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**Article**

***Of Mice and Men: On the Seclusion of  
Immigration Detainees and Hospital  
Patients***

**Stacey A. Tovino**<sup>†</sup>

INTRODUCTION

On April 28, 2013, twenty-four-year-old Elsa Guadalupe-Gonzales hanged herself while in United States Immigration and Customs Enforcement (ICE) custody at the Eloy Detention Center in Eloy, Arizona.<sup>1</sup> Two days later, forty-year-old Jorge Garcia-Mejia committed suicide at the same detention facility, also by hanging.<sup>2</sup> Guadalupe-Gonzalez and Garcia-Mejia are 2 of 153 detainees who died in ICE custody between October 2003 and October 2015.<sup>3</sup>

Immigration detainees who hang themselves usually do so while in seclusion; that is, while confined to a cell that is isolated from the general detention center population for

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1. Press Release, Immigration & Customs Enft, U.S. Dep't Homeland Sec., ICE Detainee Passes Away at Eloy Detention Center (Apr. 30, 2013) [hereinafter First Eloy Detainee].

2. Press Release, Immigration & Customs Enft, U.S. Dep't Homeland Sec., ICE Detainee Under Criminal Investigation Passes Away at Eloy Detention Center (May 2, 2013) [hereinafter Second Eloy Detainee].

3. IMMIGRATION & CUSTOMS ENF'T, U.S. DEP'T HOMELAND SEC., LIST OF DEATHS IN ICE CUSTODY, OCTOBER 2003–OCTOBER 26, 2015 (2015) [hereinafter ICE DEATHS].

purported administrative, disciplinary, or protective reasons.<sup>4</sup> Forty-four-year-old Ana Romero Rivera hanged herself while in seclusion at Franklin County Regional Jail in Frankfort, Kentucky, on August 21, 2008.<sup>5</sup> Romero Rivera, who was waiting to be deported to El Salvador, was secluded simply because she refused to eat.<sup>6</sup> Approximately 300 detainees are secluded every day in the fifty largest detention centers in the United States, and nearly half of these detainees are secluded for fifteen days or more at a time.<sup>7</sup>

In addition to suicide during seclusion, other detainees have been injured or have died while in restraints; that is, while they have a reduced or complete inability to move their arms, legs, head, or body freely due to the application of any manual, mechanical, or physical method, device, material, or piece of equipment.<sup>8</sup> In early 2007, guards at the Elizabeth Detention Center in Elizabeth, New Jersey, shackled and pinned to the floor Boubacar Bah, a fifty-two-year-old tailor

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4. See 42 C.F.R. § 482.13(e)(1)(ii) (2014) (defining seclusion in the context of federal hospital law in a similar manner); OHIO ADMIN. CODE 5122-14-01(C)(59) (2016) (defining seclusion in the context of Ohio psychiatric hospital law in a similar manner); Humphry Osmond, *The Seclusion Room—Cell or Sanctuary?*, 9 PSYCHIATRIC SERVS. 18, 18–19 (1958) (providing background information regarding the use of seclusion in the health care context). This Article uses the term seclusion to encompass a variety of practices and places referred to in the context of immigration detention as administrative segregation, disciplinary segregation, separation, confinement, solitary confinement, isolation, the hole, the secure housing unit, and the special management unit. See NAT'L IMMIGRANT JUSTICE CTR., INVISIBLE IN ISOLATION: THE USE OF SEGREGATION AND SOLITARY CONFINEMENT IN IMMIGRATION DETENTION 3 (2012) [hereinafter NIJC] (defining and distinguishing some of these terms and explaining that “[t]he vocabulary surrounding segregation and solitary confinement often can be misleading or confusing”); *infra* text accompanying notes 111–15 (discussing this Article’s choice of language).

5. See Steve Lannen & Valarie Honeycutt Spears, *Questions Remain in Immigrant’s Jail Death*, LEXINGTON HERALD-LEADER (Nov. 20, 2008), <http://www.kentucky.com/latest-news/article43983495.html>.

6. See *id.* (“Romero’s brother-in-law, Mario Aguilar, says Romero was placed in isolation because she refused to eat.”).

7. See Editorial, *Immigrants in Solitary*, N.Y. TIMES (Apr. 1, 2013), <http://www.nytimes.com/2013/04/02/opinion/immigrants-in-solitary.html> [hereinafter *Immigrants in Solitary*] (providing data regarding detainee seclusion).

8. See, e.g., 42 C.F.R. § 482.13(e)(1)(i)(A), (B) (defining restraint for purposes of the federal Medicare Conditions of Participation for Hospitals).

from Guinea who had overstayed a tourist visa.<sup>9</sup> Shortly after, Bah was transported to a nearby hospital in Newark, New Jersey, where he remained in a coma after emergency department personnel diagnosed him with a skull fracture and multiple brain hemorrhages.<sup>10</sup> Bah died four months later, on May 30, 2007, without ever regaining consciousness.<sup>11</sup> Three weeks later, twenty-three-year-old detainee Victoria Arrelano died while shackled to her bed in San Pedro, California.<sup>12</sup> Even though she had AIDS and frequently vomited blood, staff members at the San Pedro Service Processing Center refused to remove Arrelano's restraints, rendering her helpless to move away from her own excrement.<sup>13</sup>

Seclusion- and restraint-related injuries and deaths used to be common in other contexts, including in the health care context.<sup>14</sup> Between 1988 and 1998, 142 patients died during or shortly after episodes of seclusion or restraint in hospitals and other health care facilities located across the United States.<sup>15</sup>

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9. See Nina Bernstein, *Few Details on Immigrants Who Died in Custody*, N.Y. TIMES (May 5, 2008), <http://www.nytimes.com/2008/05/05/nyregion/05detain.html>.

10. See *id.*

11. See *id.*; see also ICE DEATHS, *supra* note 3, at no.78.

12. See ICE DEATHS, *supra* note 3, at no.77.

13. See Greg Krikorian, *Family To Sue over Detainee's Death*, L.A. TIMES (Aug. 11, 2007), <http://articles.latimes.com/print/2007/aug/11/local/me-custody11>. In theory, detention staff restrain detainees only to minimize injuries to detainees, to prevent escape or serious damage to detention center property, or to maintain the security and orderly operation of the detention center. See IMMIGRATION & CUSTOMS ENF'T, U.S. DEP'T HOMELAND SEC., PERFORMANCE-BASED NATIONAL DETENTION STANDARDS pt. 2.15(I), at 208 (2011) [hereinafter 2011 PBNDS]. Unfortunately, many detainees are restrained for other purposes, including coercion, discipline, convenience, or retaliation. See, e.g., Nina Bernstein, *Volunteers Report on Treatment of Immigrant Detainees*, N.Y. TIMES (Apr. 29, 2010), <http://www.nytimes.com/2010/04/29/nyregion/29visitors.html> (explaining that detention centers, including local jails, restrain detainees in violation of ICE standards because it's "convenient and cheap").

14. See, e.g., Stacey A. Tovino, *Psychiatric Restraint and Seclusion: Resisting Legislative Solution*, 47 SANTA CLARA L. REV. 511, 518–53 (2007) [hereinafter Tovino, *Psychiatric Restraint*] (historicizing restraint and seclusion use in the health care setting in the United States, providing data regarding the deaths associated with these interventions, and reviewing the development of federal and state laws governing the use of these interventions).

15. Eric M. Weiss et al., *Hundreds of the Nation's Most Vulnerable Have Been Killed by the System Intended To Care for Them*, HARTFORD COURANT, Oct. 11, 1998, at A1, ProQuest Newsstand, Doc. No. 256283163.

Of these 142 deaths, 23 patients died after being restrained by staff in face-down floor holds, 20 patients died after they were restrained using leather wrist and ankle cuffs or vests, and 33% percent of the patients died of asphyxia, including asphyxia caused by hanging<sup>16</sup> and other means.<sup>17</sup>

Following the investigation and publication of these deaths, patient safety advocates, journalists, and other stakeholders urged lawmakers to reform federal and state laws governing the use of seclusion and restraint in the health care setting.<sup>18</sup> Health law reform quickly followed, including new federal and state patients' rights standards that included more stringent regulation of the use of seclusion and restraint in hospital and other health care settings, mandatory staff training regarding safe seclusion and restraint practices, and mandatory reporting of seclusion- and restraint-related deaths.<sup>19</sup> Post-law reform studies reported associations between the reduction in seclusion and restraint use and lower numbers of patient injuries and deaths, shorter hospital lengths of stay, decreased rates of re-hospitalization, lower rates of medication usage, lower costs, higher levels of patient functioning at the time of discharge, and increased patient satisfaction.<sup>20</sup>

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16. *Id.*

17. *See, e.g.*, Scott H. Nelson et al., *An Unusual Death of a Patient in Seclusion*, 34 HOSP. & COMMUNITY PSYCHIATRY 259, 259 (1983) (reporting a case in which a secluded patient asphyxiated himself with his mattress cover).

18. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, MENTAL HEALTH: IMPROPER RESTRAINT OR SECLUSION USE PLACES PEOPLE AT RISK 1 (1999) [hereinafter GAO REPORT] (noting that concern over restraint- and seclusion-related injuries and deaths led to proposed legislation); Dave Altamari & Eric M. Weiss, *Reform Urged in Use of Restraints: U.S. Lawmakers Respond to Report on Deaths*, HARTFORD COURANT, Oct. 17, 1998, at A1, ProQuest Newsstand, Doc. No. 256071724 (referencing the call of Senator Christopher J. Dodd (D-Conn.) for more stringent standards governing the use of restraint and seclusion in psychiatric hospitals).

19. *See, e.g.*, Hospital Conditions of Participation: Patients' Rights, Interim Final Rule with Comment, 64 Fed. Reg. 36,070, 36,070 (July 2, 1999) (creating interim final rule that would establish new rights of patients in Medicare-participating hospitals, including the right to be free from restraints used in the provision of acute medical and surgical care unless clinically necessary and the right to be free from seclusion and restraints used in behavior management unless clinically necessary); Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights, 71 Fed. Reg. 71,378, 71,378 (Dec. 8, 2006) (promulgating final rule revising standards governing the use of restraint and seclusion in Medicare-participating hospitals); Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation, 77 Fed. Reg. 29,034, 29,034 (May 16, 2012) (revising certain restraint- and seclusion-related standards).

20. *See, e.g.*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S.

With a special focus on federal provisions strictly regulating Medicare-participating hospitals' use of seclusion, this Article uses developments in health law as a lens through which the uses and abuses of seclusion in immigration detention centers might be assessed and through which the standards governing detention centers might be improved. In particular, this Article argues that the unenforceable standards governing seclusion in immigration detention, including the most recent version of ICE's Performance-Based National Detention Standards,<sup>21</sup> were incorrectly modeled on correctional standards developed for use in jails and prisons with respect to convicted criminals.<sup>22</sup> This Article asserts that correctional standards are inappropriate guidelines for use in the immigration detention context for several reasons. First, immigration detention is supposed to be a form of civil, not criminal, detention,<sup>23</sup> and most detainees have no criminal record or have committed only minor crimes such as traffic violations.<sup>24</sup> Second, many detainees are extremely physically and emotionally vulnerable due to their history of torture and trauma.<sup>25</sup> Third, many immigrants have lacked access to health

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DEPT HEALTH & HUMAN SERVS., THE BUSINESS CASE FOR PREVENTING AND REDUCING RESTRAINT AND SECLUSION USE 4 (2011) [hereinafter SAMHSA, BUSINESS CASE] (citing dozens of studies reporting cost savings and other patient benefits associated with restraint- and seclusion-use reductions; concluding that "[s]ubstantial savings can result from effectively changing the organizational culture to reduce and prevent the use of restraint and seclusion").

21. See 2011 PBNDS, *supra* note 13.

22. See, e.g., NIJC, *supra* note 4, at 11–12 (“[T]he 2011 PBNDS are still based on American Correctional Association (ACA) pre-trial detention standards for jails and prisons . . .”).

23. *Padilla v. Kentucky*, 559 U.S. 356, 365 (2010) (“We have long recognized that deportation is a particularly severe ‘penalty,’ but it is not, in a strict sense, a criminal sanction. Although removal proceedings are civil in nature, deportation is nevertheless intimately related to the criminal process.” (citations omitted)); *Harisiades v. Shaughnessy*, 342 U.S. 580, 594 (1952) (“Deportation, however severe its consequences, has been consistently classified as a civil rather than a criminal procedure.”).

24. See, e.g., NIJC, *supra* note 4, at 8 (“The majority of immigration detainees have no criminal record, or have committed only minor crimes or traffic violations, often years before being detained by ICE.” (internal references and citations omitted)).

25. See, e.g., COMMONWEALTH OMBUDSMAN, SUICIDE AND SELF-HARM IN THE IMMIGRATION DETENTION NETWORK 45–46 (2013) (stating that a history of torture and trauma are among the factors contributing to self-harm in immigration detention in Australia, as “[s]tudies have indicated that people who have fled violence and disruption in their countries of origin, and who

insurance and health care since they entered the United States, and they continue to lack access to adequate mental health care following their detention.<sup>26</sup>

Borrowing the philosophy behind legally enforceable federal patients' rights laws that govern the use of seclusion in hospitals, this Article proposes to reform the unenforceable standards governing the use of seclusion in immigration detention centers. Under the federal Medicare Conditions of Participation (Conditions of Participation),<sup>27</sup> all hospital patients have a legally enforceable right to be free from mental and physical abuse.<sup>28</sup> Patients have the specific right to be free from seclusion imposed as a means of coercion, discipline, convenience, or retaliation by hospital staff.<sup>29</sup> Seclusion may be ordered for only one reason; that is, to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient herself, a staff member, or other person.<sup>30</sup> In the hospital context, only a physician or other licensed independent health care practitioner may order seclusion,<sup>31</sup> and each order for seclusion may last no longer than four hours for an adult patient.<sup>32</sup> Regardless of the length of time specified in

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may have been subject to torture and trauma, often exhibit preexisting mental health conditions or are vulnerable to developing a post traumatic condition”).

26. See, e.g., Fatma Marouf, *Creating a Subclass of Immigrants with Deferred Action Status: Denial of Health Care as an Enduring Disability*, HAMILTON & GRIFFIN ON RIGHTS (Dec. 1, 2014), <http://hamilton-griffin.com/guest-blog-fatma-marouf-creating-a-subclass-of-immigrants-with-deferred-action-status-denial-of-health-care-as-an-enduring-disability> (addressing the lack of access to health insurance by individuals with Deferred Action for Childhood Arrivals (DACA) and Deferred Action for Parental Accountability (DAPA) status).

27. The Medicare Conditions of Participation are federal regulations that hospitals must meet in order to participate in the Medicare Program and receive reimbursement for providing hospital services to Medicare beneficiaries. See 42 C.F.R. §§ 482.1–.104 (2014); *id.* § 482.1(a)(1)(i) (“Hospitals participating in Medicare must meet certain specified requirements.”); *id.* § 488.3(a), (a)(2) (“In order to be approved for participation in or coverage under the Medicare program, a prospective provider . . . must . . . be in compliance with the applicable conditions . . . prescribed in [42 C.F.R. Part 482 . . . .]”); *id.* § 489.53(a), (a)(1) (“[The Centers for Medicare and Medicaid Services] may terminate the agreement with any provider if CMS finds that . . . [the hospital] . . . is not complying with the provisions of [Title 18 of the Social Security Act and its implementing regulations] or with the provisions of the [participating-provider] agreement.”).

28. 42 C.F.R. § 482.13(e).

29. *Id.*

30. *Id.* § 482.13(e)(8)(i).

31. *Id.* § 482.13(e)(5).

32. *Id.* § 482.13(e)(8)(i)(A).

the order, all seclusion interventions must be discontinued at the earliest possible time.<sup>33</sup> Hospital leadership is responsible for creating a culture that supports each patient's right to be free from unnecessary seclusion and for developing, implementing, and evaluating systems and processes that are designed to eliminate inappropriate seclusion use.<sup>34</sup>

Hospitals that violate the Conditions of Participation risk losing Medicare-participating provider status, resulting in an inability to receive federal reimbursement for providing care to government program beneficiaries.<sup>35</sup> Because most hospitals rely heavily on Medicare and Medicaid dollars, federal health care program exclusion is considered a "financial death sentence for hospitals."<sup>36</sup> The Office of the Inspector General of the federal Department of Health and Human Services also has the authority to impose on non-compliant hospitals civil monetary penalties that accrue on a daily basis.<sup>37</sup> This Article is the first piece of legal scholarship to propose a similar set of legally enforceable standards governing the use of seclusion in immigration detention centers.

This Article proceeds as follows: Part I examines the use and abuse of seclusion in U.S. immigration detention centers.<sup>38</sup> Every day, hundreds of detainees are secluded in small, windowless cells<sup>39</sup> for days, weeks, and months at a time, with

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33. *Id.* § 482.13(e), (e)(9).

34. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T HEALTH & HUMAN SERVS., STATE OPERATIONS MANUAL, APPENDIX A—SURVEY PROTOCOL, REGULATIONS AND INTERPRETIVE GUIDELINES FOR HOSPITALS, reg. A-0154 (Rev. 122, Sept. 26, 2014).

35. *See* 42 C.F.R. § 482.1(b) ("[T]he provisions of this part serve as the basis of survey activities for the purpose of determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid.").

36. *See, e.g.*, OFFICE OF INSPECTOR GEN., U.S. DEP'T HEALTH & HUMAN SERVS., A ROADMAP FOR NEW PHYSICIANS: AVOIDING MEDICARE AND MEDICAID FRAUD AND ABUSE, SPEAKER NOTE SET 13 (2014), [http://oig.hhs.gov/compliance/physician-education/roadmap\\_speaker\\_notes.pdf](http://oig.hhs.gov/compliance/physician-education/roadmap_speaker_notes.pdf) [hereinafter SPEAKER NOTE SET] ("The effect of exclusion is very serious. Excluded [providers] may not bill for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice. Because of this prohibition, some refer to exclusion as a 'financial death sentence' for any health care provider.").

37. *See infra* notes 285–86 and accompanying text (discussing enforceable civil penalties).

38. *See infra* Part I.

39. Ian Urbina & Catherine Rentz, *Immigrants Held in Solitary Cells, Often for Weeks*, N.Y. TIMES (Mar. 23, 2013), <http://www.nytimes.com/2013/03/24/us/immigrants-held-in-solitary-cells-often-for-weeks.html> ("On any given day, about 300 immigrants are held in solitary confinement at the 50 largest



no access to visitors and little or no recreation.<sup>40</sup> Reasons for the intervention include coercion, convenience, discipline, retaliation, a lack of space, an inability to provide mental health care, an inability to protect vulnerable detainees, and a lack of other institutional solutions.<sup>41</sup>

Part I also reviews the research investigating the impact of seclusion on detainee physical and mental health.<sup>42</sup> This research shows that seclusion has a profoundly negative impact on detainee health and wellbeing, especially with respect to detainees who have preexisting physical and mental health conditions.<sup>43</sup> Seclusion is associated with a number of physiological effects, including heart palpitations, diaphoresis, insomnia, back and other joint pains, deterioration of eyesight, poor appetite, weight loss, lethargy, weakness, and tremors.<sup>44</sup> Seclusion is also associated with a number of psychological effects, including anxiety, depression, anger, cognitive

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detention facilities that make up the sprawling patchwork of holding centers nationwide overseen by Immigration and Customs Enforcement officials . . . .”).

40. See, e.g., DETENTION WATCH NETWORK, EXPOSE & CLOSE: THEO LACY DETENTION CENTER, CALIFORNIA 5 (2012) [hereinafter THEO LACY DETENTION CENTER REPORT] (“[D]isciplinary segregation at Theo Lacy means that a person is housed 24 hours a day in a small isolation room with no access to visitors and no recreation. They are released briefly every other day for a shower.”).

41. See *infra* Part I.

42. See *infra* Part I.

43. See, e.g., SHARON SHALEV, A SOURCEBOOK ON SOLITARY CONFINEMENT 10 (2008) [hereinafter SOURCEBOOK] (“There is unequivocal evidence that solitary confinement has a profound impact on health and wellbeing, particularly for those with pre-existing mental health disorders . . . .”); *id.* at 10–24 (providing an in-depth review of studies investigating the negative health consequences of seclusion); Juan E. Mendez, *Preface* to SHARON SHALEV, SOURCEBOOK ON SOLITARY CONFINEMENT 1, 2 (Spanish ed. 2014) [hereinafter Mendez, Special Rapporteur on Torture] (“There is strong evidence suggesting that solitary confinement, even for a short period, adversely impacts on mental health. The gravity of these impacts increases with the passage of time and they may eventually become irreversible. Research in this field has established that solitary confinement can cause mental illnesses, including a syndrome described as ‘prison psychosis[,]’ . . . which manifests in symptoms including anxiety, depression, anger, cognitive disturbances, paranoia and psychosis, and can lead to self-harm.”); Urbina & Rentz, *supra* note 39 (“Paranoia, depression, memory loss and self-mutilation are not uncommon.”); see also SHARITA GRUBERG, CTR. FOR AMERICAN PROGRESS, DIGNITY DENIED: LGBT IMMIGRANTS IN U.S. IMMIGRATION DETENTION 6 (2013) (referencing the negative health consequences of seclusion).

44. SOURCEBOOK, *supra* note 43, at 15.

disturbances, perceptual distortions, paranoia, and psychosis.<sup>45</sup> In light of these and other associations, the United Nations Special Rapporteur has stated that seclusion can constitute torture in certain circumstances, and that seclusion should never be used with respect to detainees who have mental disabilities,<sup>46</sup> especially in light of the high rate of self-harm and suicidal behaviors among secluded populations.<sup>47</sup> Part I argues that the justifications proffered for seclusion are rarely proportionate to the intervention's dangers and fall short of both international human rights and federal hospital patients' rights standards governing the imposition of seclusion.<sup>48</sup>

Part II reveals that seclusion-related injuries and deaths used to be common in other contexts, especially the health care context.<sup>49</sup> From the late 1980s to the late 1990s, hundreds of seclusion-related deaths occurred across the country in psychiatric hospitals, psychiatric units of general hospitals, and other health care facilities. Part II explains how these deaths led researchers, patient safety advocates, and others to study and publicize the high rates of seclusion-related deaths and to identify factors believed to contribute to these deaths, including the failure of hospital staff to attempt less restrictive measures to calm patients down before imposing seclusion, the use of seclusion by staff members untrained in safe seclusion practices, the failure of staff to comply with relevant state statutes and regulations limiting the length of time that

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45. *Id.* at 15–16.

46. Mendez, Special Rapporteur on Torture, *supra* note 43, at 2 (“Depending on the reasons for its use, the conditions through which it is imposed, its duration, the gravity of its effects and other circumstances, solitary confinement can amount to cruel, inhuman or degrading treatment, or even to torture.”); *id.* at 3 (“Solitary confinement should never be imposed to minors, pregnant or breastfeeding women, or persons with mental disability. In such cases, in view of the particular vulnerability of the detained person, solitary confinement always amounts to cruel, inhuman or degrading treatment, or torture.”).

47. See, e.g., Kevin Johnson, *Inmate Suicide Linked to Solitary*, USA TODAY (Dec. 27, 2006), [http://usatoday30.usatoday.com/news/nation/2006-12-27-inmate-suicides\\_x.htm](http://usatoday30.usatoday.com/news/nation/2006-12-27-inmate-suicides_x.htm) (reporting that sixty-nine percent of California’s prison suicides occurred in units where inmates are isolated for twenty-three hours a day; further reporting that most of Texas’s prison suicides involved inmates who were in some type of solitary confinement); see also SOURCEBOOK, *supra* note 43, at 17 (“[T]here is compelling anecdotal evidence that the prevalence of [self-harm] in segregation and isolations units is particularly high.”).

48. See *infra* Part I.

49. See *infra* Part II.

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patients may be placed in seclusion, and the use of seclusion without adequate recognition of suicide hazards.

Part II further explores the responses to these deaths by public and private agencies and associations, including the U.S. General Accounting Office, the U.S. Substance Abuse and Mental Health Services Administration, and the National Association of State Mental Health Program Directors.<sup>50</sup> These organizations issued reports formally calling for the reduction and eventual elimination of the seclusion intervention in the health care context. Part II shows that health law reform quickly followed, including new federal regulations strictly governing the imposition of seclusion in the health care context. Compelled by the threat of civil monetary penalties, exclusion from the Medicare Program, and private lawsuits, Part II reveals how many hospitals and other health care institutions quickly reduced and attempted to eliminate their use of the seclusion intervention altogether. Finally, Part II evaluates post-law reform studies reporting associations between the reduction in seclusion and restraint use and lower numbers of patient injuries and deaths, shorter hospital lengths of stay, decreased rates of re-hospitalization, lower rates of medication usage, lower costs, higher levels of patient functioning at the time of discharge, and increased patient satisfaction.<sup>51</sup>

Thus far, proposals to reform the U.S. immigration detention and deportation system have relied heavily on constitutional law and international human rights theories.<sup>52</sup> Part III takes a novel approach by proposing to correct the abuse of the seclusion intervention in immigration detention by drawing on established frameworks in health law and bioethics.<sup>53</sup> Specifically, Part III highlights the philosophical differences between federal health laws that are designed to protect the health, safety, and welfare of hospital patients and ICE's unenforceable standards that fail to protect immigration detainees.<sup>54</sup> Part III offers nine specific recommendations that, if promulgated by the Department of Homeland Security into

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50. See *infra* Part II.

51. See, e.g., SAMHSA, BUSINESS CASE, *supra* note 20, at 1–28 (citing studies reporting cost savings and other patient benefits associated with reductions in restraint and seclusion use).

52. See, e.g., text accompanying *infra* notes 74–114.

53. See *infra* Part III.

54. See *infra* Part III.

federal regulations, would improve the health, safety, and welfare of immigration detainees.<sup>55</sup>

### I. IMMIGRATION DETENTION: UNDER FIRE

The United States is home to more than 250 immigration detention centers<sup>56</sup> that are designed to confine one or more aliens<sup>57</sup> pending a determination regarding whether each alien is to be removed from the United States or, once a final order of removal has been entered, the alien's return transportation to her country of citizenship.<sup>58</sup> In 2013, the most recent year for which data are available from the federal Office of Immigration

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55. See *infra* Part III.

56. See, e.g., DETENTION WATCH NETWORK, EXPOSE & CLOSE, ONE YEAR LATER: THE ABSENCE OF ACCOUNTABILITY IN IMMIGRATION DETENTION 1 (2013) [hereinafter EXPOSE & CLOSE: ONE YEAR LATER], [http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-lyrlaternov13\\_0.pdf](http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-lyrlaternov13_0.pdf) (referencing the "network of over 250 prisons operated by federal, state, and local governments, as well as by private corporations"); LUTHERAN IMMIGRATION & REFUGEE SERV., FROM PERSECUTION TO PRISON: CHILD AND FAMILY DETENTION 1 (2014), <http://lirs.org/wp-content/uploads/2014/08/LIRS-Family-Detention-Backgrounder-140807.pdf> (referencing the "nationwide system of over 250 immigration detention facilities"); Ted Robbins, *Little-Known Immigration Mandate Keeps Detention Beds Full*, NAT'L PUB. RADIO (Nov. 19, 2013), <http://www.npr.org/2013/11/19/245968601/little-known-immigration-mandate-keeps-detention-beds-full> (referencing "some 250 facilities across the country").

57. An alien is defined as a person who is not a United States citizen or national. 8 U.S.C. § 1101(a)(3) (2014).

58. See *id.* § 1226(a) ("On a warrant issued by the Attorney General, an alien may be arrested and detained pending a decision on whether the alien is to be removed from the United States. Except as provided . . . and pending such decision, the Attorney General—(1) may continue to detain the arrested alien . . ."); *id.* § 1231(a)(1)(A), (a)(2) ("Except as otherwise provided . . . when an alien is ordered removed, the Attorney General shall remove the alien from the United States within a period of 90 days ('referred to as the removal period') . . . During the removal period, the Attorney General shall detain the alien."); OFFICE OF IMMIGRATION STATISTICS, U.S. DEP'T HOMELAND SEC., IMMIGRATION ENFORCEMENT ACTIONS: 2013, at 2 (Sept. 2014) [hereinafter 2013 DHS IMMIGRATION STATISTICS] (defining detention as the "physical custody of an alien in order to hold him/her, pending a determination on whether the alien is to be removed from the United States or awaiting return transportation to his/her country of citizenship after a final order of removal has been entered"). Reasons for alien detention include, but are not limited to, being in the United States without proper documentation, overstaying a visa, being charged or convicted of certain crimes, having been previously deported (or ordered to leave the country) and having returned to (or having remained in) the United States, and the seeking of political asylum by refugees. See, e.g., Cody Mason, *Dollars and Detainees: The Growth of For-Profit Detention*, SENTENCING PROJECT, July 2012, at 2 (providing background information regarding immigration and customs enforcement).

Statistics, ICE<sup>59</sup> detained nearly 441,000 aliens,<sup>60</sup> ninety percent of whom were nationals of Mexico, Guatemala, Honduras, and El Salvador.<sup>61</sup>

The largest detention center in the United States opened its doors in December 2014 in Dilley, Texas.<sup>62</sup> Spread across fifty acres and built to hold up to 2,400 individuals, the South Texas Family Residential Center is run by Corrections Corporation of America (CCA), a private, for-profit corrections system that designs, finances, builds, owns, and manages detention centers, prisons, and jails on behalf of ICE and other federal, state, and local agencies.<sup>63</sup> CCA, whose annual revenue is upwards of \$1.8 billion,<sup>64</sup> operates more than sixty detention facilities across the United States and manages more than 80,000 detainees and inmates.<sup>65</sup> CCA and other for-profit companies, including the GEO Group<sup>66</sup> and Community

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59. ICE, the largest investigative agency in the Department of Homeland Security, enforces federal immigration laws as part of its homeland security mission. See *Who We Are*, IMMIGRATION & CUSTOMS ENFT, <http://www.ice.gov> (last visited Apr. 20, 2016).

60. 2013 DHS IMMIGRATION STATISTICS, *supra* note 58, at 1, 5 tbl.5, 6 (“ICE detained 440,557 aliens during 2013, a decrease of 8 percent from 2012. . .”).

61. *Id.* at 5 tbl.5, 6 (providing numbers and percentages of aliens detained by country of citizenship).

62. *South Texas Migrant Detention Center, the Nation’s Largest, Opens*, DALLAS MORNING NEWS (Dec. 15, 2014), <http://www.dallasnews.com/news/local-news/20141215-homeland-secretary-opens-migrant-family-detention-center-in-south-texas.ece> (discussing the opening of the South Texas Family Residential Center); Press Release, Immigration & Customs Enft, U.S. Dep’t Homeland Sec, ICE’s New Family Detention Center in Dilley, Texas To Open in December (Nov. 17, 2014), <https://www.ice.gov/news/releases/ices-new-family-detention-center-dilley-texas-open-december>.

63. CORRECTIONS CORP. OF AM., CORRECTIONS CORPORATION OF AMERICA (CCA) AT A GLANCE: AMERICA’S LEADERSHIP IN PARTNERSHIP CORRECTIONS 1 [hereinafter CCA AT A GLANCE] (providing background information regarding CCA); John Burnett, *How Will a Small Town in Arizona Manage an ICE Facility in Texas?*, NAT’L PUB. RADIO (Oct. 28, 2014), <http://www.npr.org/2014/10/28/359411980/how-will-a-small-town-in-arizona-manage-an-ice-facility-in-texas> (discussing the history of the South Texas Family Residential Center and its operation by CCA).

64. ACLU OF GA., PRISONERS OF PROFIT: IMMIGRANTS AND DETENTION IN GEORGIA 12 (2012) [hereinafter PRISONERS OF PROFIT] (stating that CCA’s annual revenue in 2010 was \$1.7 billion).

65. CCA AT A GLANCE, *supra* note 63.

66. *Welcome to the GEO Group*, GEO GRP., <http://www.geogroup.com> (last visited Apr. 20, 2016) (providing information regarding the global detention, corrections, and reentry services provided by the GEO Group).

Education Centers,<sup>67</sup> contract with ICE to provide detention services. ICE also obtains detention services from the federal Bureau of Prisons and state and local jails<sup>68</sup> in addition to running its own detention centers.<sup>69</sup>

Over the past decade, ICE has been under heavy fire by civil rights, human rights, and immigrant advocacy groups, as well as by legal scholars, law school-based immigration clinics, and other stakeholders, for its treatment of detainees.<sup>70</sup> In March 2009, for example, Amnesty International released a

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67. *CEC Corrections*, CMTY. EDUC. CTRS., <https://www.cecintl.com/secure.html> (last visited Apr. 20, 2016) (explaining that CEC contracts with ICE among other federal, state, and local agencies, to provide detention services); *CEC Locations*, CMTY. EDUC. CTRS., [https://www.cecintl.com/facilities\\_facilities.html](https://www.cecintl.com/facilities_facilities.html) (last visited Apr. 20, 2016) (listing detention facilities operated by CEC in Ohio, Pennsylvania, and Texas).

68. *See, e.g.*, Intergovernmental Service Agreement Between the U.S. Dep't of Homeland Security, U.S. Immigration and Customs Enforcement Office of Enforcement and Removal Operations, and Karnes County, Texas, Art. I(A) (Dec. 2010) (obligating Karnes County, Texas, to provide detention services to detainees at the Karnes County Civil Detention Facility located in Karnes City, Texas). Even though immigration detention is a civil, not criminal, form of detention, immigration detainees are frequently housed with criminals in Federal Bureau of Prisons facilities as well as in state and local jails. *See, e.g., Detention Management*, IMMIGRATION & CUSTOMS ENFT (Nov. 10, 2011), <https://www.ice.gov/factsheets/detention-management> (“Nearly 67 percent of the ICE detained population are housed in local or state facilities, 17 percent are housed in contract detention facilities, 13 percent are housed in ICE-owned facilities (service processing centers), and 3 percent are housed in Bureau of Prisons facilities, which are funded either through congressional appropriations to the bureau or through ICE reimbursement.”).

