U.S. Immigration and Customs Enforcement

STATEMENT

OF

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REGARDING A HEARING ON

"PROBLEMS WITH IMMIGRATION DETAINEE MEDICAL CARE"

BEFORE THE

HOUSE COMMITTEE ON THE JUDICIARY
SUBCOMMITTE ON IMMIGRATION, CITIZENSHIP, REFUGEES,
BORDER SECURITY, AND INTERNATIONAL LAW SUBCOMMITTEE

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Good afternoon, Chairwoman Lofgren and distinguished Members of the Subcommittee. I appreciate the opportunity to appear before you to discuss the quality medical care and safe and humane treatment that Department of Homeland Security's (DHS) U.S. Immigration and Customs Enforcement (ICE) provides to immigration detainees as well as some of the initiatives we are undertaking to further improve care.

ICE was formed in March 2003 with a broad mission that includes immigration and customs enforcement and management of the detention and removal processes for apprehended aliens. In carrying out this mission, one of our highest priorities is to provide quality care to those individuals in our custody. As such, ICE remains committed to ensuring the safety and well being of the hundreds of thousands of individuals who come through our detention facilities each year.

OVERSIGHT IMPROVEMENTS ACROSS ALL ASPECTS OF DETENTION

Indeed, with such an important mandate, improved oversight of a variety of ICE functions has been a cornerstone of my approach. In the past two years, ICE has made significant strides in improving oversight and updating the decades-old practices inherited from the former Immigration and Naturalization Service (INS).

For example, in February 2007, ICE established the Detention Facilities Inspection Group. This group resides within the Office of Professional Responsibility (essentially our "internal affairs function) independent of the Office of Detention and Removal Operations (DRO) which carries out the detention and removal functions on a day-to-day basis. The DFIG has the responsibility for reviewing and validating detention inspections and ensuring the consistent application of agency standards to make certain that corrective actions are taken.

ICE has also contracted with independent experts to place full-time quality assurance professionals at each of our 40 largest facilities and to arrange for rotational visits to our

smaller facilities. Additionally, ICE has contracted with outside experts to conduct annual facility inspections, which were previously performed by ICE personnel.

To improve transparency, ICE released its first Semiannual Report on Compliance with ICE National Detention Standards January - June 2007, which tracks detention facilities' compliance with national detention standards. This first-of-its-kind report will be issued semi-annually and is posted on the front page of ICE's website. It is my hope that by publishing this information, we will help enhance transparency and general understanding of our detention system by detailing the results of more than 175 facility compliance inspections.

To improve communication and operational consistency with our Intergovernmental Service Agreement (IGSA) partners, ICE is in the process of standardizing the IGSA contracts which were individualized agreements with our 300-plus local government partners. This will allow ICE to more effectively manage these contracts to ensure that our partners are adhering to our National Detention Standards.

ICE has also, for the first time, developed a national detainee handbook. Available in both Spanish and English, the detainee handbook provides standardized information on topics such as rights and responsibilities, grievance procedures, suicide prevention, telephone access, consular notifications, visitation, mail, meals, recreation, religious services, and more.

Beyond merely complying with our standards, we have also undertaken a complete review of the existing National Detention Standards. The existing standards were developed in 2000 by the former INS in consultation with outside stakeholders. Though they've served us well, we believe we can further ensure we meet our obligations by updating policies and procedures to performance based standards that reflect past experiences, agency practices, and protocols. ICE is vigorously working to transform the current detention standards into a performance-based format, consistent with the approach used by the American Correctional Association. In doing so, ICE has solicited

feedback and is considering recommendations from Non-Governmental Organizations, the DHS Office of Inspector General, and other groups such as the United Nations High Commission on Refugees. We have worked closely with the DHS Office for Civil Rights and Civil Liberties to consider these recommendations and develop improved standards. The new standards are expected to be completed later this year.

TRENDS

Turning now more specifically to detainee health care and oversight, let me begin with some context: ICE spent almost $100 million on detainee health care last fiscal year, double the funding of just five years ago. During that same period, the number of detention beds managed by ICE has grown by approximately 30 percent. Since ICE was established, more than 1 million individuals have passed through our custody. Though the ICE detainee population has increased by more than 30 percent since 2004, the actual number of deaths in ICE detention has declined from 29 in 2004 to 7 last year. There have also been no suicides in the last 15 months.

