

Tylenol and an ICE Pack: An Inadequate Prescription for HIV/AIDS in Immigration Detention Centers

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In 2007, Victoria Arellano, a 23-year-old transgender immigrant, died from complications resulting from Acquired Immune Deficiency Virus (“AIDS”) while in U.S. Immigration and Customs Enforcement (“ICE”) custody at a San Pedro, CA, immigrant detention center.² Although her stay in the detention center was brief, her death was slow and agonizing. According to her mother, Arellano tested positive for Human Immunodeficiency Virus (“HIV”) two years prior to her encounter with ICE.³ At the time of her arrest, Arellano was asymptomatic because of the HIV medications that she took daily.⁴

From the time of her HIV diagnosis until shortly after her arrival at the San Pedro detention facility, when ICE medical staff discontinued her prescriptions for HIV, Arellano did not experience any health problems.⁵ Within two weeks of her arrival at the detention center, however, Arellano began to vomit and urinate blood.⁶ Medical staff at the detention center recommended that she take Tylenol and drink a lot of water.⁷ A week later, noticing her deteriorating condition, Arellano’s fellow inmates began taking

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² Sandra Hernandez, *A Lethal Limbo*, L.A. TIMES (June 1, 2008), <http://articles.latimes.com/2008/jun/01/opinion/op-hernandez1>.

³ *Id.*

⁴ *Death in Detention*, PRI’S THE WORLD (Aug. 31, 2007), <http://www.pri.org/theworld/?q=node/12379>.

⁵ Hernandez, *supra* note 2.

⁶ *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*, 19 HUMAN RIGHTS WATCH 5(G), 25 (2007), available at <http://www.hivlawandpolicy.org/resources/view/247> (henceforth “*Chronic Indifference*”).

⁷ *Id.*

care of her.⁸ They cleansed her, disposed of her bodily fluids, pled with the medical staff to care for the sickly inmate, and even circulated a petition with their request.⁹ When her condition finally caught the attention of an ICE captain, he placed his foot on her pillow and asked, “What’s wrong with you?”¹⁰ Arellano spent that night in the hospital.¹¹ When she returned to the detention facility, she told her cellmates that the medical and security staff at the hospital taunted her.¹² A week later – just one month after her being taken into ICE custody – Arellano died of meningitis, a condition often associated with advanced AIDS.¹³

INTRODUCTION

The administration of HIV treatment in immigration detention centers presents numerous challenges for both residents of the facilities suffering from the illness and the government agencies tasked with providing medical services for detainees. For detainees, failure to obtain access to a suitable HIV treatment regimen, and continuous monitoring by an HIV specialist, for even short periods of time, can make that regimen ineffective. Moreover, inadequate access to antiretroviral therapy increases the risk of spreading the illness, as HIV-positive individuals that do not undergo treatment are more likely to pass on the virus to others during unprotected sex.¹⁴ Incidents of sexual violence and a lack of access to condoms and prevention education in many detainment facilities, presents a serious public health threat. In addition, the lack of uniform

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*, 19 HUMAN RIGHTS WATCH 5(G), 25 (2007), available at <http://www.hivlawandpolicy.org/resources/view/247>.

¹² *Id.*

¹³ *Id.*

¹⁴ *Questions and Answers on the Use of HIV Medications to Help Prevent the Transmission of HIV*, CENTERS FOR DISEASE CONTROL, <http://www.cdc.gov/hiv/topics/treatment/resources/qa/art.htm> (last modified Apr. 13, 2010).

guidelines for HIV treatment across detention facilities nationally results in unequal treatment of HIV-positive detainees. Non-citizens fearful of the health consequences of being housed in a detention center that does not have adequate medical provisions may opt to transfer to another facility, away from their families and legal counsel or to a jurisdiction that is less-likely to produce a favorable outcome in their immigration proceeding.