69. *See, e.g.*, EXPOSE & CLOSE: ONE YEAR LATER, *supra* note 56 (referencing the network of detention centers “operated by federal, state, and local governments, as well as by private corporations”); OFFICE OF INSPECTOR GEN., U.S. DEP'T HOMELAND SEC., IMMIGRATION & CUSTOM ENFORCEMENT DETENTION BEDSPACE MANAGEMENT, OIG Rep. No. 09-52, at 2 (2009) (“ICE houses detainees in eight ICE-owned and operated service processing centers, seven contract detention facilities owned and operated by private-sector businesses on behalf of ICE, or more than 350 state and local government facilities through intergovernmental service agreements.”).

70. *See, e.g.*, Kate Linthicum, *Immigration Detention Center on Terminal Island Deemed Unsafe Again*, L.A. TIMES (Dec. 16, 2014), <http://www.latimes.com/local/california/la-me-ice-facility-20141217-story.html> (“ICE’s detention practices have previously come under fire . . . .”); Megan Sweas, *Immigration Officials Call on Churches, Nonprofits To Help Detained Families*, NAT'L CATHOLIC REP. (June 10, 2014), <http://ncronline.org/blogs/immigration-and-church/immigration-officials-call-churches-nonprofits-help-detained-families> (“ICE has been releasing families from custody because of a lack of detention facilities, but it has come under fire in recent weeks for its treatment of released migrants.”).

report highlighting U.S. detainees' lack of basic human rights.<sup>71</sup> In that report, Amnesty International argued that, "The use of detention as a tool to combat unauthorized migration falls short of international human rights law, which contains a clear presumption against detention. Everyone has the right to liberty, freedom of movement, and the right not to be arbitrarily detained."<sup>72</sup>

State affiliates of the American Civil Liberties Union (ACLU) have also issued a series of reports condemning ICE and its contracted detention service providers for their treatment of detainees.<sup>73</sup> In 2008, the ACLU of Massachusetts issued a report tracking the experiences of forty detainees in Massachusetts and concluding that, "ICE's system of vast, unchecked federal powers opens the door to violations of basic human rights."<sup>74</sup> In 2010, the New York Civil Liberties Union issued a report analyzing one year of grievances filed by detainees housed in the Varick Federal Detention Facility, New York's only federal immigration detention center.<sup>75</sup> The New York report concluded that, "the federal government has failed in its responsibilities to provide adequate care to detainees housed in immigration facilities."<sup>76</sup>

In 2011, the ACLU of Arizona issued a report documenting 115 face-to-face interviews with detainees and more than 500 grievances authored by detainees.<sup>77</sup> The Arizona report highlighted systematic civil and human rights abuses in several key areas, including deficient physical and mental health care, abusive treatment of detainees, inhumane conditions in local jails, and an overall lack of accountability.<sup>78</sup> In 2012, the ACLU of Georgia issued a similar report detailing detainee conditions in Georgia, highlighting "serious concerns about violations of detainees' due process rights, inadequate

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71. AMNESTY INT'L, JAILED WITHOUT JUSTICE: IMMIGRATION DETENTION IN THE USA 3 (2009).

72. *Id.*

73. *See, e.g., infra* text accompanying notes 74–80.

74. ACLU OF MASS., DETENTION AND DEPORTATION IN THE AGE OF ICE: IMMIGRANTS AND HUMAN RIGHTS IN MASSACHUSETTS 5 (2008).

75. N.Y. CIVIL LIBERTIES UNION, VOICES OF VARICK: DETAINEE GRIEVANCES AT NEW YORK CITY'S ONLY FEDERAL IMMIGRATION DETENTION FACILITY 1 (2010).

76. *Id.*

77. ACLU OF ARIZ., THEIR OWN WORDS: ENDURING ABUSE IN ARIZONA IMMIGRATION DETENTION CENTERS 3 (2011).

78. *Id.*

living conditions, inadequate medical and mental health care, and abuse of power by those in charge.”<sup>79</sup> In December 2014, the ACLU of Southern California issued a report concluding that the overwhelming majority of detainees should be released on bond or other conditions of release and that “their prolonged detention—at great personal cost to themselves and their families and massive financial cost to taxpayers—[is] unnecessary.”<sup>80</sup>

Amnesty International and the ACLU are not the only organizations that have critiqued the U.S. immigration detention and deportation system. In 2012, Detention Watch Network, a national coalition of organizations and individuals working to expose and challenge the injustices associated with immigration detention and deportation,<sup>81</sup> released ten “Expose and Close” reports documenting human rights violations occurring in immigration detention centers located across the United States.<sup>82</sup> The reports focused on the poor conditions of detainees in Baker County Jail in Macclenny, Florida;<sup>83</sup> Etowah County Jail in Gadsden, Alabama;<sup>84</sup> Houston Processing Center in Houston, Texas;<sup>85</sup> Hudson County Jail in Kearny, New Jersey;<sup>86</sup> Irwin County Detention Center in Ocilla, Georgia;<sup>87</sup>

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79. PRISONERS OF PROFIT, *supra* note 64.

80. ACLU OF S. CAL., RESTORING DUE PROCESS: HOW BOND HEARINGS UNDER *RODRIGUEZ V. ROBBINS* HAVE HELPED END ARBITRARY IMMIGRATION DETENTION 1 (2014).

81. *Who We Are*, DETENTION WATCH NETWORK, <http://www.detentionwatchnetwork.org/whoweare> (last visited Apr. 20, 2016).

82. *Detention Watch Network Expose and Close Reports on 10 of the Worst Immigrant Prisons in the US*, DETENTION WATCH NETWORK, <http://www.detentionwatchnetwork.org/ExposeAndClose> (last visited Apr. 20, 2016) (linking to all ten reports).

83. DETENTION WATCH NETWORK, EXPOSE & CLOSE: BAKER COUNTY JAIL, FLORIDA (2012) [hereinafter BAKER COUNTY JAIL REPORT], <http://www.detentionwatchnetwork.org/sites/default/files/reports/DWN%20Expose%20and%20Close%20Baker%20County.pdf>.

84. DETENTION WATCH NETWORK, EXPOSE & CLOSE: ETOWAH COUNTY JAIL, ALABAMA (2012) [hereinafter ETOWAH COUNTY JAIL REPORT], <http://www.detentionwatchnetwork.org/sites/default/files/reports/DWN%20Expose%20and%20Close%20Etowah%20County.pdf>.

85. DETENTION WATCH NETWORK, EXPOSE & CLOSE: HOUSTON PROCESSING CENTER, TEXAS (2012) [hereinafter HOUSTON PROCESSING CENTER REPORT], <http://www.detentionwatchnetwork.org/sites/default/files/reports/DWN%20Expose%20and%20Close%20Houston.pdf>.

86. DETENTION WATCH NETWORK, EXPOSE & CLOSE: HUDSON COUNTY JAIL, NEW JERSEY (2012) <http://www.detentionwatchnetwork.org/sites/default/files/reports/DWN%20Expose%20and%20Close%20Hudson%20County.pdf>.



Pinal County Jail in Florence, Arizona;<sup>88</sup> Polk County Adult Detention Facility in Livingston, Texas;<sup>89</sup> Stewart Detention Center in Lumpkin, Georgia;<sup>90</sup> Theo Lacy Detention Center in Orange, California;<sup>91</sup> and Tri-County Detention Center in Ullin, Illinois.<sup>92</sup> The conditions in these ten facilities were so poor that Detention Watch Network sent a letter to President Obama in November 2012 asking him to close all ten facilities and to improve the health, safety, and welfare of all detainees in the United States.<sup>93</sup>

The following year, Detention Watch Network released a follow-up report re-reviewing the conditions in the ten facilities exposed the prior year and highlighting the poor conditions of detainees in additional facilities.<sup>94</sup> Detention Watch Network's 2013 report concluded that, "Immigrants in detention are denied basic needs . . . . They are subject to sub-standard medical care and denial of specialty care, resulting in prolonged injury, sickness and/or death. There is no accountability for

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87. DETENTION WATCH NETWORK, EXPOSE & CLOSE: IRWIN COUNTY DETENTION CENTER, GEORGIA (2012) [hereinafter IRWIN COUNTY DETENTION CENTER REPORT], <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-irwinnov12.pdf>.

88. DETENTION WATCH NETWORK, EXPOSE & CLOSE: PINAL COUNTY JAIL, ARIZONA (2012) [hereinafter PINAL COUNTY JAIL REPORT], <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-pinalnov12.pdf>.

89. DETENTION WATCH NETWORK, EXPOSE & CLOSE: POLK COUNTY DETENTION FACILITY, TEXAS (2012) [hereinafter POLK COUNTY DETENTION FACILITY REPORT], <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-polknov12.pdf>.

90. DETENTION WATCH NETWORK, EXPOSE & CLOSE: STEWART DETENTION CENTER, GEORGIA (2012), <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-stewartnov12.pdf>.

91. THEO LACY DETENTION CENTER REPORT, *supra* note 40.

92. DETENTION WATCH NETWORK, EXPOSE & CLOSE: TRI-COUNTY DETENTION CENTER, ILLINOIS (2012) [hereinafter TRI-COUNTY DETENTION CENTER REPORT], <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose-tricountynov12.pdf>.

93. Letter from Int'l, Nat'l, Reg'l, State, and Local Orgs. to President Barack Obama at 1, 3, (Nov. 28, 2012), <http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/ec-obamaletter.pdf> ("[W]e, the undersigned civil and human rights organizations, call on you to . . . close at least ten facilities that advocates have identified as among the worst of immigration detention facilities across the country. . . . We also call on the Administration to fulfill our international obligations and your promise for humane and just treatment for everyone. . . . The safety, health and even the lives of thousands of immigrants, and the wellbeing of their families, depends on it.").

94. See EXPOSE & CLOSE: ONE YEAR LATER, *supra* note 56.

those who suffer needlessly behind bars.”<sup>95</sup> Most recently, in September 2014, Detention Watch Network issued a report focusing on the poor conditions of detainees at the Artesia Family Residential Center in Artesia, New Mexico.<sup>96</sup> Among other issues, the New Mexico report detailed the center’s failure to meet basic child welfare guidelines and its inability to provide minimum physical and mental health care.<sup>97</sup>

Leading American journalists also have criticized the lack of concern for detainee health, safety, and welfare. In May 2008, staff writers at the *Washington Post* published a series of four articles detailing the medical neglect and other substandard conditions suffered by U.S. detainees.<sup>98</sup> Based on interviews and thousands of internal documents, including e-mails, memos, autopsy reports, and medical records, the series’ writers highlighted the plight of detainees with mental illness: “While tens of thousands of detainees inside immigration detention centers endure substandard medical care, people with mental illness are relegated to the darkest and most neglected corners of the system . . . .”<sup>99</sup>

In April 2013, the Editorial Board of the *New York Times* boldly stated that “ICE’s detention system . . . is not a model of humane incarceration. It’s a ramshackle network of private and public lockups, prone to abuses and lacking legally enforceable standards for how detainees are treated.”<sup>100</sup> The *Houston Chronicle* published a similar article in August 2014 likening immigration detention centers to deportation factories.<sup>101</sup> That same month, the *Los Angeles Times* reported the story of an

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95. *Id.*

96. DETENTION WATCH NETWORK, EXPOSE & CLOSE: ARTESIA FAMILY DETENTION CENTER, NEW MEXICO (2014), [http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose\\_close\\_-\\_artesia\\_family\\_residential\\_center\\_nm\\_2014.pdf](http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/expose_close_-_artesia_family_residential_center_nm_2014.pdf).

97. *Id.* at 7–10.

98. See Dana Priest & Amy Goldstein, *Careless Detention*, WASH. POST, May 11, 12, 13, & 14, 2008, at A1 (documenting detention centers’ medical neglect of detainees, failure to provide health care, high rates of detainee suicide, and practice of drugging detainees prior to deportation).

99. Dana Priest & Amy Goldstein, *Careless Detention: Suicides Point to Gaps in Treatment*, WASH. POST, May 13, 2008, at A1.

100. *Immigrants in Solitary*, *supra* note 7.

101. David McCumber & Susan Carroll, *Immigrant Detention Centers Decried by Critics as “Deportation Factories,”* HOUS. CHRON. (Aug. 12, 2014), <http://www.houstonchronicle.com/news/article/Immigrant-detention-centers-decried-by-critics-as-5684471.php>.

eleven-year-old boy who, as a United States citizen, was mistakenly placed in ICE custody for more than one month.<sup>102</sup>

Legal scholars and other academics also have spent a considerable amount of time identifying, analyzing, and proposing solutions to concerns associated with the U.S. immigration detention and deportation system. These concerns include due process concerns,<sup>103</sup> human rights concerns,<sup>104</sup>

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102. Cindy Carcamo, *Child's Detention Despite Citizenship Reveals Immigration Case Woes*, L.A. TIMES (Aug. 14, 2014), <http://www.latimes.com/world/mexico-americas/la-na-citizen-detained-20140815-story.html> (“The boy spent more than a month at the detention center in Artesia, N.M., before an immigration attorney who happened to be visiting the facility discovered his status last week.”).

103. See, e.g., Farrin R. Anello, *Due Process and Temporal Limits on Mandatory Immigration Detention*, 65 HASTINGS L.J. 363, 363 (2014) (using Supreme Court due process doctrine to argue that “the mandatory detention statute should be construed to govern detention for no longer than six months, after which time a bond hearing should be required”); David Cole, *In Aid of Removal: Due Process Limits on Immigration Detention*, 51 EMORY L.J. 1003, 1008 (2002) (identifying several aspects of INS’s then-current detention policies and practices that the author believed violated due process); Jennifer Lee Koh, *Waiving Due Process (Goodbye): Stipulated Orders of Removal and the Crisis in Immigration Adjudication*, 91 N.C. L. REV. 475, 476 (2013) (“[T]his Article argues that the stipulated order of removal program, as implemented thus far, violates due process, and offers suggestions for reform.”); Fatma E. Marouf, *Incompetent but Deportable: The Case for a Right to Mental Competence in Removal Proceedings*, 65 HASTINGS L.J. 929, 929 (2014) (arguing that “courts should recognize a substantive due process right to competence in removal proceedings” that “would prevent those found mentally incompetent from being deported”); Mark Noferia, *Cascading Constitutional Deprivation: The Right to Appointed Counsel for Mandatorily Detained Immigrants Pending Removal Proceedings*, 18 MICH. J. RACE & L. 63, 63 (2012) (“In this Article, I call this the cascading constitutional deprivation of wrongful detention and deportation. I argue, under modern procedural due process theories, that this cascading constitutional deprivation warrants appointed counsel, notwithstanding traditional plenary power over immigration laws.”); Faiza W. Sayed, Note, *Challenging Detention: Why Immigrant Detainees Receive Less Process than “Enemy Combatants” and Why They Deserve More*, 111 COLUM. L. REV. 1833, 1833 (2011) (arguing that “immigrant detainees deserve more process to protect against erroneous detention” and proposing “ways to reform immigrant challenges to mandatory detention”).

104. See, e.g., Denise Gilman, *Realizing Liberty: The Use of International Human Rights Law To Realign Immigration Detention in the United States*, 36 FORDHAM INT’L L.J. 243, 249 (2013) (“[T]he Article demonstrates how the application of international human rights law standards can bring rationality and humanity to US immigration detention by revitalizing the right to liberty, which constitutes a core conception in both international human rights law and US law.”); César Cuauhtémoc García Hernández, *Invisible Spaces and Invisible Lives in Immigration Detention*, 57 HOW. L.J. 869, 871 (2014) (“These individuals are not just migrants ineligible for the privileges of full participation in civic life. Rather, detained migrants have been moved, by law,

empirical concerns,<sup>105</sup> and concerns regarding the high rates of all types of detainee abuse, including physical, sexual, and emotional abuse.<sup>106</sup> Still other scholars have critiqued immigration detention's penal nature<sup>107</sup> as well as its flawed

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outside the law, and rendered ineligible for basic human dignities.”); Susan Marx, *Throwing Away the Key: The Constitutionality of the Indefinite Detention of Inadmissible Aliens*, 35 TEX. TECH L. REV. 1259, 1263 (2004) (analyzing “issues of public policy and human rights as they pertain to indefinite detention” and concluding that “such detention is contrary to international human rights laws and agreements, as well as to public policy within the United States”); Shana Tabak & Rachel Levitan, *LGBTI Migrants in Immigration Detention: A Global Perspective*, 37 HARV. J.L. & GENDER 1, 2 (2014) (“Although all detainees are vulnerable to human rights abuses, LGBTI detainees are particularly susceptible to heightened levels of physical and mental abuse.”).