DETAINEE HEALTHCARE TODAY

As a unit within ICE, DIHS serves as the provider of medical and mental health care for detainees housed in DIHS-staffed detention facilities and manages certain healthcare functions provided by medical professionals at non-DIHS-staffed detention facilities. But there is still much work to do. It's important to recognize that ICE law enforcement officers are not medical professionals, so we have historically relied on the independent medical judgment of the professionals within DIHS, which include doctors, clinical support professionals and support staff (some of whom are detailed to DHS from the U.S Public Health Service (PHS)), contractors, and general schedule employees. We will continue to work closely with DHS Office of Health Affairs and PHS to evaluate and improve processes and practices.

All detainees are required to receive an initial health screening within 12 hours of arrival at the detention facility in order to determine the appropriate medical, mental health, and/or dental treatment that may be needed. At that time, ICE provides immediate attention to detainees who present a danger or an imminent risk to themselves or others, including those who have infectious diseases, uncontrolled mental health disorders, or conditions that would deteriorate if not addressed immediately by medical personnel. In addition to the initial health care screening, ICE policy also requires that detainees receive a health appraisal and physical examination within 14 days of arrival to identify medical conditions that require monitoring or treatment.

Last year, 34 percent of detainees screened were diagnosed with, and treated for, preexisting chronic conditions, such as hypertension and diabetes. Many of these detainees would not have identified their medical ailment or received medical care and treatment were it not for the comprehensive health screening they received.

In addition to the initial screening and medical evaluation, the ICE standards on Medical Care require that all detainees, regardless of classification, have access to sick call, which provides detainees the opportunity to request health care services provided by a physician or other qualified medical officer in a clinical setting. Procedures are in place to ensure that all requests for health care services are received by the health service provider in a timely manner. During screenings, evaluations, and visits, a medical professional assesses the detainee's health and treatment requirements and arranges any medications, consultations, or other services needed. The sick call process allows detainees to access non-emergency 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.

Medical care provided at each detention facility also includes access to necessary prescription medications. Prescriptions written for detainees by the health service provider are filled either by an on-site pharmacy or by a local community pharmacy. If a prescription medication is not readily available and a detainee has a supply of the

medication needed or can obtain a supply of the medication from a family member, that medication may be used as long as the facility's medical staff can verify the validity of the medication to ensure it is appropriate for the detainee to take and to prevent contraband from entering a facility. In FY 2007, DIHS alone wrote more than 210,000 prescriptions.

ICE detainees also have access to mental health care provided by qualified professionals and receive a mental health screening within 12 hours of admission. Detainees who request mental health services or are identified upon intake screening as needing further evaluation are referred to an appropriate mental health professional, usually a clinical psychologist or social worker.

DIHS psychologists and social workers provide 23 different types of psychological services that are therapeutic in nature. These services include not just supportive therapy or counseling, but psychological assessment, psychoeducation, crisis intervention services, suicide risk assessment, suicide watch follow-up services to ensure safety, case management services and consultation with other medical professionals. Psychiatric services are also available to ICE detainees. Psychiatrists provide psychiatric evaluations, follow-up medication management, and they consult with the psychologists, social workers, and primary care providers when appropriate.

Detainees who require medical care beyond what can be provided at their detention facility have access to specialized care by submitting Treatment Authorization Requests (TARs) to the DIHS Managed Care Program. Specialized procedures provided through the TAR process may include heart surgery, cancer treatment, dialysis, and a variety of general surgical procedures. In an effort to even further enhance the TAR process, ICE is working to improve the appeal process for the relatively small number of TARs that are disapproved. I will talk a bit more about that shortly, but once this process has been developed, the ICE Detainee Handbook and orientation process will be updated to provide a complete description of the TAR process.

The ICE Medical Program has an established covered benefits package that delineates the health care services, medical products, and treatment options available to all detainees in ICE custody. The ICE covered services package emphasizes that benefits are provided for conditions that pose an imminent threat to life, limb, hearing or sight, rather than to elective or non-emergency conditions. Medical conditions that the local treating physicians believe would cause suffering or deterioration of a detainee's health are also assessed and evaluated through the DIHS Managed Care Program. The DIHS Managed Care Program has a network of more than 500 hospitals, 3000 physicians, and 1300 other health care facilities that provide a wide range of medical care and services.

As the number of individuals in ICE custody has risen in recent years -from approximately 227,000 detainees in FY 03 to more than 300,000 in FY 07- demand for health care and medical services has also grown significantly.

In FY 03, DIHS staff had 256,843 detainee visits, including 9,349 dental; 8,950 mental health; 14,566 short stay unit visits: and 47,372 sick calls. In FY 07 DIHS showed a total caseload of 711,719 health/medical visits, including 16,885 dental; 23,224 mental health; 56,823 short stay unit visits; and 97,620 sick calls.