From the government's perspective, administering HIV treatment in detention facilities does not come without its challenges. The costs of antiretroviral therapy are exorbitant – the most effective antiretroviral drugs are also the most expensive. Additionally, providing the range of services available in many privately funded HIV clinics, including quarterly doctor visits, blood tests, and mental health services, can prove burdensome on detention facilities. It would be difficult for the federal government to justify placing this burden on taxpayers, especially when treatment for poor HIV-positive U.S. citizens is deficient.

Issues concerning the distribution of HIV medication also present challenges. On the one hand, training and establishing protocols for nurses or guards to administer treatment may prove cumbersome, but leaving medicine in the care of detainees presents its own risks. Recent news reports note an emerging underground drug market for HIV medications.¹⁵ Further, the appropriate standard of care for HIV patients is highly debated. Specialists particularly disagree on when a patient should begin treatment. While some providers recommend beginning treatment as early as possible after diagnosis, others recommend treating the illness when it shows signs of maturity.

This Note will explore legal and public policy strategies to address inadequate access to medical treatment for HIV in immigration centers. Part I will provide a brief history of AIDS

¹⁵ Diane Jeantet, *Sales of HIV Meds Catch Lawmakers Eyes*, CITY LIMITS (Jan. 18, 2012), http://www.citylimits.org/news/article_print.cfm?article_id=4513.

and an overview of HIV/AIDS treatment options. Part II will address the legal basis for the right to HIV treatment in correctional and detention facilities under the Eighth Amendment ban on cruel and unusual punishment and the Fifth Amendment due process clause. Parts III and IV will discuss the current state of HIV treatment in detention facilities including the failures of the U.S. Department of Homeland Security's ("DHS") existing policies and procedures for detainee medical care and some of the challenges to the administration of HIV treatment in detention centers. Finally, Part V will consider some of the solutions to the challenge of HIV-care in immigration detention centers that have been proposed by advocates and implemented by states and municipal correctional administrators, which, in turn, can be adapted to the immigration detention context.

BACKGROUND

I. THE HISTORY OF AIDS IN THE UNITED STATES

AIDS first emerged in the United States in 1981.¹⁶ It was during that year, that several New York City and San Francisco doctors recognized a trend of highly unusual and opportunistic infections in young, healthy, gay men.¹⁷ Specifically, the men had suppressed immune systems that made them susceptible to Karposi's Sarcoma (KS), a rare skin cancer, and Pneumocystis Carinii Pneumonia (PCP).¹⁸ Initially, the disease was termed the "gay cancer."¹⁹ But as more cases were reported, women, blood transfusion patients, intravenous drug users, recipients of blood products, and sexually active

¹⁶ Donald P. Francis, Merle A. Sande, John L. Ziegler, *The AIDS Epidemic in San Francisco: The Medical Response 1981-1984, Volume IV*, THE S.F. AIDS ORAL HISTORY SERIES (Nov. 2011), http://content.cdlib.org/view?docId=kt729005cr&brand=calisphere&doc.view=entire_text.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

heterosexual individuals, were also being diagnosed with AIDS.²⁰ In 1984, it was found that AIDS was caused by an immune suppressing virus, later renamed the Human Immunodeficiency Virus (“HIV”).

Those that “die of AIDS” do not actually die of the disease itself. Rather, they die from one of several opportunistic infections that afflict people with the illness. These opportunistic infections kill because HIV causes a person’s immune system to become ineffective in fighting diseases and infections.²¹ Early on doctors found that HIV destroys certain essential blood cells known as CD4 + T-cells.²² The virus can be found throughout the bodies of infected individuals, in every body fluid, and even in the brain.²³ Therefore, infections that ordinarily would be prevented or fought by the body’s immune system in individuals who do not have the illness become deadly in those with HIV.²⁴

According to the Centers for Disease Control (“CDC”), HIV is primarily spread by: having unprotected sex with a person that is infected with HIV; having multiple sex partners; the presence of other sexually transmitted diseases (STD’s); sharing needles, syringes, rinse water or other equipment used to prepare illicit drugs for injection; or being born to an HIV infected mother.²⁵

Prior to 1996, it was estimated that about half of those living with HIV would develop AIDS within ten years of infection with the virus.²⁶ Since then, the introduction

²⁰ Lawrence K. Altman, *New Homosexual Disorder Worries Health Officials*, N.Y. TIMES (May 11, 1982), <http://www.nytimes.com/1982/05/11/science/new-homosexual-disorder-worries-health-officials.html>.

