

Diversion of Patients With Mental Illness From Court-Ordered Care to Immigration Detention

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Over 350,000 immigrants are detained by U.S. Immigration and Customs Enforcement (ICE) each year. An unknown fraction of these detainees have serious mental illnesses and are taken into ICE custody even though a criminal court has ordered them to enter inpatient mental health care. The authors report findings from 16 such cases in which they have provided advocacy over the past four years. In some cases, they were able to secure release of detainees into inpatient care in community (non-forensic) settings, which involved substantial logistical challenges. Given the well-documented concerns about securing adequate care for ICE detainees with mental illness, a logical policy change would be for ICE to allow these patients to enter court-ordered inpatient care. This move would improve care for patients and would also unburden ICE from the untenable proposition of caring for patients that the criminal justice system has deemed unfit for incarceration. (*Psychiatric Services* 63: 377–379, 2012; doi: 10.1176/appi.ps.201100040)

More than 350,000 immigrants are detained by U.S. Immigration and Customs Enforcement

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(ICE) each year. Use of detention by ICE has escalated dramatically in the past decade, and numerous advocacy organizations have documented problems with mental health screening and care for this population. Particular problems for detainees include interruption of medication, reliance on segregation (isolation) to control symptoms of mental illness, and scant mental health services in the approximately 250 settings in which detainees are held (1,2). The jails and private and public detention centers where detainees are held receive little from ICE in the way of clinical guidelines on mental health care.

In the past three years, ICE has increasingly relied on two parallel federal programs that incorporate local law enforcement into ICE detention efforts. One program, called Secure Communities, involves automated screening of persons who come into local custody for criminal offenses in approximately 700 law enforcement settings in 33 states (3). The second program, called 287(g), incorporates specially trained local law enforcement officers in 71 agencies in 25 states to screen and process criminal arrestees into the ICE detention system (4). ICE has reported the success of these two programs in bringing a criminal population into proceedings for detention and removal. However, one clear result is that risk factors for arrest and incarceration (such as mental illness and substance abuse) have been transformed into risk factors for ICE detention and removal. Most persons detained by ICE are undocumented, but there are cases in

which persons with serious mental illness are legal permanent residents who have been charged with a crime.

In this Open Forum we describe cases in which immigrants with mental illnesses have been placed in ICE custody. The cases involve a troubling substitution of detention for court-ordered mental health care. Because this detention occurs under the custody of ICE, the mechanisms that exist within the criminal justice system to detect persons in need of dedicated mental health treatment outside a jail setting are thwarted. The cases we report here also provide examples of successful advocacy on behalf of these patients in redirecting them toward inpatient mental health care and away from the ICE detention system.

Description of cases

Over the past four years, we have been engaged in medical advocacy at the individual and policy levels on behalf of detained immigrants. Among the approximately 130 cases with which we have been involved (5), many have been related to issues of mental health care. A particularly concerning trend that we have recently noted is the diversion of patients with mental illness from court-ordered inpatient mental health care to ICE detention. A typical scenario involves a person with long-standing, well-documented mental health problems and numerous interactions with both inpatient mental health facilities and the criminal justice system for minor (misdemeanor) offenses, such as trespassing (for example, sleeping in a bus station). In these cases, the patient has been charged with a mi-

nor offense, ruled incompetent to stand trial by a judge, and ordered for further inpatient mental health evaluation and care. Normally, these patients are then transferred from jail to an inpatient mental health facility under the authority of the state office of mental health.

One such case involved a 50-year-old man who was detained by police in New York City in 2010 for trespassing. This patient, a legal permanent resident of the United States since 1974, had a long-standing history of schizophrenia that had been treated in numerous settings, including inpatient and outpatient facilities. A motion was made by the patient's attorney for psychiatric evaluation for competence to face the criminal charge of trespassing. On the basis of that evaluation, the court found him incompetent to stand trial, and he was ordered to receive inpatient mental health care.

When the court order for inpatient care was made, the patient was in jail, where he was known to ICE. He was taken directly into ICE custody and transferred to Willacy Detention Center in Texas. This transfer occurred without the knowledge of the patient's family or attorney. At the detention center, the patient did not receive any medication for at least one month. When the patient's family interceded on his behalf, they were informed that the patient's medical record at the detention center included no documentation of mental illness. Shortly thereafter the patient was deported.