STRENGTHENED HEALTHCARE OVERSIGHT

Despite these many accomplishments, ICE has recognized the need for a variety of both medical and administrative oversight revisions.

Among them was the need to strengthen the suicide prevention process. The reality is that since 2003, suicides have accounted for 18 percent of the 74 deaths of detainees in custody. Even one preventable death is too many. Accordingly, over the past two years, ICE instituted an extensive suicide prevention program. The goal of the program is to ensure that all individuals at our detention facilities remain both safe and healthy. Suicide is always a risk at any detention facility and anyone suffering from mental illness is at

increased risk. ICE has continuously taken a proactive approach to mitigating these risks. I am pleased to report ICE has not had a single suicide in over 15 months.

Here are some of the steps we have taken to address this ongoing challenge.

ICE's National Detention Standards require that all staff working with detainees in detention facilities be trained to recognize signs and situations potentially indicating a suicide risk. Staff must act to prevent suicides with appropriate sensitivity, supervision, and referrals. Any clinically suicidal detainee must receive preventive supervision and treatment.

On October 17, 2006, ICE DRO issued a memorandum to all Field Office Directors reiterating the requirements of the Suicide Prevention and Intervention detention standard and directing them to verify compliance with the standard for all detention facilities used to house ICE detainees within their respective geographic areas of responsibility.

Furthermore, all Field Office Directors verified that their staff are receiving annual training, that facilities have appropriate medical coverage to provide for detainees' mental health needs, and that policy and procedures are in place to ensure prompt reporting of suicides and suicide attempts.

Each of these initiatives demonstrates our firm and continuing commitment to protecting the well-being of those in our detention facilities and ensuring that those who may be at risk for suicide immediately receive all appropriate care and counseling.

Additionally, ICE is working with the DHS Office of Health Affairs (OHA) to improve operations at DIHS. Already numerous improvements have been implemented, and others are underway, including the selection of a new Acting DIHS director, streamlining the hiring process to address staff shortages and moving towards an improved electronic medical records system.

I want to expand a bit on just one of these improvements: ICE has asked OHA and outside medical experts to assess all of DIHS' procedures to determine what changes we can make to ensure the best quality care for those in our custody.

ICE is also working with the DHS OHA on developing an enhanced appeal process for the very small number of TAR's that are initially denied. I believe this is an area where we can improve. Currently, there are a variety of reasons that TARs may not be approved such as: the person for whom treatment is being sought may not in fact be in ICE custody; the TAR does not include enough information to determine medical necessity; there are alternate acceptable treatment options at the facility; or the request was not submitted in a timely fashion and the treatment has already be delivered. Any TAR that is denied due to a lack of timeliness by a managed care coordinator is forwarded to the Managed Care Coordinator Branch Chief for reconsideration.

DIHS has a formal appeals process for denied TARs. The request can be resubmitted for reconsideration to the MCC. If unsuccessful it can be appealed to the DIHS Medical Director. If that is still unsuccessful, a final appeal can be submitted to the Managed Care Review Committee (MCRC), which is comprised of the DIHS Medical Director, appropriate medical, dental, or mental health consultants, and MCCs. Decisions of the MCRC will be made in writing within 3 working days of the appeal and faxed back to the requestor.

ICE, DIHS, and OHA are working to develop a more independent appeal body outside of DIHS and ICE. One possibility under consideration is to have OHA perform this final level of appeal function. This will allow an alien to have even greater say in his or her own medical care.

ICE and DIHS will also begin working with OHA on a general stand-alone medical care grievance process that would be separate from the standard facility grievance process. As soon as we complete these initiatives, the National Detainee Handbook and local orientation procedures will be updated to reflect these changes.

CONCLUSION

In closing, I would like to say on behalf of each and every ICE employee that we remain committed to ensuring the safety and well being of the hundreds of thousands of individuals who come through our detention facilities each year. Please also know that I have had the distinct pleasure to meet with a number of the fine men and women at DIHS who provide healthcare services to ICE detainees. I can tell you that they share my dedication to providing high quality health care to all of their patients and to working with the Department of Homeland Security – with ICE and our colleagues at the Office of Health Affairs – to continue to improve our administrative processes and medical oversight. As in the past, as we continue to improve we will seek your input and guidance, as well as that of NGOs, the IG and others.

I would like to thank you, Ms. Chairwoman and Members of the Subcommittee, for the opportunity to appear before you today. In developing this testimony, I've consulted with experts on these matters and offer testimony and answers to your questions based upon this information. I will gladly answer your questions.