²¹ *HIV/AIDS Basics*, CENTER FOR DISEASE CONTROL, <http://www.cdc.gov/hiv/resources/qa/definitions.htm> (last modified Nov. 6, 2006).

²² *Id.*

²³ *Health Guide*, N.Y. TIMES, <http://health.nytimes.com/health/guides/disease/aids/overview.html> (last modified Apr. 30, 2012).

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Living with AIDS*, CENTER FOR DISEASE CONTROL, <http://www.cdc.gov/hiv/resources/brochures/livingwithhiv.htm> (last modified June 21, 2007).

of antiretroviral therapies (“ART”) have slowed the progression of the virus, dramatically increasing the amount of time between initial infection with HIV and the onset of AIDS.²⁷ Once an individual is infected with HIV, it takes the immune system several weeks to react to develop antibodies.²⁸ Most people who are infected develop flu-like symptoms within a month or two after the virus enters the body.²⁹ This illness, known as primary or acute HIV infection, may last for several weeks.³⁰ Symptoms include fever; rash; headache; sore throat; night sweats; and severe diarrhea, amongst others.³¹ Often, these symptoms are mild enough to go unnoticed.³² However, the amount of virus in the blood stream (viral load) is particularly high during this period.³³

In 1987, responding to public fears, the rapid spread of the illness, and allegations that the disease was brought to the U.S. by a single Haitian immigrant during the late 1970’s, the U.S. Department of Health and Human Services (HHS) added HIV to the list of “exclusionary communicable diseases” within the Immigration and Nationality Act (INA).³⁴ The new regulation prohibited HIV positive immigrants and travelers from entering the U.S. This travel restriction was codified within the INA by Congress in 1993 and was in effect until 2009, when it was lifted by President Obama.³⁵

²⁷ *Id.*

²⁸ *HIV/AIDS: Symptoms*, MAYO CLINIC, <http://www.mayoclinic.com/health/hiv-aids/DS00005/DSECTION=symptoms> (last modified Aug. 11, 2012).

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ Coco Jervis, *United States’ HIV Ban Eliminated? Not So Fast*, THE BODY (Sept. 2008), <http://www.thebody.com/content/art48694.html>. [CHANGED LINK/SOURCE]

³⁵ Victoria Colliver, *Obama Lifts HIV Travel Ban for U.S. Visitors*, S.F. CHRONICLE (Oct. 31, 2009), <http://www.sfgate.com/health/article/Obama-lifts-HIV-travel-ban-for-visitors-to-U-S-3211599.php>. [CHANGED LINK]

Treatment for HIV first emerged in 1989 with the announcement of the drug azidothymidine (AZT).³⁶ AZT was found to slow the progression of HIV in individuals who did not yet exhibit symptoms of AIDS.³⁷ That same year, a second drug treatment for HIV was introduced, dideoxyinosine (ddI), and in 1991, a third retroviral drug, dideoxycytidine (ddC), was introduced for those intolerant of AZT.³⁸ While these early treatment options provided a glimmer of hope for those impacted by the illness, their high cost – over \$10,000 per year to treat one individual – produced public outcry.³⁹

Today there are more than twenty approved antiretroviral medications in the United States. In most instances doctors prescribe a combination of drugs - referred to as Highly Active Antiretroviral Therapy (HAART) - that must be taken every day for the rest of an infected individual's life to attack HIV on multiple fronts. With HAART, the life expectancy of an HIV-positive individual that maintains a CD4 count above 500 is consistent with that of the general population.⁴⁰

Unfortunately, HIV drug costs are still exorbitant. Prices of commonly prescribed drug combinations include \$1,195.15 per month for Truvada⁴¹, \$1,469.81 per month for Prezista/Norvir⁴², and \$1,858.15 per month for Atripla, the only all-in-one HIV

³⁶ AZT, BRITANNICA ONLINE, <http://www.britannica.com/EBchecked/topic/46868/AZT> (last modified Apr. 9, 2013).

