ICE/ERO El Paso Field Office Director
Sen. Martin Heinrich
Sen. Ben Ray Luján
Rep. Melanie Stansbury
Sen. Dick Durbin, Chairman, Senate Judiciary Committee
Sen. Jon Ossoff, Chairman, Senate Permanent Subcommittee on Investigations, Homeland Security
Sen. Patty Murray, Chairwoman, Senate Committee on Health, Education, Labor & Pensions
Rep. Carolyn B. Maloney, Chairwoman, House Committee on Oversight and Reform
Rep. Bennie G. Thompson, House Committee of Homeland Security

Mental Health Practices in Torrance County Detention Facility as Reported by Detainees to Humanitarian Outreach for Migrant Emotional Health (H.O.M.E.)

Jenifer Wolf-Williams, Ed.D., LPC-S, LPA
H.O.M.E. Executive Director

Judy Iwens Eidelson, Ph.D.
H.O.M.E. Clinical Advisor

Persons seeking asylum in the United States face daunting legal hurdles and emotional challenges in overcoming the traumatic events that pushed them to leave their homes. Parents and children flee cartels that have threatened them with kidnapping, sexual violence, and death. Adults and teens struggle to escape from governments that threaten them with imprisonment and torture due to their faith or politics. Women flee violent partners in places where police will not protect them. Women and girls seek refuge from forced marriage, sexual abuse, and female genital mutilation (FGM). Yet arrival in the US often brings new traumas, including forced detention that is often re-traumatizing and can last for months or even years.

Humanitarian Outreach for Migrant Emotional Health (H.O.M.E.) is a mental health nonprofit whose licensed professionals assess and evaluate the emotional needs of persons engaged in the U.S. immigration process. In this capacity, beginning in October 2021, at the request of attorneys from nonprofit legal agencies, H.O.M.E. clinicians conducted interviews with nine persons detained at the Torrance County Detention Facility (TCDF) in Estancia, New Mexico and a tenth person who was previously detained there. Four of these interviews took place in November, 2022. H.O.M.E. experts have also reviewed the records kept by TCDF healthcare providers for seven of the 15 men still in detention at TCDF.

This document summarizes our findings and analyzes them in the light of relevant scholarly literature. Particular attention is given to (1) the tragic increased likelihood of *preventable* suicide deaths among persons detained in Immigration and Customs Enforcement (ICE) facilities, (2) the grievous shortfalls in TCDF suicide prevention protocols compared to evidence-based best practices, (3) detainees' fear of solitary confinement in response to their acknowledging suicidal thoughts to TCDF healthcare staff, and (4) serious and disturbing inadequacies in the detainee mental healthcare records of TCDF providers.

Increased likelihood of preventable suicide deaths at TCDF and other ICE facilities

As survivors of life threatening events and trauma, asylum seekers are more likely to suffer from Posttraumatic Stress Disorder (PTSD) and/or depression. And while most patients with these diagnoses do not attempt suicide, associated symptoms such as hopelessness and self-blame increase this worrisome possibility. Even among non-detained migrants, separation from family, fears about those left behind, and loss of social network all create risks for suicidal behavior (Forte et al, 2018).

The increased likelihood of suicide among migrants is also tied to ICE detention. A team of researchers (Erfani, et al., 2021) from Harvard University, Stanford University, and Boston Children's Hospital reviewed public records and found that in 2020 suicide deaths among detained migrants increased eleven times over the previous ten-year average. These researchers identified the following contributing factors: increasing lapses in mental health care in ICE detention, increased length of detention, delayed psychiatric appointments, falsified observation logs for suicide patients, and the use of solitary confinement for depressed patients.

Because these risks are well known, the heightened potential for suicide deaths in ICE detention centers is not at all surprising. And when this risk is recognized and acknowledged, preventive action can (and should) be taken (e.g., Haroz, et al., 2020).

TCDF fails to employ effective, evidence-based suicide prevention strategies

One example of a successful suicide prevention strategy is the World Health Organization Brief Intervention and Contact program (WHO BIC), which has been validated over several years and across many global populations. The goals of the program are to increase the survivor's engagement with treatment, build their self-efficacy, and increase their social support (WHO, 2001). ***But what our clinicians found in their interviews of TCDF detainees was exactly the opposite:***

- First, instead of promoting treatment engagement, TCDF's practices leave detained persons terrified of engaging with ICE health professionals because they fear they will be treated punitively and placed in solitary confinement. One patient told our evaluator he was worried about disclosing his suicidal thoughts even to her, an external clinician, because of the risk that ICE staff might find out.