105. See Fatma Marouf et al., *Justice on the Fly: The Danger of Errant Deportations*, 75 OHIO ST. L.J. 337, 337 (2014) (shedding “light on the doctrinal controversies surrounding stays of removal” by empirically analyzing 1,646 cases “in all the circuits that hear immigration appeals” and finding that “the circuit courts denied stays of removal in about half of the appeals that were ultimately granted, an alarming type of error that could result in people being errantly deported to countries where they risk persecution or torture”).

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106. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-14-38, IMMIGRATION DETENTION: ADDITIONAL ACTIONS COULD STRENGTHEN DHS EFFORTS TO ADDRESS SEXUAL ABUSE (2013) (reviewing sexual abuse that occurs in immigration detention); Maunica Sthanki, *Deconstructing Detention: Structural Impunity and the Need for an Intervention*, 65 RUTGERS L. REV. 447, 447 (2013) (“A culture of abuse and ‘othering’ of immigrant detainees has resulted in numerous reports of dehumanizing physical, sexual, and medical abuse.”); Catherine Rentz, *How Much Sexual Abuse Gets “Lost in Detention”?*, PBS FRONTLINE (Oct. 19, 2011), <http://www.pbs.org/wgbh/frontline/article/how-much-sexual-abuse-gets-lost-in-detention> (referencing the hundreds of allegations of sexual abuse that have been filed against guards and other staff members of immigration detention centers located across the United States).

107. See, e.g., Mary Fan, *The Case for Crimmigration Reform*, 92 N.C. L. REV. 75, 75 (2013) (“This Article is about curbing the most problematic excesses of the ‘crimmigration complex.’ . . . [C]rimmigration complex refers to the expanding array of government agencies and private contractors using the expensive artillery of criminal sanctions to enforce civil immigration law.”); César Cuahtémoc García Hernández, *Immigration Detention as Punishment*, 61 UCLA L. REV. 1346, 1346 (2014) (“This Article . . . contends that immigration detention—apart from the deportation that often results—itsself constitutes penal incarceration. In particular, legislation enacted over roughly fifteen years in the 1980s and 1990s indicates a palpable desire to wield immigration detention as a tool in fighting the nation’s burgeoning war on

institutional design.<sup>108</sup> Student attorneys affiliated with law school immigration clinics also have authored reports exposing substandard detainee conditions, ICE policy violations, and instances of coercion by ICE officers in particular detention centers, as well as briefs and position papers critiquing various immigration detention laws, policies, and practices.<sup>109</sup>

This Article builds on this literature with a very specific focus: the use and abuse of the seclusion intervention in U.S. immigration detention centers. By seclusion, this Article refers

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drugs by penalizing and stigmatizing criminal behavior.”); César Cuauhtémoc García Hernández, *Creating Crimmigration*, 2013 B.Y.U. L. REV. 1457, 1460 (discussing “the willingness with which United States law and society [has] turned to penal norms to address social phenomena deemed problematic”).

108. See, e.g., Alina Das, *Immigration Detention: Information Gaps and Institutional Barriers to Reform*, 80 U. CHI. L. REV. 137, 139 (2013) (examining immigration detention through the lens of “institutional design” by examining “how the legal institutions and administrative rules governing immigration detention affect the government’s ability and incentives to access the information necessary to achieve its purported goals”).

109. See BAKER COUNTY JAIL REPORT, *supra* note 83, at 1 (stating that research for the report was conducted, in part, by students from the Florida Coastal School of Law Immigrant Rights Clinic during a visit to Baker County Jail in June 2012); IMMIGRATION CLINIC, THOMAS & MACK LEGAL CLINIC, WILLIAM S. BOYD SCH. OF LAW, UNIV. OF NEV., LAS VEGAS, THE CONDITIONS OF IMMIGRATION DETENTION IN NEVADA: A REPORT ON THE HENDERSON DETENTION CENTER (2013), [http://law.unlv.edu/sites/default/files/clinic\\_immigration\\_hendersondetentioncenterreport\\_2013\\_11\\_19.pdf](http://law.unlv.edu/sites/default/files/clinic_immigration_hendersondetentioncenterreport_2013_11_19.pdf) (reporting on conditions at the Henderson Detention Center in Henderson, Nevada); IMMIGRANT RIGHTS CLINIC, UNIV. OF CAL. IRVINE SCH. OF LAW, SECOND CHANCES FOR ALL: WHY ORANGE COUNTY PROBATION SHOULD STOP CHOOSING DEPORTATION OVER REHABILITATION FOR IMMIGRANT YOUTH (2013), [http://www.law.uci.edu/academics/real-life-learning/clinics/UCILaw\\_SecondChances\\_dec2013.pdf](http://www.law.uci.edu/academics/real-life-learning/clinics/UCILaw_SecondChances_dec2013.pdf) (analyzing the Orange County Probation Department’s policy of referring immigrant children in its care to ICE; arguing that this policy violates confidentiality laws, undermines the rehabilitative goals of the juvenile justice system, impedes community policing efforts, unlawfully entangles its officers in federal immigration enforcement and diverts county resources; and recommending possible solutions to address these harms); JAYASHRI SRIKANTIAH ET AL., STANFORD LAW SCH. IMMIGRANTS RIGHTS’ CLINIC & CTR. FOR JUSTICE & INT’L LAW, SUPPLEMENTAL REPORT ON PROSECUTORIAL DISCRETION AND FAMILY UNITY ADDRESSING U.S. GOVERNMENT POLICIES ISSUED AFTER SUBMISSION OF PETITIONERS’ REPORT (2013), <https://law.stanford.edu/publications/supplemental-report-on-prosecutorial-discretion-and-family-unity-addressing-u-s-government-policies-issued-after-submission-of-petitioners-report> (challenging a U.S. immigration policy directive for its failure to consider family unity and the rights of the child and arguing that these failures violate international human rights norms); *Report from the Front: Law School’s Immigration Clinic Director Visits Federal Detention Facility*, CATHOLIC UNIV. OF AM., <http://www.law.edu/2014-Fall/Report-from-the-Front-Law-Schools-Immigration-Clinic-Director-Visits-Federal-Detention-Facility.cfm> (last visited Apr. 20, 2016).

to the involuntary confinement of a detainee alone—away from the general detention population—in a cell or other room from which the detainee is physically prevented from leaving.<sup>110</sup> The term is intentionally used to encompass a variety of practices and places referred to in the detention context as segregation,<sup>111</sup> administrative segregation,<sup>112</sup> disciplinary segregation,<sup>113</sup> separation, confinement, solitary confinement,<sup>114</sup> isolation, “the hole,” the secure housing unit, and the special management unit.<sup>115</sup> As discussed in more detail below, detention centers offer a range of justifications for their frequent use of seclusion. This Article argues that these justifications are rarely proportionate to the dangers of seclusion and fall short of federal health law standards governing the imposition of seclusion.

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110. See 42 C.F.R. § 482.13(e)(1)(ii) (2014) (establishing a similar definition of seclusion in regulations governing hospitals); OHIO ADMIN. CODE 5122-14-01(C)(59) (2016) (establishing a similar definition of seclusion in a regulation governing Ohio-licensed psychiatric hospitals and units).

111. The National Immigrant Justice Center (NIJC) defines segregation as the “practice of separating vulnerable individuals or those who have been deemed dangerous to themselves or others from the general population in a prison or detention facility.” NIJC, *supra* note 4, at 2.

112. ICE defines administrative segregation as “a non-punitive form of separation from the general population for administrative reasons.” U.S. IMMIGRATION & CUSTOMS ENF’T, DIRECTIVE NO. 11065.1, REVIEW OF THE USE OF SEGREGATION FOR ICE DETAINEES § 3.1, at 2 (Sept. 4, 2013).

113. ICE defines disciplinary segregation as “a punitive form of separation from the general population for disciplinary reasons.” *Id.* § 3.2, at 2.

114. The United Nations Special Rapporteur defines solitary confinement as the “physical and social isolation of individuals who are confined to their cells for 22 to 24 hours a day.” Mendez, Special Rapporteur on Torture, *supra* note 43, at 1. The NIJC uses the term solitary confinement to refer to situations in which a detainee is locked in her cell for twenty-three or more hours each day and “rarely” has any “contact with other people.” NIJC, *supra* note 4, at 2.

115. See NIJC, *supra* note 4, at 2 (noting that solitary confinement also may be called “isolation,” “the hole,” or “Secure Housing Unit” and that special management units “are still used to hold detainees in solitary confinement”). See generally SOURCEBOOK, *supra* note 43, §§ 1.1, 1.3 (providing detailed information regarding the practice of solitary confinement and its harmful consequences; explaining that “[i]solation, segregation, separation, cellular or solitary confinement are some of the terms used to describe a form of confinement where prisoners are held alone in their cell for up to 24 hours a day”; and further stating that “[n]otwithstanding the different meanings attached to each of these terms in different jurisdictions, the term ‘solitary confinement’ will be used interchangeably with the terms ‘isolation’ and ‘segregation’ when describing regimes where prisoners do not have contact with one another”); Manfred Nowak, *Preface* to SOURCEBOOK, *supra* note 43.

## A. DISPROPORTIONATE SECLUSION

Notwithstanding ICE's detention guidelines, which prohibit seclusion without justification,<sup>116</sup> immigration detainees may be secluded for arbitrary reasons, minor rules violations that are not serious enough to warrant seclusion, or, really, for no reasons at all. During a July 2012 tour of the Houston Processing Center in Houston, Texas (HPC), by Grassroots Leadership<sup>117</sup> and Texans United for Families,<sup>118</sup> guards admitted placing detainees with known mental health conditions in seclusion for long periods of time for no reason.<sup>119</sup> When asked why certain detainees had been secluded, even the HPC warden could provide no "answers."<sup>120</sup> Other detention centers seclude detainees for reasons as simple as overcrowding.<sup>121</sup> At the Tri-County Detention Center in Ullin, Illinois, for example, asylum seekers were secluded twenty-three hours each day simply because "space was . . . scarce."<sup>122</sup>

Reviews of disciplinary reports and in-person interviews with detainees at Baker County Jail in Macclenny, Florida (Baker), from June 2012 revealed that detainees were secluded for permitted conduct, such as complaining to ICE, as well as minor rules violations, such as using curse words when referring to conditions at Baker.<sup>123</sup> Although the Baker County Sheriff's Office, which provides detention services through an

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116. See *infra* Part III (discussing ICE's current detention guidelines and identifying their many limitations).

117. Grassroots Leadership is a non-profit organization working to end for-profit incarceration and reduce reliance on detention. *About Us*, GRASSROOTS LEADERSHIP, <http://grassrootsleadership.org/mission.html> (last visited Apr. 20, 2016) ("Grassroots Leadership fights to end for-profit incarceration and reduce reliance on criminalization and detention through direct action, organizing, research, and public education.").

118. Texans United for Families is a grassroots advocacy coalition fighting to end immigration detention. See *Texans United for Families*, GRASSROOTS LEADERSHIP, <http://grassrootsleadership.org/programs/texans-united-families> (last visited Apr. 20, 2016) ("We support and coordinate . . . members in their mission to fight back against immigrant detention and deportation close to home.").

119. HOUSTON PROCESSING CENTER REPORT, *supra* note 85, at 4 (containing an entire section titled "Inhumane Use of Solitary Confinement").

120. *Id.* (concluding that HPC detainees were secluded "under quite arbitrary rules with very little external oversight").

121. See, e.g., SOURCEBOOK, *supra* note 43, at 26 ("Prisoners may also be segregated due to prison overcrowding whilst waiting for space to become available in a setting appropriate to their security classification.").

122. TRI-COUNTY DETENTION CENTER REPORT, *supra* note 92, at 4.

123. BAKER COUNTY JAIL REPORT, *supra* note 83, at 5.

Intergovernmental Service Agreement with ICE, allows detainees a hearing regarding the reason for seclusion within seven to ten days, Baker detainees may spend the full ten days in seclusion waiting for that hearing, only to be found innocent of the conduct proffered by the guard as a reason for seclusion.<sup>124</sup> In other detention centers, individuals are placed in or returned to seclusion even *after* they are found innocent of an alleged rules violation. Guards at Washoe County Jail in Reno, Nevada, for example, continued to seclude a detainee *after* he was found innocent of fighting.<sup>125</sup> The written reason given for the detainee's continued seclusion was his "suspected involvement in the incident."<sup>126</sup>

At Pinal County Jail in Florence, Arizona, detainees also reported that they could be secluded for minor rules violations, such as not making their beds.<sup>127</sup> Similarly, guards at McHenry County Correctional Facility in Woodstock, Illinois, secluded one detainee for weeks because the detainee had an extra piece of underclothing and because she placed her shampoo bottle on a windowsill.<sup>128</sup> Guards at Sherburne County Jail in Elk River, Minnesota, secluded a detainee after finding some peanut butter and a Kool-Aid packet back in her cell.<sup>129</sup> Guards at the Atlanta Pretrial Detention Center in Atlanta, Georgia, secluded one detainee because he provided translation services to a fellow detainee who had limited English proficiency.<sup>130</sup> Guards at the Stewart Detention Center in Lumpkin, Georgia (Stewart), secluded a detainee for twenty-nine days after he was caught providing information to the ACLU of Georgia.<sup>131</sup> Guards at Stewart also secluded detainees for complaining about the drinking water and for refusing to work more than eight hours a day.<sup>132</sup> Guards at Nobles County Jail in Worthington, Minnesota, secluded detainees for "[f]ailure to speak English when able."<sup>133</sup> Guards at Butler County Jail in Hamilton, Ohio, placed one detainee in seclusion for an entire month after she was found playing cards during church

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124. *Id.* at 5–6.

125. NIJC, *supra* note 4, at 18.

126. *Id.*

127. PINAL COUNTY JAIL REPORT, *supra* note 88, at 3.

128. NIJC, *supra* note 4, at 17.

129. Urbina & Rentz, *supra* note 39.

130. NIJC, *supra* note 4, at 17.

131. PRISONERS OF PROFIT, *supra* note 64, at 19.

132. *Id.* at 19, 57.

133. NIJC, *supra* note 4, at 18.



services.<sup>134</sup> At Irwin County Detention Center in Ocilla, Georgia, detainees grew so fearful of arbitrary seclusion that they refused to complain about anything, even their own emergency medical conditions.<sup>135</sup>

#### B. SECLUSION IN LIEU OF MENTAL HEALTH CARE

In many immigration detention centers, seclusion is used in lieu of providing mental health care.<sup>136</sup> At Pinal County Jail in Florence, Arizona, for example, detainees with serious mental health conditions are secluded for no reason other than their underlying mental illness.<sup>137</sup> Once in seclusion, the mental health of these detainees declines even further.<sup>138</sup> At North Georgia Detention Center (NGDC) in Gainesville, Georgia, an inability to provide needed mental health care also is reported to be a reason for seclusion.<sup>139</sup> Although the National Detainee Handbook states that “all potentially suicidal or severely depressed individuals [shall be] treated with sensitivity and receive proper referrals for assistance” and the NGDC Detainee Handbook specifically encourages detainees with depression or suicidal thoughts to speak with their Unit Managers, NGDC detainees who follow these instructions are secluded rather than treated.<sup>140</sup>

At York County Prison in York, Pennsylvania, detainees who are flagged as suicidal also are secluded rather than treated.<sup>141</sup> At Mira Loma Detention Center in Lancaster,

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134. *Id.* at 17.

135. See PRISONERS OF PROFIT, *supra* note 64, at 90 (“Many detainees we spoke to [at Irwin] are afraid to voice their mental health concerns because they believe that instead of receiving treatment, they will be placed in segregation.”); see also IRWIN COUNTY DETENTION CENTER REPORT, *supra* note 87, at 1, 2, 4 (explaining that detainees “fear retaliation from facility staff if they complain”).

136. See SOURCEBOOK, *supra* note 43, at 26 (“[P]risoners are also sometimes held in solitary confinement because there are no appropriate alternatives available for housing them. For example, mentally ill prisoners may be isolated because there are no available secure hospital beds for them.”).

137. PINAL COUNTY JAIL REPORT, *supra* note 88, at 6.

138. *Id.* at 6.

139. NIJC, *supra* note 4, at 16.

140. PRISONERS OF PROFIT, *supra* note 64, at 77 (quoting U.S. DEP’T OF HOMELAND SEC., NATIONAL DETAINEE HANDBOOK (2007)); *id.* (“Those with mental disabilities are often put in segregation in lieu of receiving treatment.”); *id.* at 80 (“[I]nstead of receiving treatment, detainees are just put in segregation.”).