³⁷ *Id.*

³⁸ *History of AIDS 1987-1992*, AVERT, <http://www.avert.org/aids-history87-92.htm> (last visited Feb. 25, 2012).

³⁹ *Id.*

⁴⁰ Tim Horn, *Normal Life Expectancy with CD4 Maintenance Above 500*, AIDS MEDS (Mar. 2, 2010), http://www.aidsmeds.com/articles/hiv_survival_mortality_1667_18083.shtml.

⁴¹ *Truvada*, POSITIVELY AWARE (Mar./April 2011), http://positivelyaware.com/2011/11_02/drugs/truvada.shtml

⁴² *Prezista*, POSITIVELY AWARE (Mar./April 2011), *available at* http://positivelyaware.com/2011/11_02/drugs/prezista.shtml; *See also, Norvir*, POSITIVELY AWARE (Mar./April 2011), *available at* http://positivelyaware.com/2011/11_02/drugs/norvir.shtml.

drug approved by the Food and Drug Administration (FDA).⁴³ Researchers project the maximum lifetime cost for HIV treatment per individual may be as high as \$618,900.⁴⁴

II. LEGAL PROTECTIONS AFFORDED IMMIGRANT DETAINEES

The stories of Juan Carlos Baires and Teofilo Miranda raise important legal and policy questions concerning the rights of HIV-positive detainees to adequate treatment while in ICE custody. Baires, a former immigration detainee, died of complications resulting from HIV in November 2008, while in ICE custody.⁴⁵ Like most patients inflicted with the illness, he depended on antiretroviral therapy to fend off opportunistic infections.⁴⁶ And like Arellano, Baires begged ICE officials for his medications to no avail.⁴⁷

The effects of Baires' untreated condition first appeared when he developed a foot infection.⁴⁸ Baires informed medical personnel and security guards of his condition, but was denied care. The infection progressively worsened to the point that Baires could not walk and his foot turned blue.⁴⁹ Still, prison guards, staff, and medical personnel turned a blind eye. After fifty-four days of incarceration, most of them filled with agonizing pain for Baires, prison officials finally took him to the hospital.⁵⁰ But it was too late. Baires died the next day from an undiagnosed and untreated staph infection that had traveled into his bloodstream.⁵¹

Miranda, another immigration detainee and co-plaintiff in *Baires v. United States*, also

⁴³ *Atripla*, POSITIVELY AWARE (Mar./April 2011), available at http://positivelyaware.com/2011/11_02/drugs/atrilpa.shtml

⁴⁴ Bruce R. Schackman, *The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States*. 44 MEDICAL CARE 990 (2008), available at <http://webserver.rilin.state.ri.us/HIV/Documents/lifetimecostofHIV.pdf>.

⁴⁵ *Baires v. United States*, No. C 09-5171 CRB, 2010 WL 3515749, at *2-3 (N.D. Ca. Sept. 8, 2010).