- Second, instead of building self-efficacy, a basic psychological need, asylum seekers at TCDF are locked away from any possibility of participating in normal home and community life. Every minute of their day and every aspect of their personal functioning is controlled by TCDF officers, making self-efficacy impossible.

- Third, instead of *strengthening* social support, another basic human need, TCDF detention destroys it by imprisoning vulnerable individuals in an environment where they have no contact with their loved ones or with a stable supportive community. Some detainees succeed in establishing friendships with other migrants, only to lose them through deportation or even suicide. Moreover, when a detainee confides suicidal thoughts to a staff member, TCDF responds by locking that person in solitary confinement.

In a meta-analysis of several empirical studies, Jobes and colleagues (2015) identified four common characteristics of evidence-based approaches to suicide prevention:

1. Successful interventions help the patient recognize factors that trigger their suicide risk. In contrast, trauma survivors detained in TCDF report that they deny their suicidality out of fear of being placed in solitary confinement.

2. Successful interventions are collaborative. They are implemented in a spirit of empathy and understanding, and they validate the person's emotional state. Reports from TCDF detainees, however, describe an adversarial environment in which they are shamed and dehumanized, not only for mental health symptoms, but for exhibiting basic human needs and emotions.

3. Successful suicide interventions inspire, and in turn draw from, the patient's own motivations to live. But TCDF detainees we interviewed reported increased fear, despondency, and hopelessness during their time in detention.

4. Finally, successful interventions emphasize hope and a life worth living. The reality for detained trauma survivors is that they know their odds of attaining immigration protection are low. Many perceive their immigration quest as a life-or-death struggle, yet each time a peer is deported or an authority figure fails to listen, their hope is diminished. Some see death by suicide as preferable to the torture and other life-threatening experiences from which they fled and to which they could be returned.

Fear of solitary confinement among H.O.M.E. interviewees

Without exception, when a detained migrant disclosed suicidal thoughts to a H.O.M.E. evaluator, they also noted their unwillingness to discuss these thoughts with TCDF staff, including internal healthcare professionals. Their consistent reason for hiding this critically important symptom was fear of the inevitable detention center response: solitary confinement and its associated humiliations:

One TCDF detainee told a H.O.M.E. clinician that he experienced solitary confinement as demoralizing, and his symptoms increased as a result. He feared being placed there again and therefore did not want TCDF staff to know about his suicidal thoughts.

Another patient reported he had stopped speaking with the TCDF psychiatrist out of fear of being placed in solitary confinement. Peers who had been confined there described a cell with a concrete bed and a diet limited to raw celery, carrots, and garlic cloves. Despite extreme cold, they were forced to remove all clothing except an open medical gown, and they were given no blanket. This patient's fear of solitary confinement inhibits him from disclosing suicidal thoughts or showing negative emotions. He stated, "I avoid letting anyone see me cry. That way, they don't suspect I'm not okay."

A third patient confirmed the above description of conditions in solitary confinement through his own direct experience. He detailed his unsuccessful attempts to find relief from the cold, and he reported health concerns due to the inadequate diet he received in solitary confinement. He does not disclose any information to TCDF staff and stated, "No one in here tries to understand."

A fourth patient, despite severe PTSD symptoms that began after trauma in his country of origin, reported that he avoids appointments with the TCDF psychologist or psychiatrist out of fear he will be locked in solitary confinement.

These migrants have good reason to be fearful about solitary confinement. The risk of suicide rises significantly when detained persons are subject to this debilitating form of incarceration. Extensive research on this practice shows a significant association between solitary confinement and mental health deterioration, including increased depression, PTSD, psychosis, and mortality (Luigi, et al., 2020). After only a few days in solitary confinement, detained persons may exhibit sleep disorders, panic attacks, appetite disturbance, hallucinations, and increased suicidal ideation (Patler, et al., 2018). Psychological harm from solitary confinement worsens with its extended or repeated use, and the impacts can persist well past release from detention. Yet despite these widely known effects, TCDF and other ICE facilities continue to impose solitary confinement on trauma survivors who acknowledge thoughts of suicide.

Serious and disturbing inadequacies in the detainee mental healthcare records of TCDF providers

Experts from H.O.M.E. reviewed internal TCDF mental healthcare records of seven detainees and found numerous troubling inadequacies. Several are described below.