141. NIJC, *supra* note 4, at 16.

California, even a detainee's belief that another detainee is suicidal may lead to the seclusion of the second detainee.<sup>142</sup> Dora Schriro, the former Director of the Department of Homeland Security's Office of Detention Policy and Planning, admits that, "[f]ew beds are available for in-house psychiatric care for the mentally ill. Aliens with mental illnesses are often assigned to segregation, as are aliens on suicide watch."<sup>143</sup>

### C. SECLUSION IN LIEU OF PROTECTION

In many detention centers, individuals who are vulnerable to abuse, including individuals who are lesbian, gay, bisexual, or transgender (LGBT),<sup>144</sup> are automatically and involuntarily secluded.<sup>145</sup> Guards at Ventura County Jail in Ventura, California, automatically seclude detainees who have "obvious alternative life style[s]."<sup>146</sup> Guards at Washoe County Jail in Reno, Nevada, seclude detainees who have "overt homosexual tendencies."<sup>147</sup> The story is the same for detainees at Cobb County Jail in Marietta, Georgia, who are classified as "gender challenged," as well as detainees at Clinton County Correctional Facility in McElhattan, Pennsylvania, who are noted to be "overly . . . emotional."<sup>148</sup> At Theo Lacy Detention Center in Orange, California, sexual minorities are secluded for twenty-two hours each day without any type of individualized assessment and without the opportunity to challenge the seclusion order.<sup>149</sup> The National Immigrant Justice Center also

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142. *Id.*

143. *Id.*

144. See *Stop Abuse of Detained LGBT Immigrants*, NAT'L IMMIGRANT JUSTICE CTR., <http://www.immigrantjustice.org/stop-abuse-detained-lgbt-immigrants> (last visited Apr. 20, 2016) (reporting complaints of abuse and neglect of LGBT detainees, including "sexual assault, denial of medical and mental health treatment, arbitrary long-term solitary confinement, and frequent harassment by officers and facility personnel").

145. NIJC, *supra* note 4, at 19 (citation omitted).

146. *Id.* (citation omitted).

147. *Id.* (citation omitted).

148. *Id.* (citation omitted).

149. Letter from Mary Meg McCarthy, Exec. Dir., Heartland Alliance, Nat'l Immigrant Justice Ctr., & Eric Berndt, Supervising Attorney, Nat'l Asylum P'ship on Sexual Minorities, to Officer Margo Schlanger, Dep't of Homeland Sec., Office for Civil Rights & Civil Liberties, at 5 (Apr. 13, 2011), <https://www.immigrantjustice.org/sites/immigrantjustice.org/files/OCRCCL%20Global%20Complaint%20Letter%20April%202011%20FINAL%20REDACTED.pdf>.

reports the seclusion of detainees who behave in an “effeminate” manner.<sup>150</sup>

In September 2013, ICE issued a directive addressing the seclusion of individuals with special vulnerabilities and clarifying that, “[p]lacement in segregation should occur only when necessary and in compliance with applicable detention standards. In particular, placement in administrative segregation due to a special vulnerability should be used only as a last resort and when no other viable housing options exist.”<sup>151</sup> Because the ICE directive fell short of mandating the creation of viable housing options for vulnerable individuals, detention centers continued to involuntarily seclude LGBT detainees for months at a time, leading more than 100 LGBT organizations across the country to send a letter to President Obama in December 2014 asking for the release of LGBT detainees.<sup>152</sup> ICE responded by referencing its 2013 directive and stating that it has a “strict zero tolerance policy for any kind of abusive or inappropriate behavior in its facilities.”<sup>153</sup> At the time of this writing, however, LGBT detainees continue to be involuntarily secluded for long periods of time due to detention centers’ inability to provide safe housing options and other protective services.<sup>154</sup>

#### D. EXCESSIVE DURATION OF SECLUSION

Notwithstanding research showing that the gravity of seclusion’s negative mental health impact increases with the duration of seclusion,<sup>155</sup> detainees in ICE custody are frequently

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150. GRUBERG, *supra* note 43, at 7.

151. U.S. IMMIGRATION & CUSTOMS ENF’T, *supra* note 112, at 1; *id.* at 2, § 3.3 (defining individuals with “special vulnerabilities” to include individuals “who would be susceptible to harm in general population due in part to their sexual orientation or gender identity”).

152. Letter from Advocates for Informed Choice et al., to President Barack Obama (Dec. 16, 2014) (referencing the months of solitary confinement of Johanna, a transgender detainee from El Salvador).

153. Matthew Hendley, *ICE Seeming To Have a Hard Time Housing Trans Detainees*, PHX. NEW TIMES (Feb. 5, 2015), <http://www.phoenixnewtimes.com/news/ice-seeming-to-have-a-hard-time-housing-trans-detainees-6638309>.

154. *Id.* (reporting the story of Marichuy Gamino, a transgender woman who was raped at an immigration facility in Eloy, Arizona after she reported harassment and staff took no protective measures; after she was raped, guards involuntarily secluded her (but not the rapist)).

155. *See, e.g.*, Mendez, Special Rapporteur on Torture, *supra* note 43, at 2 (“There is strong evidence suggesting that solitary confinement, even for a short period, adversely impacts on mental health. The gravity of these impacts

secluded for days, weeks, and months at a time.<sup>156</sup> At Houston Processing Center (HPC) in Houston, Texas, guards secluded one detainee, a native of Africa, for more than three and one-half months.<sup>157</sup> A second detainee, a native of Tanzania, was secluded at HPC for more than nine months.<sup>158</sup> When the HPC warden was asked by a representative of the grassroots organization that toured the facility to identify the length of time the Tanzanian had been secluded, the warden simply responded, “[a] long time.”<sup>159</sup>

Guards at Polk County Detention Facility in Livingston, Texas, also seclude detainees for long periods of time—anywhere from fifteen to thirty days—without adequate justification.<sup>160</sup> One twenty-eight-year-old detainee from Mexico spent most of his two months at Polk in seclusion for “misbehaving.”<sup>161</sup> According to the detainee, staff made him sign papers consenting to the long seclusion even though he could not understand the consent forms, which were written in English.<sup>162</sup> When the detainee requested assistance during seclusion, staff dismissed his pleas and threatened to lengthen his seclusion order by an additional ten-day period.<sup>163</sup>

At Theo Lacy Detention Center in Orange, California, guards explain that they “only” seclude detainees for ten days, although each seclusion period can, somewhat confusingly, last up to a “maximum of 30 days.”<sup>164</sup> At Theo Lacy, secluded detainees spend twenty-four hours a day in a small room with no access to visitors and no recreation.<sup>165</sup>

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increases with the passage of time and they may eventually become irreversible.”).

156. See *Peoples v. Fischer*, No. 11 Civ. 2694 (S.D.N.Y. Mar. 6, 2013) (challenging the constitutionality of the State of New York’s practice of placing non-immigration prisoners in solitary confinement for long periods of time in a civil rights lawsuit; arguing specifically that the “astonishingly long sentences imposed on the Plaintiffs were arbitrary, grossly disproportionate to the underlying misbehavior, had no legitimate penological justification, and constituted a gratuitous infliction of wanton and unnecessary pain that fell far short of evolving standards of decency”).

157. HOUSTON PROCESSING CENTER REPORT, *supra* note 85, at 4.

158. *Id.*

159. *Id.*

160. POLK COUNTY DETENTION FACILITY REPORT, *supra* note 89, at 5.

161. *Id.*

162. *Id.*

163. *Id.*

164. THEO LACY DETENTION CENTER REPORT, *supra* note 40.

165. *Id.*

Long periods of seclusion are typical at other detention centers as well. One detainee at Stewart Detention Center in Lumpkin, Georgia, was secluded for more than three months, while a second Stewart detainee was secluded for more than five months.<sup>166</sup> One detainee was secluded in detention centers in Illinois and Wisconsin for a combined fifteen months before he was granted asylum.<sup>167</sup> One Texas detainee spent more than half of his nine-month detention in seclusion.<sup>168</sup> Another detainee was secluded for almost eight months by guards at the Oakdale Federal Detention Center in Oakdale, Louisiana.<sup>169</sup> Interestingly, the Oakdale detainee had never violated a single detention center rule.<sup>170</sup>

Some detention centers have written policies that expressly authorize long periods of seclusion. The Detainee Handbook of Stewart Detention Center expressly permits seclusion up to sixty days.<sup>171</sup> Policies at Josephine County Jail in Grants Pass, Oregon (Josephine), also permit sixty-day periods of seclusion.<sup>172</sup> Written policies at Yakima County Jail in Yakima, Washington (Yakima) permit thirty-day periods of seclusion.<sup>173</sup> Neither Josephine nor Yakima requires a hearing before the initiation of the seclusion intervention.<sup>174</sup>

Although ICE standards require detention centers to report instances of seclusion that last longer than thirty days, many detention centers skirt this reporting requirement by

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166. PRISONERS OF PROFIT, *supra* note 64, at 16, 68.

167. See Norma E. Loza, *Abuse in Illinois Immigration Detention Centers: Does the Current System Grant Human Rights to All Humans?*, 17 PUB. INT. L. REP. 143, 143 (2012).

168. *Conditions of Detention: The Use of Isolation and Segregation*, PHYSICIANS FOR HUMAN RIGHTS (Aug. 12, 2010, 8:14 PM), <http://phrtoolkits.org/toolkits/asylum-detention/background/segregation> (“When they put you in ‘el pozo’ [the hole or solitary confinement] you only have a little space. You have a toilet and a little space where you can sleep. And there is a little place where they put the food, but they throw it without caring. If you don’t take it rapidly, they throw it, whether it is hot or cold. They don’t care. They throw it as if you were an animal. It makes you lose control mentally. That is why I did not come out so well, mentally. I would lose my mind—I would lose my mind severely. I even wanted to commit suicide.”).

169. NIJC, *supra* note 4, at 23.

170. *Id.*

171. PRISONERS OF PROFIT, *supra* note 64, at 67 (“Depending on the nature of the offense, per the Stewart Detainee Handbook, time spent in the segregation unit can range from 24 hours to 60 days.”).

172. NIJC, *supra* note 4, at 21.

173. *Id.*

174. *Id.*

secluding detainees for twenty-nine days or less, followed by one day of relief, followed by another lengthy period of seclusion.<sup>175</sup> At Mira Loma Detention Center in Lancaster, California, fifty-three detainees were secluded between May 2011 and May 2012.<sup>176</sup> Only four of these detainees were secluded for longer than thirty days, while ten were secluded between twenty-six and twenty-nine days.<sup>177</sup> Guards secluded one particular detainee for nineteen days, followed by one day of relief, followed by a second nineteen-day period of seclusion.<sup>178</sup>

#### E. SELF-HARM AND SUICIDE IN SECLUSION

Research shows that seclusion has a profoundly negative impact on detainee physical and mental health and that the negative impact may be worse for detainees with preexisting physical and mental health conditions.<sup>179</sup> For example, research shows that seclusion is associated with a number of physiological effects, including heart palpitations, diaphoresis, insomnia, back and other joint pains, deterioration of eyesight, poor appetite, weight loss, lethargy, weakness, and tremors.<sup>180</sup> Research also shows that seclusion is associated with a number of psychological effects, including anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia, and psychosis.<sup>181</sup> In light of these and other negative health

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175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

179. SOURCEBOOK, *supra* note 43 (“There is unequivocal evidence that solitary confinement has a profound impact on health and wellbeing, particularly for those with pre-existing mental health disorders . . . .”); *id.* at 10–24 (providing an in-depth review of studies investigating the negative health consequences of seclusion); Mendez, Special Rapporteur on Torture, *supra* note 43, at 2 (“There is strong evidence suggesting that solitary confinement, even for a short period, adversely impacts on mental health. The gravity of these impacts increases with the passage of time and they may eventually become irreversible. Research in this field has established that solitary confinement can cause mental illnesses, including a syndrome described as ‘prison psychosis[,]’ [] which manifests in symptoms including anxiety, depression, anger, cognitive disturbances, paranoia and psychosis, and can lead to self-harm.”); Urbina & Rentz, *supra* note 39 (“Paranoia, depression, memory loss and self-mutilation are not uncommon.”); *see also* GRUBERG, *supra* note 43 (referencing the negative health consequences of seclusion).

180. SOURCEBOOK, *supra* note 43, at 15.

181. *Id.* at 15–16.

impacts, the United Nations Special Rapporteur has stated that seclusion can constitute torture in certain circumstances, and that seclusion should never be used with respect to detainees who have mental disabilities.<sup>182</sup>

Indeed, detainee self-harm and suicide are more common in secluded populations than in non-secluded populations.<sup>183</sup> The features of seclusion that are believed to drive self-harm and suicide include, but are not limited to, extreme social isolation, reduced environmental stimulation, and loss of control over almost all aspects of life.<sup>184</sup> One researcher who carefully reviewed the literature investigating the impact of seclusion on detainee physical and mental health concluded that, “[T]here is a large and growing body of literature that demonstrates the harmful impact of isolation, particularly when used punitively, without clear time limits, for periods that are longer than four weeks and for people with prior mental health problems and poor social adjustment.”<sup>185</sup>

Some detainees do attempt suicide while in seclusion, especially if they have not received needed mental health care during detention. One detainee, who had a history of bipolar disorder, panic attacks, addiction, and depression when he arrived at Stewart Detention Center in Lumpkin, Georgia, had been successfully managing his condition through psychotherapy, prescription drugs, and other supports.<sup>186</sup> Once detained, his treatments were discontinued and he suffered a

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182. Mendez, Special Rapporteur on Torture, *supra* note 43, at 2 (“Depending on the reasons for its use, the conditions through which it is imposed, its duration, the gravity of its effects and other circumstances, solitary confinement can amount to cruel, inhuman or degrading treatment, or even to torture.”); *id.* at 3 (“Solitary confinement should never be imposed to minors, pregnant or breastfeeding women, or persons with mental disability. In such cases, in view of the particular vulnerability of the detained person, solitary confinement always amounts to cruel, inhuman or degrading treatment, or torture.”).

183. See Johnson, *supra* note 47 (reporting that sixty-nine percent of California’s prison suicides occurred in units where inmates are isolated for twenty-three hours a day; further reporting that most of Texas’s prison suicides involved inmates who were in some type of solitary confinement).

184. SOURCEBOOK, *supra* note 43, at 17–20 (discussing in detail the factors that make solitary confinement so harmful); see also COMMONWEALTH OMBUDSMAN, *supra* note 25, at 45–69 (discussing other factors, including vulnerability, the detention environment, frustrations associated with immigration processing, and lengthy periods of detention).

185. SOURCEBOOK, *supra* note 43, at 23.

186. PRISONERS OF PROFIT, *supra* note 64, at 63.

panic attack so severe that guards thought he had a stroke.<sup>187</sup> In response, the detainee was secluded for over six months, during which time he attempted suicide.<sup>188</sup>

Interviews with detainees across the country reveal similar stories. One detainee from Mexico who was secluded for four months in 2010 became deeply depressed when he heard three of his fellow detainees try to take their own lives. “Please God,’ he remembers praying, ‘don’t let me be the same.’”<sup>189</sup> Although this detainee lived to tell his story, many do not. On April 30, 2013, forty-year-old Jorge Garcia-Mejia hanged himself at the Eloy Detention Center in Eloy, Arizona.<sup>190</sup> Two days earlier, twenty-four-year-old Elsa Guadalupe-Gonzales committed suicide at the same detention facility, also by hanging.<sup>191</sup> Garcia-Mejia and Guadalupe-Gonzalez are 2 of 141 detainees who died in ICE custody between October 2003 and December 2013.<sup>192</sup>

Forty-four-year-old Ana Romero Rivera also hanged herself while in seclusion at Franklin County Regional Jail in Frankford, Kentucky, on August 21, 2008.<sup>193</sup> Romero Rivera, who was waiting to be deported to El Salvador, was secluded simply because she refused to eat.<sup>194</sup> Jose Lopez-Gregorio, Carlos Cortes Raudel, Sung Soo Heo, and Geovanny Garcia-Mejia also hanged themselves while in ICE custody at detention centers located in Arizona, California, New Jersey, and Texas, respectively.<sup>195</sup> Research shows that the most common cause of death among detainees is suicide, in part because detainees with mental illness “are relegated to the darkest and most neglected corners of the [immigration detention] system.”<sup>196</sup> An estimated 13.5% of deaths that occur in U.S. detention centers are suicides.<sup>197</sup>

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187. *Id.*

188. *Id.*

189. Urbina & Rentz, *supra* note 39.

190. Second Eloy Detainee, *supra* note 2.

191. First Eloy Detainee, *supra* note 1.

192. ICE DEATHS, *supra* note 3.

193. Lannen & Spears, *supra* note 5.

194. *Id.*

195. See Priest & Goldstein, *supra* note 98 (reporting these four suicides).

196. *Id.*

197. See Kristen C. Ochoa et al., *Disparities in Justice and Care: Persons with Severe Mental Illnesses in the U.S. Immigration Detention System*, 38 J. AM. ACAD. PSYCHIATRY & L. 392, 393 (2010) (citing Nina Bernstein, *Officials Say Detainee Fatalities Were Missed*, N.Y. TIMES (Aug. 17, 2009), <http://www.nytimes.com/2009/08/18/us/18immig.html>). In addition to the seclusion-



## II. HOSPITAL SECLUSION: BURNED AND REFORMED

Seclusion-related incidents, injuries, and deaths used to be common in other contexts, including in the hospital and health care facility context.<sup>198</sup> In 1998, a patient was secluded in an Oregon hospital for thirty straight hours, during which time she was not allowed to use the restroom.<sup>199</sup> In 1999, a patient was secluded in a Missouri state psychiatric hospital for thirty days, during which time he developed severe kidney problems and muscle atrophy.<sup>200</sup> Although these two seclusion incidents did not result in death, many others have.