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

received grossly inadequate and negligent medical care while under the care of DHS, ICE, and the Division of Immigration Health Services (“DIHS”).⁵² Like Baires, Miranda, told officials at the detention center that he was HIV-positive and needed medications.⁵³ But despite their knowledge of Miranda’s condition, medical personnel administered extra-strength aspirin for pain rather than prescribing appropriate HIV medications.⁵⁴

Miranda was released from detention in December 2008. During his entire seventy-eight day detainment, Miranda never received HIV medication nor saw a HIV specialist.⁵⁵ Upon his release, he immediately went to San Francisco General Hospital where doctors treated his severely deteriorated condition.⁵⁶ In 2009 Miranda, along with Baires’ estate, brought suit in federal district court against the medical staff at the Lerdo Detention Facility where they were housed, the Kern County Medical Center where they were treated, and a number of federal defendants including DHS, ICE, DIHS, and several other individual federal employees.⁵⁷

A. Eighth Amendment Protections

The Eighth Amendment prohibits the federal government from imposing cruel and unusual punishment on those convicted of criminal offenses.⁵⁸ The Amendment has long applied to torture and other “barber(ous) methods of punishment.”⁵⁹ The Supreme Court has determined that punishment involving unnecessary and wanton infliction of pain⁶⁰ or a lingering death

⁵² *Id.* at *4.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.* at *4-5.

⁵⁸ U.S. CONST. amend. VIII.

⁵⁹ *See Estelle v. Gamble*, 429 U.S. 97, 102 (1976).

⁶⁰ *See Gregg v. Georgia*, 428 U.S. 153, 173 (1976).

violates the Amendment.⁶¹ In *Estelle v. Gamble*, the Court concluded that deliberate indifference to the serious medical needs of prisoners constitutes unnecessary and wanton infliction of pain and is prohibited by the Eighth Amendment.⁶² The Court explained:

An inmate must rely on prison authorities to treat his medical needs – if authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical “torture or a lingering death”... the evils of most immediate concern to the drafters of the Amendment. In less serious cases denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose... it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.⁶³

The elements of the “deliberate indifference to serious medical needs” standard are both objective and subjective.⁶⁴ The objective “medical need” element measures the severity of the alleged deprivation, while the subjective “deliberate indifference” element considers whether or not the prison official acted with a sufficiently culpable state of mind.⁶⁵

Not every lapse in prison medical care suggests a constitutional violation.⁶⁶ While society bears the burden of meeting the medical needs of those incarcerated, it does not expect that prisoners will have unqualified access to health care.⁶⁷ Rather, a prisoner must make a threshold showing of *serious* illness or injury in order to state an Eighth Amendment claim for denial of medical care.⁶⁸ Further, “medical malpractice does not become a constitutional violation merely because the victim is a prisoner”; a prisoner must demonstrate more than a mere failure to provide adequate medical care by prison officials.⁶⁹ A prison official acts with

⁶¹ See *In re Kemmler*, 136 U.S. 436, 447 (1890) (“Punishments are cruel when they involve torture or a lingering death...”).

⁶² *Estelle*, 429 U.S. at 104.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*; see also *Smith v. Carpenter*, 316 F.3d 178, 183-84 (2003).

⁶⁶ *Smith*, 316 F.3d at 184.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Estelle*, 429 U.S. at 105-06.

indifference when the official knows of and disregards an excessive risk to an inmate's health or safety.⁷⁰

Federal courts have determined that treatment for HIV/AIDS is a "serious medical need" under the Eighth Amendment.⁷¹ However, the serious need inquiry under *Estelle* is fact specific and narrowly tailored to each case.⁷² The Second Circuit has held that where an inmate claims temporary delay or interruption in HIV treatment, it is more appropriate to focus on the *challenged* delay or interruption in treatment rather than the prisoner's underlying medical condition alone in analyzing whether the alleged deprivation is serious.⁷³

The absence of adverse medical effects or physical injury is one factor used to gauge the seriousness of the medical need.⁷⁴ In *Evans v. Bonner*, the Eastern District of New York found that untimely administration of HIV medication did not cause sufficiently serious injury to give rise to an Eighth Amendment violation because the plaintiff was unable to show serious adverse effects of the deprivation.⁷⁵ In *Smith*, the court focused on the particular risks attributable to missed HIV medication, rather than on the plaintiff's HIV status alone.⁷⁶ The *Smith* court found that although the plaintiff suffered from HIV, he failed to show that the alleged episodes of missed medication resulted in permanent or ongoing harm to his health, or why the absence of physical injury was not a relevant factor in assessing the seriousness of the medical need.⁷⁷ In *Taylor v. Barnett*, a federal district court in Virginia denied the defendant's motion to dismiss

⁷⁰ *Smith*, 316 F.3d at 184.