In the past four years, we have encountered 16 cases that involve a diversion to ICE custody of patients with court orders for mental health care. All of these patients had serious mental illnesses involving an axis I disorder, and most of the cases occurred in New York State. The total number of such cases in New York or nationwide in the past ten years is unknown. Neither ICE nor the New York State Office of Mental Health (NYSOMH) officially tracks these cases. Because these cases originate in the criminal justice system, all of these patients have a criminal defense attorney (usually a public defender) but not an immigration attorney.

However, for many criminal defense attorneys, ICE detention is unfamiliar territory—and this, combined with the swiftness of the transfer into ICE detention, means that many of the cases do not come to the attention of medical or mental health advocates or attorneys who specialize in ICE detention. We have been involved with 16 such cases, and all cases have concerned individuals who were originally charged with misdemeanors.

We asked ICE to release the patient from detention in nine of the 16 cases, and five requests were granted. To approach ICE with these requests, we worked with the patients' attorneys to formulate a plan for mental health care upon release. In three cases, we also approached NYSOMH to request that the original order for inpatient mental health care be honored. In only one of the three cases was the patient released from ICE detention to enter NYSOMH care as was originally ordered by the court. In other cases we asked for release from custody after the original order for mental health care had been cancelled. In these cases, we attempted to coordinate care in an inpatient facility and to transport the patient from ICE detention to that facility. This was an exceedingly difficult endeavor, partly because few inpatient beds were available and partly because of the difficulty of arranging transport from ICE detention to the site of mental health care. In one instance, a plan to transport a patient with serious mental illness from ICE detention to inpatient mental health care on a Monday morning was thwarted when the detention center released the patient to the street on a Sunday night.

Discussion

Mental health screening and care of immigrants have been identified as a top priority for improvement by advocates of detained immigrants (6) and by ICE itself (7). In its struggle to appropriately identify and care for detainees with mental illness, ICE has enlisted the assistance of mental health professionals and has sought to place detainees with serious mental health concerns in facilities with adequate resources.

One drawback of this centralization is that detainees are moved away from their homes, families, and attorneys, resulting in further isolation and potential exacerbation of their symptoms.

Court-ordered mental health treatment presents ICE with a partial solution to this challenge. Most detainees with mental illness have not been identified by a criminal court as needing inpatient mental health care (as an alternative to incarceration); therefore, if they are detained by ICE, their needs must be identified and appropriately addressed by ICE. However, for the (unknown) fraction of detainees who have already been identified by a court as meriting inpatient mental health care rather than incarceration, there are clear advantages for the patient—as well as for ICE—to let this process take place.

For this policy change to be implemented, ICE will first need to assess how often and in what circumstances this practice—deportation of persons with mental illness who are legal residents—currently occurs across the nation. Our understanding from working in the New York area is that this practice is generally limited to misdemeanor cases that result in court-ordered mental health treatment; however, it is clear from working with multiple agencies and organizations that ICE practices, even in a single geographic area, vary. In writing this Open Forum, we communicated with other medical and legal organizations who reported similar practices in Illinois, Florida, Arizona, and Texas.

An additional need is to address any ICE concerns about allowing patients to enter court-ordered care. One concern may be that court-ordered inpatient care for persons with a misdemeanor offense might involve a move to a setting with less security or one that is more difficult for ICE to monitor. Another concern may be the desire to avoid negative publicity if a person with mental illness reoffends after being allowed to enter court-ordered care. However, the cases with which we were involved stemmed from nonviolent misdemeanor charges, and these concerns seem unlikely in such cases.

The cases discussed here likely represent a small percentage of immigrants who are detained and eventually deported by ICE. What stands out about these patients, and others like them in many states across the country, is that their mental health problems were deemed so severe by a criminal court as to merit inpatient treatment. In almost complete contradiction of the court's findings and intent, ICE uses this decision as a trigger to detain these patients in a system that even by optimistic appraisal cannot be considered to provide a level of care equal to that of an inpatient psychiatric setting. In addition, the original court-ordered plan incurs no cost for ICE. For these patients, mental illness is likely the single greatest risk factor for incarceration.

In undoing the appropriate actions of local criminal courts, ICE has transformed mental illness into a risk factor for detention and removal. Undoing this policy will improve care for these patients and save cost and liability for ICE.

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