In 1990, a patient who was secluded at Creedmoor Psychiatric Center in Queens, New York, set fire to his room.<sup>201</sup> The patient was not discovered until after he had burned to death.<sup>202</sup> A similar incident occurred in 1995 at a private Nevada hospital.<sup>203</sup> There, a secluded patient also set fire to her room and she, too, was not discovered until after she had died of smoke inhalation.<sup>204</sup>

In 1980, a patient at a state mental hospital in Pennsylvania asphyxiated himself with his mattress cover while he was in seclusion.<sup>205</sup> In 1990, a patient at Mohawk Valley Psychiatric Center in Utica, New York, was found with no vital signs following a four-hour seclusion.<sup>206</sup> In 1991, a patient secluded at Mid-Hudson Psychiatric Center in New Hampton, New York, asphyxiated himself with his sock.<sup>207</sup> In 1992, a patient at Creedmoor Psychiatric Center died of an

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related injuries and deaths discussed above, many immigration detainees in the U.S. and abroad are also injured or killed during the application of restraint. See generally PETER STURMEY, REDUCING RESTRAINT AND RESTRICTIVE BEHAVIOR MANAGEMENT PRACTICES 113 (2015) (discussing detainee injuries and deaths associated with restraint).

198. See Tovino, *Psychiatric Restraint*, *supra* note 14 (historicizing restraint and seclusion use in the health care setting in the United States, providing data regarding the deaths associated with these interventions, and reviewing the development of federal and state laws governing the use of these interventions).

199. GAO REPORT, *supra* note 18, at 8.

200. *Id.*

201. Eric M. Weiss et al., *Deadly Restraint: Database*, CHARLY D. MILLER, <http://charlydmiller.com/LIB05/1998hartforddata.html> (last visited Apr. 20, 2016).

202. *Id.*

203. *Id.*

204. *Id.*

205. See Nelson et al., *supra* note 17.

206. See Weiss et al., *supra* note 201.

207. *Id.*

overdose of six different drugs taken while in seclusion.<sup>208</sup> In 1993, a patient at Capital District Psychiatric Center in Albany, New York, was found dead in his seclusion room of an apparent heart attack.<sup>209</sup> In 1996, a patient at Finger Lakes Developmental Disabilities Service Office in Rochester, New York, was found dead in his seclusion room of a subdural hematoma.<sup>210</sup> In 1998, a researcher from the Center for Risk Analysis at Harvard School of Public Health estimated that between 50 and 150 patients were dying each year from unsafe seclusion and restraint practices.<sup>211</sup> A related investigative report estimated that approximately 5.5% of these deaths were related to the seclusion intervention.<sup>212</sup>

Beginning in the mid-1990s, a number of public and private organizations began investigating these deaths with the hope of identifying contributing factors that could be corrected. In 1994, the New York State Commission on Quality of Care (Commission) reported that 111 patients had died during episodes of seclusion or restraint in New York psychiatric hospitals during a ten-year period (1984 to 1993).<sup>213</sup> The Commission identified factors that were believed to have contributed to these deaths, including the failure of hospital staff to attempt less restrictive measures to calm patients down before imposing seclusion, the use of seclusion by staff members untrained in safe seclusion practices, the failure of staff to comply with relevant state statutes and regulations limiting the length of time that patients may be placed in seclusion, and the use of seclusion without adequate recognition of suicide hazards.<sup>214</sup>

Four years later, in 1998, the *Hartford Courant* published a Pulitzer-Prize winning report highlighting the number of

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208. *Id.*

209. *Id.*

210. *Id.*

211. See STEPHAN HAIMOWITZ ET AL., RESTRAINT AND SECLUSION—A RISK MANAGEMENT GUIDE 3 (2006) (reporting the Harvard estimates).

212. See Weiss et al., *supra* note 15 (classifying patient deaths over a ten-year period by the type of restraint, including physical restraint (47.2%), mechanical restraint (44.1%), and combination of physical and mechanical restraint (3.1%), as well as seclusion-related deaths (5.5%)).

213. N.Y. STATE COMM'N ON QUALITY OF CARE FOR THE MENTALLY DISABLED, RESTRAINT & SECLUSION PRACTICES IN NEW YORK STATE PSYCHIATRIC FACILITIES 1 (1994) (“[I]n total, over the ten-year period 1984–1993, 111 deaths associated with restraint and seclusion use have been reported, investigated, and reviewed by the Board . . .”).

214. *Id.* at 2.

patients who died in the United States while in seclusion or restraint during a ten-year period (1988 to 1998).<sup>215</sup> According to the *Courant*, 142 patients died during or shortly after episodes of seclusion or restraint in hospitals and other health care facilities located across the country.<sup>216</sup> Of these 142 deaths, 23 patients died after being restrained by staff in face-down floor holds, 20 patients died after they were restrained using leather wrist and ankle cuffs or vests, and 33 percent of the patients with confirmed causes of death died of asphyxia.<sup>217</sup> The *Courant* reported that inadequate staffing, inadequate staff training, and a lack of standards governing the use of seclusion and restraint placed patients at risk for injury and death.<sup>218</sup>

The following year, the U.S. General Accounting Office (GAO) also issued a report stating that improper seclusion practices could place patients at risk for injury and death.<sup>219</sup> Among other recommendations, the GAO urged health care facilities to adopt policies establishing minimum staffing ratios, identifying safe seclusion practices, and requiring staff training relating to alternatives to seclusion.<sup>220</sup>

Also in 1999, the National Association of State Mental Health Program Directors (NASMHPD) issued the first of a three-part report presenting the NASMHPD's findings, strategies, and recommendations regarding the reduction and eventual elimination of seclusion and restraint.<sup>221</sup> In particular,

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215. See Weiss et al., *supra* note 15.

216. *Id.*

217. *Id.*

218. See Kathleen Megan & Dwight F. Blint, *Why They Die: Little Training, Few Standards, Poor Staffing Put Lives at Risk*, HARTFORD COURANT, Oct. 12, 1998, at A1, ProQuest Newsstand, Doc. No. 256278401.

219. GAO REPORT, *supra* note 18, at 8, 22.

220. *Id.* at 22–23.

221. See NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS.' MED. DIRS. COUNCIL, REDUCING THE USE OF SECLUSION AND RESTRAINT: FINDINGS, STRATEGIES, AND RECOMMENDATIONS 1 (1999) ("This report is intended to help guide the development of and to complement a NASMHPD position statement on seclusion and restraint. . . . It is also intended as a tool for helping states to prevent and reduce the overall need for seclusion and restraint . . ."); NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS.' MED. DIRS. COUNCIL, REDUCING THE USE OF SECLUSION AND RESTRAINT PART II: FINDINGS, PRINCIPLES, AND RECOMMENDATIONS FOR SPECIAL NEEDS POPULATIONS, at iv (2001) ("It is NASMHPD's goal to prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that, when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained personnel."); NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS.' MED. DIRS. COUNCIL, REDUCING THE USE OF SECLUSION AND RESTRAINT PART III: LESSONS FROM

the NASMHPD stated that seclusion and restraint should only be used as a last resort to protect the immediate health, safety, or welfare of a patient or other person and should never be used for patient discipline, patient coercion, staff convenience, or as a substitute for a lack of staffing.<sup>222</sup>

In 2003, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) recommended changes to the mental health care system that would facilitate the elimination of seclusion.<sup>223</sup> These changes included improving staff-to-patient ratios, requiring additional staff training regarding crisis management and de-escalation techniques, actively treating patients with mental health conditions, and creating an institutional culture that values patient dignity and supports each patient's right to be free from unnecessary seclusion.<sup>224</sup> SAMHSA also recommended law reforms that would limit the imposition of seclusion to situations in which a patient presents an imminent danger to herself or others, limit the length of seclusion orders, require ongoing physician monitoring and assessment of secluded patients, and require patient and staff debriefing and education following each seclusion intervention.<sup>225</sup>

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THE DEAF AND HARD OF HEARING COMMUNITIES 3 (2002) (“[T]his report emphasizes the major lessons of the first two reports: That to reduce the use of seclusion and restraint will require a broad cultural change in mental health treatment settings.”); *Position Statement on Seclusion and Restraint*, NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRS., [hereinafter *Position Statement on Seclusion*] <http://www.nasmhpd.org/content/position-statement-seclusion-and-restraint> (last visited Apr. 20, 2016) (“It is NASMHPD’s goal to prevent, reduce, and ultimately eliminate the use of seclusion and restraint . . . .”); see also Robert W. Glover, *Reducing the Use of Seclusion and Restraint: A NASMHPD Priority*, 56 PSYCHIATRIC SERVS. 1141, 1141 (2005) (“I believe that state facilities and other service providers must continue to make it a priority to reduce and ultimately eliminate these coercive practices in order to improve the quality of people’s lives.”).

222. *Position Statement on Seclusion*, *supra* note 221 (“[S]eclusion and restraint . . . are safety interventions of last resort and are not treatment interventions. Seclusion and restraint should never be used for the purposes of discipline, coercion, or staff convenience, or as a replacement for adequate levels of staff or active treatment.”).

223. U.S. DEP’T HEALTH & HUMAN SERVS., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., A NATIONAL CALL TO ACTION: ELIMINATING THE USE OF SECLUSION AND RESTRAINT (2003) [hereinafter NATIONAL CALL TO ACTION]; see also Charles G. Curie, *SAHMSA’s Commitment To Eliminating the Use of Seclusion and Restraint*, 56 PSYCHIATRIC SERVS. 1139, 1139–40 (2005) (reviewing SAHMSA’s commitment to eliminating the use of seclusion and restraint in mental health care settings).

224. NATIONAL CALL TO ACTION, *supra* note 223, at 5.

225. *Id.* at 6.

Health law reform quickly followed.<sup>226</sup> In 1999, the Health Care Financing Administration (HCFA) issued an interim final rule applicable to all Medicare-participating hospitals (Interim Final Rule) that established several new patients' rights, including the right: (1) to be free from seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff; (2) to be free from seclusion imposed for any reason other than to ensure the patient's physical safety after less restrictive interventions have been determined to be ineffective; (3) to be free from seclusion that is not ordered by a physician or other licensed independent health care practitioner; (4) to be free from seclusion as a standing order or on an "as needed" basis; (5) to an evaluation by a physician or other licensed independent health care practitioner within one hour after the initiation of a seclusion intervention; (6) to seclusion orders that last no longer than four hours for adults (and less time for younger patients) and that end at the earliest possible time, regardless of the time written in the order; (7) to a physical assessment by a physician or licensed independent health care practitioner before a subsequent seclusion order is issued; and (8) to be treated by staff who have ongoing education and training in the proper and safe use of seclusion as well as alternative methods for handling behavior, symptoms, and situations that traditionally have been managed through the use of seclusion.<sup>227</sup>

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226. See, e.g., Hospital Conditions of Participation: Patients' Rights, Interim Final Rule with Comment, 64 Fed. Reg. 36,070, 36,070 (July 2, 1999) (creating interim final rule that would establish new rights of patients in Medicare-participating hospitals, including the right to be free from restraints used in the provision of acute medical and surgical care unless clinically necessary and the right to be free from seclusion and restraints used in behavior management unless clinically necessary); Medicare and Medicaid Programs, Hospital Conditions of Participation: Patients' Rights, 71 Fed. Reg. 71,378, 71,378 (Dec. 8, 2006) (promulgating final rule revising standards governing the use of restraint and seclusion in Medicare-participating hospitals); Medicare and Medicaid Programs, Reform of Hospital and Critical Access Hospital Conditions of Participation, 77 Fed. Reg. 29,034, 29,034 (May 16, 2012) (revising certain restraint- and seclusion-related standards); see also Janice LeBel, *Regulatory Change: A Pathway To Eliminating Seclusion and Restraint or "Regulatory Scotoma?"*, 59 PSYCHIATRY SERVS. 194, 194 (2008) (noting that "[r]eports of deaths related to restraint and seclusion fueled recent national regulatory changes and a federal agenda to eliminate their use"; summarizing the health law reform that followed the *Hartford Courant* investigative report).

227. Interim Final Rule, 64 Fed. Reg. at 36,089 (adopting then-current 42 C.F.R. § 482.13(f) (1999)).

In 2006, the Centers for Medicare and Medicaid Services (CMS) issued its final patients' rights rule applicable to Medicare-participating hospitals (Final Rule).<sup>228</sup> The Final Rule strengthened the rights set forth by HCFA seven years earlier in the Interim Final Rule, including the right of all patients to be free from seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff.<sup>229</sup> The Final Rule also added a new right relating to safe implementation of seclusion by trained staff<sup>230</sup> and a requirement that hospitals report all deaths associated with seclusion.<sup>231</sup> Six years later, in 2012, CMS issued a revised rule strengthening the death reporting requirements set forth in the Final Rule.<sup>232</sup>

During the same time period, many states' departments of mental health and freestanding mental health care institutions formally committed themselves to reducing or attempting to eliminate seclusion and restraint. Illustrative, not exhaustive, examples of these departments and institutions include the Massachusetts Department of Mental Health,<sup>233</sup> the Pennsylvania State Hospital System,<sup>234</sup> Sheppard Pratt Hospital,<sup>235</sup> Creedmoor Psychiatric Center,<sup>236</sup> Western State

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228. Hospital Conditions of Participation, 71 Fed. Reg. at 71,426–28 (adopting then-current 42 C.F.R. §§ 482.13(e), (f), and (g)).

229. *Id.* at 71,426–27 (adopting 42 C.F.R. § 482.13(e)).

230. *Id.* at 71,427–28 (adopting 42 C.F.R. § 482.13(f)).

231. *Id.* at 71,427–28 (adopting then-current 42 C.F.R. §§ 482.13(f), (g)).

232. Medicare and Medicaid Programs, Reform of Hospital and Critical Access Hospital Conditions of Participation, 77 Fed. Reg. at 29,074 (revising 42 C.F.R. §§ 482.13(g)(1)–(3) and adding 42 C.F.R. § 482.13(g)(4)).

233. See Janice LeBel & Robert Goldstein, *The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination*, 56 PSYCHIATRIC SERVS. 1109, 1109–10 (2005) (discussing the Massachusetts Department of Mental Health's initiative to reduce seclusion and restraint in psychiatric facilities serving children and adolescents; and, reporting a sixty-eight percent decrease in the number of episodes of seclusion and restraint and a seventy-nine percent decrease in the number of hours of seclusion and restraint).

234. See Gregory M. Smith et al., *Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, 56 PSYCHIATRIC SERVS. 1115, 1115–17 (2005) (reviewing the Pennsylvania State Hospital System's seclusion and restraint reduction initiatives; reporting a decrease in the rate and duration of seclusion and mechanical restraint from 4.2 to 0.3 episodes per 1,000 patient-days as well as a decrease in the average duration of seclusion from 10.8 to 1.3 hours).

235. See Steven S. Sharftstein, *Reducing Restraint and Seclusion: A View From the Trenches*, 59 PSYCHIATRIC SERVS. 197, 197 (2008) (“In our hospital in Baltimore with nearly 7,500 admissions per year, we have been successful in dramatically reducing seclusion and restraint . . . Episodes of seclusion and restraint have dramatically decreased but have not yet been eliminated.”).

Hospital,<sup>237</sup> Yale-New Haven Children's Hospital,<sup>238</sup> North Texas State Hospital Forensic Unit,<sup>239</sup> Salem Hospital,<sup>240</sup> and Connecticut's Whiting Forensic Division,<sup>241</sup> just to name a few.<sup>242</sup>

Soon thereafter, researchers began reporting associations between the reduction in seclusion and restraint use and lower numbers of patient injuries and deaths, shorter hospital lengths of stay, decreased rates of re-hospitalization, lower

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236. See William A. Fisher, *Elements of Successful Restraint and Seclusion Reduction Programs and Their Application in a Large, Urban, State Psychiatric Hospital*, 9 J. PSYCH. PRAC. 7, 12 (2003) (reporting that Creedmoor Psychiatric Center experienced a sixty-seven percent decline in its combined restraint and seclusion rate between 1999 and 2001 and a reduction in the maximum restraint and seclusion order duration from four hours to one hour over the same two-year period).

237. See Dennis C. Donat, *An Analysis of Successful Efforts To Reduce the Use of Seclusion and Restraint at a Public Psychiatric Hospital*, 54 PSYCHIATRIC SERVS. 1119, 1119 (2003) (reporting a seventy-five percent reduction in the use of seclusion and restraint at Western State Hospital in Staunton, Virginia, and underscoring the importance of identifying critical cases and initiating clinical and administrative case reviews for such cases).