⁷¹ *Taylor v. Barnett*, 105 F. Supp. 2d 483, 487 (E.D. Va. 2000); *see also* *Montgomery v. Pinchak*, 294 F.3d 492, 500 (3d Cir. 2002).

⁷² *Smith*, 316 F.3d at 185.

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Evans v. Bonner*, 196 F. Supp. 2d 252, 256 (E.D.N.Y. 2002).

⁷⁶ *Smith*, 316 F.3d at 187.

⁷⁷ *Id.*

where the plaintiff showed that a switch in his medication caused serious side effects and shortened his life.⁷⁸

Whether or not failure to provide adequate treatment for the HIV constitutes “deliberate indifference” has also spurred conflict. To establish “deliberate indifference” a prisoner must show that the defendant’s actions were “[s]o grossly incompetent, inadequate, or excessive, as to shock the conscience or to be intolerable to fundamental fairness.”⁷⁹ However, judicial guidance regarding the level of medical care necessary for HIV/AIDS treatment in prisons is minimal.⁸⁰ Courts have found that failure to provide an inmate with prescribed medication in a timely manner is insufficient to establish deliberate indifference.⁸¹ An inmate’s disagreement with the course of medical treatment has also been held to be insufficient to state a claim.⁸²

But like the “serious need” prong of the *Estelle* analysis, deliberate indifference is analyzed case-by-case, and the results in federal cases have varied. Most of the district court opinions addressing this issue are unpublished.⁸³ One district court denied a defendant’s summary judgment motion where an inmate alleged that his treatment for HIV was inconsistent, that he was administered incorrect dosages, and that his medication, AZT, was the only medication that proved successful in treating AIDS. In an earlier case, a federal court found that an inmate alleging that his disease was not monitored and that his requests for treatment were ignored stated a supportable Eighth Amendment claim.⁸⁴ Another court allowed a claim to go forward where an inmate alleged that jail personnel failed to provide her treatment until she was

⁷⁸ *Taylor*, 105 F. Supp. 2d at 489.

⁷⁹ *Miltier v. Beorn*, 896 F.2d 848, 851 (4th Cir. 1990).

⁸⁰ *Taylor*, 105 F. Supp. 2d at 489.

⁸¹ *Nolley v. County of Erie*, 776 F. Supp. 715, 740 (W.D.N.Y. 1991) (holding that the occasional failure to provide an inmate with her AZT medication did not violate the Eighth Amendment).

⁸² *See Perkins v. Kan. Dept. of Corrections*, 165 F.3d 803, 811 (10th Cir. 1999).

⁸³ *Taylor*, 105 F. Supp. 2d at 488.

⁸⁴ *Lewis v. Prison Health Servs., Inc.*, No. 88-1247, 1988 WL 95082, at *3-4 (E.D. Pa. Sept. 13, 1988).

comatose in her cell.⁸⁵ Other cases were dismissed where the defendant's disagreed with their medical prescription.⁸⁶

B. Fifth Amendment Protections for Immigration Detainees

The constitutional rights of immigration detainees have been recognized since 1896.⁸⁷ Unlike prisoners, immigration detainees are civil, not criminal detainees.⁸⁸ Hence, the rights of immigration detainees to challenge conditions of confinement are granted by the Fifth Amendment Due Process Clause.⁸⁹ Protections given to immigration and other civil detainees under the Due Process Clause require that the conditions and restrictions of a detention facility not amount to punishment.⁹⁰ The Due Process Clause requires that conditions for all persons confined without adjudication of criminal guilt exceed the requirements under the Eighth Amendment for prisoners.⁹¹ For individuals detained on criminal charges awaiting trial, this means that they too may not be subjected to punitive conditions of detention.⁹² Thus, courts have invalidated policies subjecting pre-trial detainees to conditions similar to those of convicted prisoners.⁹³