Sparse and meager healthcare records

The most striking feature of these records was their sparsity. Mental health reports normally include:

- Detailed descriptions of the patient's symptoms and analysis of how these symptoms do or do not indicate a mental health diagnosis.
- Wellness goals, developed in collaboration with the patient, that detail desired treatment outcomes.
- A treatment plan that describes how the goals will be achieved.
- Psychotherapy notes for every contact between patient and caregiver. It is standard for such notes to include descriptions of session content, changes in the patient's functioning or mood, application of the treatment plan, and progress toward goals (or the lack thereof).

H.O.M.E.'s careful review of the TCDF mental health records determined that they consistently lacked these key features. Even patients placed under suicide-watch precautions had no psychotherapy notes. One detainee's reported symptoms included auditory hallucinations ("hearing voices") — a clear indication of the need for thorough psychiatric evaluation. Yet no such follow-up was noted. In another case, a detainee with nightmares and flashbacks was diagnosed with PTSD but the provider failed to record the nature of the precipitating trauma event — the first requirement for such a diagnosis (APA, 2022). Furthermore, the provider's

records did not indicate any treatment plan or therapeutic counseling to address this patient's PTSD.

Non-therapeutic framing of patient needs

Effective mental healthcare professionals are empathetic. They respect their patients' expressed emotions, they acknowledge their pain, and they recognize the daunting realities of their patients' lives. But TCDF providers described their patients' experiences in euphemistic terms that minimized the extent of their suffering, and they assigned blame to patients for traumatic circumstances over which they had no control. For example:

- A patient's physical pain was described as "impaired comfort."
- A patient who reported extreme fear of being deported was described as displaying "ineffective coping."
- A patient who reported intense fear of forced removal to his country of origin was told to "think positively" and "be grateful for what he has."

These approaches deny the patient's experience, diminish his humanity, discourage him from acknowledging his trauma, and fail to account for the reality that he may be forced to return to a place where he was tortured or faced other life-threatening circumstances.

Conclusion

The clinical interviews that H.O.M.E. mental health professionals conducted with TCDF detainees and our review of TCDF healthcare records revealed serious, sometimes life-threatening, lapses in care. Furthermore, they revealed that TCDF practices stand in stark contradiction to evidence-based recommendations by mental health experts while contributing to the emotional suffering and deteriorating mental health of detainees in their custody.

Best practices for mental health care in general and for suicide prevention in particular begin with placing patients in a safe and caring community. For example, recovery from PTSD requires that a patient develop a sense of safety and security. When the patient remains in an adverse or threatening environment, this crucial step toward healing is not possible.

It is therefore clear that the most appropriate approach to the care of TCDF detainees experiencing mental health-related symptoms is release to a safe and stable environment, participation in normal home and community life, and the opportunity to seek appropriate care.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Erfani P, Chin ET, Lee CH, Uppal N, Peeler KR. (2021). Suicide rates of migrants in United States immigration detention (2010-2020). *AIMS Public Health, 8*(3), 416-420. https://doi.org/10.3934/publichealth.2021031

Forte, A., Trobia, F., Gualtieri, F., Lamis, D. A., Cardamone, G., Giallonardo, V., Fiorillo, A., Paolo Girardi, P., & Pompili, M. (2018). Suicide risk among immigrants and ethnic minorities: A literature overview. *International Journal of Environmental Research and Public Health, 15*(7), 1438. http://dx.doi.org/10.3390/ijerph15071438

Haroz EE, Decker E, Lee C, Bolton P, Spiegel P, Ventevogel P. Evidence for suicide prevention strategies with populations in displacement: a systematic review. Intervention (Amstelveen). 2020 Jan-Jun;18(1):37-44. Epub 2019 May 29. PMID: 32665770; PMCID: PMC7359961.

Jobes, D.A., Au, J.S. & Siegelman, A. (2015). Psychological approaches to suicide treatment and prevention. *Current Treatment Options in Psychiatry, 2*, 363–370. https://doi.org/10.1007/s40501-015-0064-3

Luigi, M., Dellazizzo, L., Giguère, C. É., Goulet, M. H., & Dumais, A. (2020). Shedding light on "the Hole": A systematic review and meta-analysis on adverse psychological effects and mortality following solitary Confinement in correctional settings. *Frontiers in Psychiatry*, 11, 840. https://doi.org/10.3389/fpsyt.2020.00840

Patler, C., Sacha, J. O., & Branic, N. (2018). The black box within a black box: Solitary confinement practices in a subset of US immigrant detention facilities. *Journal of Population Research*, 35(4), 435-465. https://doi.org/10.1007/s12546-018-9209-8

World Health Organization. (2001). The World Health Report 2001: Mental health: new understanding, new hope.