238. See Andres Martin et al., *Reduction of Restraint and Seclusion Through Collaborative Problem Solving: A Five-Year Prospective Inpatient Study*, 59 PSYCHIATRIC SERVS. 1406, 1409 (2008) (reporting a 37.6-fold reduction in restraint use and a 3.2-fold reduction in seclusion use one and one-half years after implementation of a collaborative problem solving program for aggressive children and adolescents).

239. See Kelly R. Goodness & Nancy S. Renfro, *Changing a Culture: A Brief Program Analysis of a Social Learning Program on a Maximum-Security Forensic Unit*, 20 BEHAV. SCI. & L. 495, 503-04, 504 fig.2 (2002) (reporting reductions in the raw number of restraint and seclusion interventions despite significant increases in patient admissions).

240. See Sandra L. Bloom, *Foreword to RESTRAINT AND SECLUSION: THE MODEL FOR ELIMINATING THEIR USE IN HEALTHCARE*, at ix (Tim Murphy & Maggie Bennington-Davis eds., 2005) ("They reduced the use of restraint and seclusion [at Salem Hospital] to a point nearing total elimination . . . They radically reduced the amount of violence on the unit and thereby reduced staff injuries, reduced workmen's compensation cases, and improved staff morale. And the unit became more fiscally sound than it had ever been.").

241. See Michael Rezendes, *Bridgewater State Hospital Slow To Embrace Change*, BOS. GLOBE (June 1, 2014) ("The results were stunning: the use of seclusion and restraints at Whiting, Connecticut's mental health center for patients involved in the criminal justice system, has dropped by more than 88 percent since 2004 . . .").

242. *But see* Christine Montross, *The Modern Asylum*, N.Y. TIMES (Feb. 18, 2015), <http://www.nytimes.com/2015/02/18/opinion/the-modern-asylum.html> ("[W]e have worked to minimize the use of restraint and seclusion on my unit, but have seen the frequency of both skyrocket.").

rates of medication usage, higher levels of patient functioning at the time of discharge, and increased patient satisfaction.<sup>243</sup>

For example, the Massachusetts Department of Mental Health (Department) implemented a statewide Restraint/Seclusion Reduction Initiative (Initiative) in 2000 that was designed to reduce seclusion and restraint of minors treated in public and private health care facilities across the state.<sup>244</sup> Within two years of the implementation of the Initiative, the Department achieved significant reductions in the number of seclusion and restraint interventions as well as decreases in the rates of injuries to both patients and staff.<sup>245</sup> The Department reported a sixty-eight percent decrease in the number of episodes of seclusion and restraint (from 8,599 to 2,712) and a seventy-nine percent decrease in the number of hours of seclusion and restraint (from 14,085 to 2,924).<sup>246</sup> The Department also experienced a decrease in costs associated with seclusion and restraint as well as decreases in staff sick time, staff turnover and replacement costs, workers' compensation costs, injuries to adolescents and staff, and patient recidivism, as well as significant improvements in Adolescent Global Assessment of Functioning scores at discharge.<sup>247</sup> In its published report of the Initiative, the Department concluded, "Th[ese] shift[s] appear[] to have contributed to better outcomes for adolescents, fewer injuries to adolescents and staff, and lower staff turnover. The [I]nitiative may have enhanced adolescent treatment and work conditions for staff."<sup>248</sup>

Mental health care institutions that have successfully reduced their use of the seclusion intervention have identified several elements as keys to their success.<sup>249</sup> These elements include endorsement of seclusion-free initiatives by administrators and other high-level leaders, patient

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243. See, e.g., SAMHSA, BUSINESS CASE, *supra* note 20 (citing dozens of studies reporting patient benefits associated with reductions in the use of restraint and seclusion).

244. See EXEC. OFFICE OF HEALTH & HUMAN SERVS., MASS. DEP'T OF MENTAL HEALTH, RESTRAINT/SECLUSION REDUCTION INITIATIVE (2000) [hereinafter MDMH INITIATIVE].

245. LeBel & Goldstein, *supra* note 233, at 1109.

246. *Id.* at 1110.

247. MDMH INITIATIVE, *supra* note 244.

248. LeBel & Goldstein, *supra* note 233, at 1109.

249. See, e.g., Fisher, *supra* note 236, at 7–12 (identifying and discussing elements key to successfully reducing seclusion).



participation in the initiatives, staff training, culture changes, and individualized treatment of patients.<sup>250</sup> Although the relative importance of these elements may vary depending on the setting in which they are applied, clinicians believe that these elements may have relevance in other contexts in which the seclusion intervention is being used and abused.<sup>251</sup>

### III. *OF MICE AND MEN*: ON THE SECLUSION OF IMMIGRATION DETAINEES AND HOSPITAL PATIENTS

This Part III uses the health law developments described in Part II as a lens through which the uses and abuses of seclusion in immigration detention centers might be assessed and through which the standards governing detention centers might be improved. In particular, this Part argues that the unenforceable standards governing seclusion in immigration detention, including the most recent version of ICE's Performance-Based National Detention Standards,<sup>252</sup> were incorrectly modeled on correctional standards developed for use in jails and prisons with respect to convicted criminals.<sup>253</sup> This Part asserts that correctional standards are inappropriate guidelines for use in the detention context for three reasons.

First, immigration detention is a form of civil, not criminal, detention. Detention is imposed to ensure that immigrants will be physically present for one or more immigration hearings and will otherwise comply with the orders of an immigration judge.<sup>254</sup> Immigration detention is not punitive; that is, it is not intended to punish individuals who are suspected of violating immigration laws or any other laws.<sup>255</sup> Indeed, most detainees have no criminal record or have committed only minor crimes

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250. *See id.* at 12 (“The methods of applying these essential elements will differ depending on the setting in which they are applied. However, some of the techniques described in this paper may be applicable, without major changes, to other treatment settings attempting to reduce their use of restraint and seclusion.”).

251. *See id.*

252. *See* 2011 PBNDS, *supra* note 13.

253. *See, e.g.,* NIJC, *supra* note 4, at 11 (“[T]he 2011 PBNDS are still based on American Correctional Association (ACA) pre-trial detention standards for jails and prisons . . .”).

254. *Immigrants in Solitary*, *supra* note 7 (“Civil detention is imposed not as punishment, but simply to make sure somebody shows up for a hearing.”).

255. *See* García Hernández, *supra* note 107, at 1346 (explaining that, in practice, the modern immigration detention system has accomplished punitive goals and therefore requires reform to return to its intended civil nature).

such as traffic violations.<sup>256</sup> For this reason alone, ICE's reliance on correctional standards is inappropriate.

Second, many detainees are extremely physically and emotionally vulnerable due to their history of torture and trauma.<sup>257</sup> Detainees may be victims of human trafficking, sexual violence, political oppression, psychosocial trauma, and acculturative stress, among other sources of violence and social disruption.<sup>258</sup> Research shows that a significant number of detainees have severe mental illnesses that may be associated with or exacerbated by their histories of torture and trauma.<sup>259</sup> For these reasons, standards governing the imposition of seclusion in hospitals (i.e., facilities that are designed to house and care for patients who are physically ill and emotionally vulnerable) are especially appropriate.

Third, many immigrants have lacked access to health insurance and health care since they entered the United States, and they continue to lack access to adequate mental health care following their detention.<sup>260</sup> Indeed, of the 141 deaths that occurred in U.S. detention facilities between 2003 and 2013, most were caused by untreated coronary artery disease, blood cancer, lymphatic cancer, pancreatic cancer, lung cancer, brain

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256. See, e.g., NIJC, *supra* note 4, at 8 (“The majority of immigration detainees have no criminal record, or have committed only minor crimes or traffic violations, often years before being detained by ICE.” (footnote omitted)).

257. See, e.g., COMMONWEALTH OMBUDSMAN, *supra* note 25, at 46 (stating that a history of torture and trauma are among the factors contributing to self-harm in immigration detention in Australia).

258. See, Lisa Lopez Levers & Debra Hyatt-Burkhart, *Immigration Reform and the Potential for Psychosocial Trauma: The Missing Link of Lived Human Experience*, 12 ANALYSES SOC. ISSUES & PUB. POL’Y 68, 68 (2012) (examining the “stress and potential psychosocial trauma that may be associated with immigration and the acculturation process”); *Immigrants in Solitary*, *supra* note 7 (“Many detainees are victims of political oppression or human trafficking, many are only seeking better lives, some are ill. These are people America should be sheltering, not arbitrarily brutalizing.”).

259. See, e.g., Ochoa et al., *supra* note 197 (stating that officials estimate that fifteen percent of immigration detainees are mentally ill); Katy Robjant et al., *Mental Health Implications of Detaining Asylum Seekers: Systematic Review*, 194 BRITISH J. PSYCHIATRY 306, 306 (2009) (“Findings consistently report high levels of mental health problems among detainees. There is some evidence to suggest an independent adverse effect of detention on mental health.”); Lindy Kerin, *Alarming Rates of Mental Illness Among Kids in Immigration Detention*, ABC.NET (July 31, 2014, 8:24 AM) (discussing the high rates of mental illness among Australian immigration detainees).

260. See Marouf, *supra* note 26 (addressing the lack of access to health insurance by individuals with Deferred Action for Childhood Arrivals (DACA) and Deferred Action for Parental Accountability (DAPA) status).

cancer, sepsis, liver disease, renal failure, pneumonia, seizure disorders, emphysema, HIV, and drug addictions, among other conditions.<sup>261</sup> In light of the high rate of untreated physical illness among detained populations, the imposition of hospital standards, rather than correctional standards, is especially appropriate.

This Article proposes to reform the standards governing the use of seclusion in immigration detention centers in nine different ways. First, ICE should impose one uniform set of standards on all detention centers located in the United States. As background, patients in Medicare-participating hospitals have uniform patients' rights that are codified in federal regulations.<sup>262</sup> There is one current set of patients' rights standards governing the imposition of seclusion that are set forth at 42 C.F.R. § 482.13(e), (f), and (g) (Patients' Rights Standards), and these Patients' Rights Standards apply to all Medicare-participating hospitals, regardless of whether they are public or private hospitals, general or special hospitals, psychiatric hospitals, children's hospitals, cancer hospitals, long-term care hospitals, or other hospitals.<sup>263</sup> These Standards also apply to all hospital patients, regardless of their location in the hospital. For example, the Patients' Rights Standards apply to patients who are admitted to psychiatric units, labor and delivery units, and other inpatient units, as well as patients who receive services through the emergency department or other outpatient departments.<sup>264</sup> The uniform application of

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261. See ICE DEATHS, *supra* note 3 (providing information regarding the final cause of death in the last column).

262. See 42 C.F.R. §§ 482.13(e), (f), (g) (2014) (regulating the use of seclusion in Medicare-participating hospitals); sources cited *supra* note 226 (identifying the history and sources of the current patients' rights standards set forth in the Medicare Conditions of Participation).

263. See CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 34, reg. A-0154 (“[T]hese restraint and seclusion regulations apply to . . . [a]ll hospitals (acute care, long-term care, psychiatric, children’s, and cancer); [a]ll locations within the hospital (including medical/surgical units, critical care units, forensic units, emergency department, psychiatric units, etc.); and [a]ll hospital patients, regardless of age, who are restrained or secluded (including both inpatients and outpatients.”)).

264. See *id.* (“The patient protections contained in this standard apply to all hospital patients when the use of restraint or seclusion becomes necessary, regardless of patient location. The requirements contained in this standard are not specific to any treatment setting within the hospital. They are not targeted only to patients on psychiatric units or those with behavioral/mental health care needs. Instead, the requirements are specific to the patient

these Patients' Rights Standards to all Medicare-participating hospitals, all units and departments within each hospital, and all inpatients and outpatients who receive services from these hospitals ensures that staff members are not confused regarding when the substantive rules governing the imposition of seclusion apply.

In the detention setting, ICE does have some detention standards that contain instructions relating to the seclusion of detainees, but these instructions do not apply uniformly to all detention centers. That is, the former Immigration and Naturalization Service (INS) issued one set of National Detention Standards in 2000 (2000 NDS),<sup>265</sup> ICE issued a second set of Performance-Based National Detention Standards in 2008 (2008 PBNDS),<sup>266</sup> and ICE issued a third set of Performance-Based National Detention Standards in 2011 (2011 PBNDS).<sup>267</sup> Some detention centers only comply with the 2000 NDS or the 2008 PBNDS because their contracts with ICE do not specify that they have to comply with the more recent 2011 PBNDS. The Etowah County Jail in Gadsden, Alabama, for example, is only contractually obligated to follow the 2000 PBNDS.<sup>268</sup> Similarly, the Theo Lacy Detention Center in Orange, California, is only contractually obligated to follow the 2008 PBNDS.<sup>269</sup>

In addition, ICE has several sets of seclusion standards that apply differently depending on the location of the detainee and the purported reason for the seclusion, unlike the strict rules governing seclusion in the Patients' Rights Standards that apply to all hospital patients regardless of their location or

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behavior that the restraint or seclusion intervention is being used to address.”).

265. *2000 Detention Operations Manual*, U.S. IMMIGRATION & CUSTOMS ENF'T (2000), <http://www.ice.gov/detention-standards/2000> (describing the implementation of the 2000 standards).

266. *2008 Operations Manual ICE Performance-Based National Detention Standards*, U.S. IMMIGRATION & CUSTOMS ENF'T (2008), <https://www.ice.gov/detention-standards/2008> (describing the implement of 2008 standard).

267. 2011 PBNDS, *supra* note 13.

268. ETOWAH COUNTY JAIL REPORT, *supra* note 84, at 6–7 (“Etowah currently operates according to the 2000 National Detention Standards. There have been two new editions of the Detention Standards since 2000, but ICE has so far failed to implement them at Etowah. ICE recently approached Etowah about implementation of the latest standards . . . but the feasibility and timeline for this remains unclear.”).

269. THEO LACY DETENTION CENTER REPORT, *supra* note 40, at 5–6 (noting that the Orange County Sheriff's Department is contractually obligated to follow the 2008 PBNDS).

the reason for their seclusion. Using the 2011 PBNDS as an example, there are some isolation standards that apply when the proffered reason for seclusion is a detainee's "medical care,"<sup>270</sup> other isolation standards that apply when the proffered reason is a detainee's risk of "significant self-harm and suicide,"<sup>271</sup> other "administrative segregation" standards that apply in special management units,<sup>272</sup> still other "disciplinary segregation" standards that apply in special management units,<sup>273</sup> and still other segregation standards that apply to situations involving the "use of force and restraints."<sup>274</sup> Having five different sets of seclusion standards that apply in five different situations or locations is less than ideal and can result in a lack of clarity regarding when and how a detainee may be secluded.

Second, the Department of Homeland Security (DHS) must make the standards governing immigration detention centers legally enforceable in the same way that the Department of Health and Human Services (HHS) has made the Patients' Rights Standards legally enforceable. As background, hospitals that violate the Patients' Rights Standards risk termination of their Medicare participating-provider status,<sup>275</sup> which is a financial death sentence for most hospitals.<sup>276</sup> Hospitals that violate the Patients' Rights Standards also risk loss of their

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270. See 2011 PBNDS, *supra* note 13, at 277, 282–85 (Standard 4.3, Medical Care).

271. See *id.* at 314, 316–19 (Standard 4.6, Significant Self-Harm and Suicide Prevention and Intervention).

272. See *id.* at 178, 181–84 (Standard 2.12, Special Management Units).

273. See *id.* at 184–86.

274. See *id.* at 208, 210–18 (Standard 2.15, Use of Force and Restraints).

275. See 42 C.F.R. § 482.1(b) (2014) ("[T]he provisions of this part serve as the basis of survey activities for the purpose of determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid."); *id.* § 489.53(a)(1), (3) (allowing the Centers for Medicare and Medicaid Services (CMS) to terminate a hospital's participating-provider agreement if CMS finds that the hospital is not complying with the Conditions of Participation); *Broughton Hosp. v. Ctrs. for Medicare & Medicaid Servs.*, Docket No. C-08-34 (Dep't of Health & Human Servs. Appeals Board Mar. 19, 2009) (involving a case in which CMS sought to terminate Broughton Hospital's provider agreement based on allegations of violations of the Patients' Rights Standards).

276. See, e.g., SPEAKER NOTE SET, *supra* note 36, at 13 slide 18 ("The effect of exclusion is very serious. Excluded [providers] may not bill for treating Medicare and Medicaid patients, nor may their services be billed indirectly through an employer or a group practice. Because of this prohibition, some refer to exclusion as a 'financial death sentence' for any health care provider.").