In theory, immigration detainees should be provided a higher level of medical care and have more legal protections than prisoners or criminal detainees. The Ninth Circuit has gone as far as to hold that conditions of confinement for civil detainees must be superior to the conditions

⁸⁵ *Rivera v. Sheahan*, No. 97 C 2735, 1998 WL 531875, at *6 (N.D. Ill. Aug. 14, 1998).

⁸⁶ *See* *Cloud v. Goldberg*, No. 98-4250, 2000 WL 157159, at *3 (E.D. Pa. Feb. 14, 2000); *see also* *Carter v. Cash* No.92-CV-5526, 1995 WL 347028, at *3 (E.D.N.Y. May 31, 2005).

⁸⁷ *Wong Wing v. United States*, 163 U.S. 228, 238 (1896) (“[I]t must be concluded that all persons within the territory of the United States are entitled to the protection guaranteed by [the Fifth and Sixth] amendments, and that even aliens shall not be deprived of... due process of law.”).

⁸⁸ *Zadvydas v. Davis*, 533 U.S. 678, 690 (2001).

⁸⁹ *Bell v. Wolfish*, 441 U.S. 520, 535 (1979).

⁹⁰ *Id.* at 536-37.

⁹¹ Sarah Botz and Robert C. Scherer, *Substantive Rights Retained by Prisoners*, 84 GEO. L. J. 1465, 1498 (1996).

⁹² *Id.*

⁹³ *Id.*

for both convicted prisoners and pre-trial detainees.⁹⁴ As the court explained:

[T]he more protective Fourteenth Amendment standard applies to conditions of confinement when detainees ... have not been convicted of a crime. The Fourteenth Amendment requires the government to do more than provide the “minimal civilized measure of life's necessities,” for non-convicted detainees. Rather, “due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.”⁹⁵

If a civil detainee is confined in conditions that are identical or similar to, or more restrictive than, those under which pre-trial detainees or convicted prisoners are held, then those conditions are presumptively punitive and unconstitutional.⁹⁶ Or as the Ninth Circuit put it, “purgatory cannot be worse than hell.”⁹⁷ Nevertheless, in practice, ICE detainees are afforded a level of care at odds with accepted standards of practice, even for correctional settings.⁹⁸

III. ADMINISTRATION OF MEDICAL SERVICES IN IMMIGRATION DETENTION CENTERS

A. A Brief Overview of Immigration Detention in the United States

The Constitution provides Congress with broad authority to detain non-citizens while they wait for a determination of whether or not they should be removed from the United States. The Department of Homeland Security (“DHS”) is the principle agency tasked with enforcing the Immigration and Naturalization Act – the federal statute outlining most U.S. immigration laws.⁹⁹ Removal, detention, and investigative functions are managed by U.S. Immigration and Customs Enforcement (“ICE”), a division of DHS.

⁹⁴ Jones v. Blanas, 393 F.3d 918, 933-34 (9th Cir. 2004).

⁹⁵ *Id.* at 931.

⁹⁶ *Id.* at 934.

⁹⁷ *Id.* at 933.

⁹⁸ Homer D. Venters, Jennifer McNeely, Allen S. Keller, *HIV Screening and Care for Immigration Detainees*, 11 HEALTH & HUMAN RIGHTS J. (No. 2) 91 (2009) <http://www.hhrjournal.org/index.php/hhr/article/view/177/261>.

⁹⁹ *About DHS*, U.S. DEPARTMENT OF HOMELAND SECURITY, <http://www.dhs.gov/about-dhs> (last visited Feb. 25, 2012).