Joint Commission accreditation,<sup>277</sup> the imposition of steep civil monetary penalties (ranging from \$3,050 to \$10,000 per day, per violation) from the HHS Office of Inspector General for situations that have caused, or are likely to have caused, serious injury, harm, impairment, or death to a patient,<sup>278</sup> as well as civil penalties for false claims submitted to the Medicare program for treatments and services provided to inappropriately secluded patients under the federal False Claims Act.<sup>279</sup> Non-compliant hospitals also risk private lawsuits by patients alleging violations of general patients' rights statutes and specific statutes governing seclusion as well as common law negligence and false imprisonment causes of action.<sup>280</sup> Patients also can obtain injunctions preventing hospital staff from continuing their inappropriate seclusion practices.<sup>281</sup>

Faced with these legal risks, many hospitals accused of inappropriate patient seclusion or restraint quickly settle.<sup>282</sup> On

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277. *Interested in Hospital Accreditation?*, JOINT COMM'N, [http://www.jointcommission.org/accreditation/hospital\\_seeking\\_accreditation.aspx](http://www.jointcommission.org/accreditation/hospital_seeking_accreditation.aspx) (last visited Apr. 20, 2016).

278. See 42 C.F.R. § 488.438(a)(1)(i) (2014) (detailing the \$3,050 to \$10,000 per day civil monetary penalties that may be imposed for deficiencies constituting immediate jeopardy); *id.* § 489.3 (defining immediate jeopardy as a situation in which a health care provider's noncompliance with one or more Conditions of Participation "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident"); CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL: APPENDIX Q—GUIDELINES FOR DETERMINING IMMEDIATE JEOPARDY (2004), [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_q\\_immedjeopardy.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf) (outlining situations that constitute immediate jeopardy).

279. See, e.g., *United States ex rel. Aranda v. Cmty. Psychiatric Ctrs.*, 945 F. Supp. 1485 (W.D. Okla. 1996) (evaluating whether a psychiatric hospital that failed to provide patients with a reasonably safe environment and then billed Medicare for services provided to those patients submitted "false claims" within the meaning of the federal False Claims Act).

280. See, e.g., *O'Sullivan v. Sec'y of Human Servs.*, 521 N.E.2d 997, 997 (Mass. 1988) (holding that state officials engaged in inappropriate seclusion and restraint practices in violation of state statute governing seclusion); *Alt v. Parker*, 435 S.E.2d 773, 774 (N.C. Ct. App. 1993) (considering a secluded patient's alleged cause of action against a hospital for false imprisonment and violation of North Carolina's patients' rights standards); *Schaidler v. Mercy Med. Ctr.*, 563 N.W.2d 554, 556 (Wis. Ct. App. 1997) (involving a suit where a secluded and restrained patient alleged patients' rights violations, negligence, and false imprisonment against hospital and physicians).

281. E.g., *O'Sullivan*, 521 N.E.2d at 997.

282. See DEP'T OF JUSTICE, SETTLEMENT AGREEMENT BETWEEN THE UNITED STATES DEPARTMENT OF JUSTICE AND CENTRAL MONTGOMERY MEDICAL CENTER (2005) [hereinafter SETTLEMENT AGREEMENT] (setting forth the terms of Central Montgomery Medical Center's \$200,000 settlement with

August 6, 2002, for example, a seventy-nine-year-old woman with Alzheimer's disease died at Central Montgomery Medical Center after an inappropriate restraint intervention.<sup>283</sup> Even though county medical officials ruled that the woman's death was an accidental asphyxiation, the federal government used the incident as an opportunity to investigate the hospital's restraint policies.<sup>284</sup> On July 25, 2005, the U.S. Attorney for the Eastern District of Pennsylvania announced that the Department of Justice had reached a settlement agreement with the hospital based on allegations that the hospital had, throughout much of 2002, restrained patients in violation of the Patients' Rights Standards.<sup>285</sup> Although the hospital denied the improper restraint allegations, the hospital quickly agreed to pay the federal government \$200,000 and hire an independent consultant who would evaluate the hospital's policies governing patient restraints.<sup>286</sup>

In the detention setting, ICE does have some standards that provide instructions on the use of seclusion in the detention context.<sup>287</sup> However, unlike the Patients' Rights Standards, the detention standards are not enforceable in court.<sup>288</sup> DHS must make these standards legally enforceable. The lack of accountability of detention centers under the 2000 NDS, the 2008 PBNDS, and the 2011 PBNDS results in insufficient protections for the health, safety, and welfare of immigration detainees.

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the federal government relating to allegations of improper use of physical and chemical restraints); Stacey A. Tovino, *Patient Restraint Allegations and the False Claims Act*, HEALTH L. PERS. (Aug. 23, 2005), [http://www.law.uh.edu/healthlaw/perspectives/August2005/\(ST\)Restraints.pdf](http://www.law.uh.edu/healthlaw/perspectives/August2005/(ST)Restraints.pdf) (discussing the Settlement Agreement).

283. Tovino, *supra* note 282, at 1.

284. *Id.*

285. Press Release, U.S. Attorney, E.D. Pa., U.S. Attorney's Office Reaches Agreement with Hospital To Resolve Failure of Care Allegations Stemming from Improper Use of Patient Restraints (July 25, 2005), <http://www.uft-a.com/PDF/cmmc.pdf>.

286. SETTLEMENT AGREEMENT, *supra* note 282, at 2–3.

287. See *supra* notes 270–74 and accompanying text (identifying a variety of seclusion standards set forth in the 2011 PBNDS that apply in different situations).

288. See ETOWAH COUNTY JAIL REPORT, *supra* note 84, at 7 (“Furthermore, as internal ICE guidelines, the Detention Standards are not legally enforceable, so immigrants have very limited recourse if the facility does not follow them.”); NIJC, *supra* note 4, at 9 (noting that the 2011 PBNDS “remain legally unenforceable”).

Third, the philosophy behind ICE's detention standards must be improved. (To give ICE the benefit of the argument, this Article will compare ICE's 2011 PBNDS to HHS's Patients' Rights Standards, even though many detention centers are only contractually obligated to comply with the less stringent 2000 NDS or the 2008 PBNDS.) For example, the Patients' Rights Standards require seclusion and restraint of hospital patients to be "discontinued at the earliest possible time," regardless of the length of time identified in the order.<sup>289</sup> Compare this language with the 2011 PBNDS provision stating that, "[s]taff may not remove restraints until the detainee is no longer a danger to himself or others."<sup>290</sup> This is an important philosophical difference: In health law, hospital patients are relieved of these interventions at the first possible moment. In immigration detention, these interventions continue as long as necessary. ICE should adopt the seclusion- and restraint-free philosophy behind the Patients' Rights Standards.

Fourth, the Patients' Rights Standards have specific rules governing the imposition of seclusion. Under federal health law, hospitals may only impose seclusion or restraint for one reason; that is, "to ensure the immediate physical safety of the patient, a staff member, or others."<sup>291</sup> Hospital patients cannot be secluded for any other reason, including for "coercion, discipline, convenience, or retaliation by staff."<sup>292</sup> In its "Use of Force and Restraints" standard, however, ICE permits the restraint of detainees "as a precaution against escape during transfer; for medical reasons, when directed by the medical officer; or to prevent self-injury, injury to others, or property damage."<sup>293</sup> In its "Medical Care" standard, ICE permits the isolation of a detainee "who is at high risk for violent behavior because of a mental health condition," regardless of whether the detention center has attempted to treat that mental health condition and regardless of whether that detainee poses an immediate danger to herself or others.<sup>294</sup> In its "Special Management Units" standard, ICE permits the administrative

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289. 42 C.F.R. § 482.13(e) (2014) ("Restraint or seclusion . . . must be discontinued at the earliest possible time."); *id.* § 482.13(e)(9) ("Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.").

290. 2011 PBNDS, *supra* note 13, at 211 (Standard 2.15(V)(B)(9)).

291. 42 C.F.R. § 482.13(e).

292. *Id.*

293. 2011 PBNDS, *supra* note 13, at 210 (Standard 2.15(V)(B)(1)).

294. *Id.* at 292 (Standard 4.3(V)(N)(5)).



segregation of detainees simply “to ensure the safety of detainees or others, the protection of property, or the security or good order of the facility.”<sup>295</sup> ICE also allows for disciplinary segregation “[t]o provide detainees in the general population a safe and orderly living environment.”<sup>296</sup> This Article argues that detainees should not be restrained, isolated, segregated, or otherwise secluded for any reason other than to ensure the immediate physical safety of the detainee himself or herself, a staff member, or others. In addition, the intervention must be ended at the earliest possible time.

Fifth, the Patients’ Rights Standards limit the individuals who may order restraint or seclusion to a physician or other licensed independent health care practitioner. On the other hand, the 2011 PBNDS allow “staff” to impose administrative segregation,<sup>297</sup> an “institution disciplinary panel” to impose disciplinary segregation,<sup>298</sup> and “staff” to impose restraints.<sup>299</sup> Given the high risk of injury, self-harm, and suicide in secluded and restrained populations, this Article argues that only physicians and other licensed, independent health care practitioners who are trained in identifying detainees who are at risk for self-harm and suicide should have the authority to order seclusion and restraint.

Sixth, the Patients’ Rights Standards have specific rules governing the duration of seclusion orders. In the hospital setting, a seclusion order for an adult patient may be written for a maximum time period of four hours.<sup>300</sup> Orders for the seclusion of children aged nine to seventeen may be written for no longer than two hours,<sup>301</sup> and orders for the seclusion of children less than nine years of age may be written for no longer than one hour.<sup>302</sup> Again, all seclusion orders “must be discontinued at the earliest possible time, regardless of the length of time identified in the order.”<sup>303</sup> Compare these health law standards with ICE’s standards, which permit disciplinary segregation for periods lasting as long as thirty *days* (not

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295. *Id.* at 181 (Standard 2.12(V)(A)).

296. *Id.* at 184 (Standard 2.12(V)(B)).

297. *Id.* at 178 (Standard 2.12(II)(4)).

298. *Id.* at 185 (Standard 2.12(V)(B)).

299. *Id.* at 210 (Standard 2.15(V)(B)(4)).

300. 42 C.F.R. § 482.13(e)(8)(i)(A) (2014).

301. *Id.* § 482.13(e)(8)(i)(B).

302. *Id.* § 482.13(e)(8)(i)(C).

303. *Id.* § 482.13(e)(9).

hours), “except in extraordinary circumstances” involving certain offenses, in which case the segregation may last for a *longer* period of time.<sup>304</sup> Given the finding of the United Nations Special Rapporteur that lengthy seclusion can constitute torture and that individuals should not be secluded for more than fifteen days, ICE should adopt the maximum time periods set forth in federal health law.

Seventh, the Patients’ Rights Standards have strict rules governing the frequency with which secluded patients shall be monitored. For example, secluded hospital patients must be seen face-to-face within one hour after the initiation of the seclusion intervention by a physician or other licensed independent practitioner to evaluate the patient’s immediate situation, the patient’s reaction to the intervention, the patient’s medical and behavioral condition, and the need to continue or terminate the seclusion intervention.<sup>305</sup> Compare these rules with the administrative segregation rules that apply to detainees, which only require a review “within 72 hours of the detainee’s placement in administrative segregation to determine whether segregation is still warranted.”<sup>306</sup> Further compare the disciplinary segregation rules that apply to detainees, which only require a review “every seven days” to determine whether continued segregation is warranted.<sup>307</sup> These standards should be revised to require more frequent monitoring and review of the continued need for the seclusion order.

Eighth, the Patients’ Rights Standards contain stringent staff training requirements. That is, hospitals are required to train staff members regarding all of the following: (1) techniques to identify behaviors, events, and environmental factors that may trigger situations historically calling for restraint or seclusion; (2) the use of less restrictive non-physical intervention skills; (3) the selection of the least restrictive intervention based on an individualized assessment of the patient’s physical and emotional status; (4) the safe

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304. 2011 PBNDS, *supra* note 13, at 185 (“The maximum sanction is 30 days in disciplinary segregation per violation, except in extraordinary circumstances, such as violations of offense 101 through 109 listed in the ‘Greatest’ offense category in Appendix 3.1.A. After the first 30 days, and each 30 days thereafter, the facility administrator shall send a written justification for the continued segregation to the Field Office Director.”).

305. 42 C.F.R. § 482.13(e)(12).

306. 2011 PBNDS, *supra* note 13, at 184 (Standard 2.12(V)(A)(3)(a)).

307. *Id.* at 185 (Standard 2.12(V)(B)(3)(a)).

application and use of restraint and seclusion, including training regarding how to recognize and respond to physical and psychological distress; (5) the identification of specific behavioral changes that indicate that the restraint or seclusion interventions are no longer necessary; and (6) the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification, among other requirements.<sup>308</sup> Compare these requirements with ICE's minimal training requirements, which simply provide that, "all staff responsible for supervising detainees shall receive a minimum of eight hours of training initially during orientation and repeated at least annually, on effective methods for identifying significant self-harm, as well as suicide prevention and intervention with detainees."<sup>309</sup> ICE must improve the content and frequency of its staff training requirements.

Finally, the Patients' Rights Standards contain important death reporting requirements. That is, hospitals must report the following information to the Centers for Medicare and Medicaid Services no later than the close of business on the next business day following knowledge of a patient's death: (1) each death of a secluded patient; (2) each death that occurs within twenty-four hours after the completion of a seclusion intervention; and (3) each death that is known to a hospital and that occurs within one week after seclusion where it is reasonable to assume that seclusion directly or indirectly contributed to a patient's death.<sup>310</sup> Compare these reporting requirements with ICE's death reporting requirements, which only require the completion of an incident report within twenty-four hours as well as adherence to the Notification and Reporting of Detainee Deaths Directive.<sup>311</sup> ICE must strengthen its death reporting requirements.

In summary, HHS and DHS have very different philosophical and practical approaches to the oversight of, and the rights of individuals in Medicare-participating hospitals and immigration detention centers, respectively. It is the central thesis of this Article that federal health law can provide significant guidance with respect to appropriate detention center regulation.

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308. 42 C.F.R. § 482.13(f)(2).

309. 2011 PBNDS, *supra* note 13, at 314 (Standard 4.6(II)(1)).

310. 42 C.F.R. § 482.13(g)(1)(i)–(iii).

311. 2011 PBNDS, *supra* note 13, at 319 (Standard 4.6(V)(I)).

Under 8 U.S.C. § 1103(a)(3), the Secretary of DHS has the authority to issue legally enforceable federal regulations establishing the standard of care for individuals in ICE custody.<sup>312</sup> This Article proposes that DHS issue a proposed rule that would establish enforceable regulations guided by the nine recommendations above. These regulations could be codified at 8 C.F.R. Part 242, a currently open Part within Subchapter B of Title 8 of DHS's Immigration Regulations.<sup>313</sup> Using the nine recommendations outlined in this Article above as a roadmap and using HHS's Patients' Rights Standards codified at 42 C.F.R. § 482.13(e), (f), and (g) as a guide, this Article recommends the following structure for these new regulations:

8 C.F.R. Part 242

242.1 Definitions

242.2 Right to Be Free from Unnecessary Restraint and Seclusion

242.3 Standard for Restraint and Seclusion

242.4 Individuals Who May Order Restraint or Seclusion

242.5 Maximum Time Limits for Restraint and Seclusion Orders

242.6 Discontinuation of Restraint and Seclusion Orders at the Earliest Possible Time

242.7 Detainee Monitoring Requirements

242.8 Staff Training Requirements

242.9 Death Reporting Requirements

242.10 Complaints and Investigations

242.11 Penalties for Non-Compliance

To enforce these regulations, DHS should strengthen the authority of its current Detention Service Managers within ICE's Detention Management Division<sup>314</sup> to investigate detainee complaints and other allegations of non-compliance and to impose penalties for confirmed regulatory violations.

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312. See 8 U.S.C. § 1103(a)(3) (2014) (“[The Secretary of Homeland Security] shall establish such regulations . . . and perform such other acts as he deems necessary for carrying out his authority under the provisions of this chapter.”).

313. See 8 C.F.R. pt. 242 (2014) (Reserved).

314. See *Detention Management*, U.S. IMMIGRATION & CUSTOMS ENF'T (Nov. 10, 2011), <http://www.ice.gov/factsheets/detention-management> (describing the operations and activities of the Detention Management Division).

## CONCLUSION

This Article has carefully examined the uses and abuses of seclusion in the context of immigration detention and draws three primary conclusions. First, ICE's unenforceable detention standards lack uniformity and fail to protect the health, safety, and welfare of detainees. Second, current proposals for detention center reform are based on constitutional law and international human rights provisions, which lack the specificity necessary to protect detainees from physical and emotional abuse and neglect. Third, federal health law, including regulations governing the imposition of seclusion in Medicare-participating hospitals, provide an excellent guide for the reform of detention center seclusion standards. This Article makes nine recommendations that are designed to correct detention centers' excessive use and abuse of the seclusion intervention. This Article also proposes a structure for legally enforceable federal regulations governing the imposition of seclusion. If promulgated by DHS, these regulations will protect detainees from further abuse, self-harm, and suicide, and will re-align the philosophy of detainee care with the civil nature of immigration detention.