Certain categories of non-citizens are subject to mandatory detention by DHS.¹⁰⁰ Those not subjected to mandatory detention may be paroled, released on bond, or required to remain in detention.¹⁰¹ Any non-citizen can be detained while DHS determines whether the non-citizen should be removed from the United States.¹⁰² Amongst those able to be detained are non-citizens who entered the U.S. unlawfully, lawful permanent residents facing deportation as a consequence of a criminal offense, asylum seekers who have not committed a crime, and those present without status who, while in violation of their immigration status, have not committed a criminal offense.¹⁰³

Although non-citizens in immigration detention are in the custody of ICE, most are detained at facilities that are not owned or fully contracted by ICE.¹⁰⁴ In October 2007, 65% of non-citizen detainees were detained at state and local prisons subcontracted by ICE via Inter-Governmental Service Agreements (IGSAs), 19% at contract facilities, 14% at Service Processing Centers (SPCs) owned and operated by ICE, and 2% at Bureau of Prisons (BOP) facilities.¹⁰⁵

B. Guidelines for Medical Operations in ICE Detention Centers

DHS's Detention Management Control Program governs medical care for ICE detainees. These guidelines and procedures for ICE detention operations do not carry the force of law. Consequently, when detention centers fail to provide adequate medical care for detainees, there are only a few repercussions. Medical and dental services to detainees held in government operated facilities are provided by the U.S. Public Health Service's (USPHS) Division of

¹⁰⁰ ALISON SISKIN, CRS REPORT FOR CONGRESS: HEALTH CARE FOR NON-CITIZENS IN IMMIGRATION DETENTION 3 (2008), available at <http://www.scribd.com/doc/22565178/CRS-Health-Care-for-Non-Citizens-in-Immigration-Detention-June-27-2008> (henceforth "CRS Report").

¹⁰¹ *Id.*

¹⁰² *Id.* at 3-4.

¹⁰³ *Id.* at 4.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 4.

Immigration Health Services (DIHS).¹⁰⁶ DIHS’s medical care policies are outlined in the “DIHS Medical Dental Covered Services Package” (“the Covered Services Package”).¹⁰⁷ The Covered Services Package places significant limitations on non-emergency care, outlining that such situations will be reviewed on a case-by-case basis and evaluated on an estimate of how long the detainee will remain in ICE custody and whether the condition will affect the detainee’s deportation status.¹⁰⁸ As one ICE Official notes:

The ICE Medical Program has an established covered benefits package that delineates the health care services, medical products, and treatment options available to any and all detainees in ICE custody. The ICE covered services package emphasizes that benefits are provided for conditions that pose an imminent threat to life, limb, hearing or sight, rather than to elective or non-emergent conditions.¹⁰⁹

The DHS Office of Inspector General (“OIG”) stated in its review that the detention standards on sick calls do not clearly define what is considered a timely response to a non-emergency request.¹¹⁰ In the absence of national standards, local detention facilities have established differing policies regarding response time to non-emergency care.¹¹¹ At three of the four detention facilities inspected by OIG, nearly 30% of detainee non-emergency medical requests were not responded to in the time frame specified by the facility.¹¹²

In most facilities housing immigration detainees, DIHS does not have an on-site presence. At these facilities medical care is provided either by a county jail, a private company

¹⁰⁶ 42 U.S.C. § 249(a) (2003); 42 C.F.R. § 34.7(a) (2003).

¹⁰⁷ *Id.*

¹⁰⁸ *Chronic Indifference*, 19 HUMAN RIGHTS WATCH 5(G) at 47.

¹⁰⁹ DETENTION AND REMOVAL: IMMIGRATION DETAINEE MEDICAL CARE: HEARING BEFORE THE SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW OF THE COMMITTEE ON THE JUDICIARY HOUSE OF REPRESENTATIVES, 110th Congress 53 (2007), *available at* <http://judiciary.house.gov/hearings/printers/110th/38115.PDF>.

¹¹⁰ DEPARTMENT OF HOMELAND SECURITY, OFFICE OF INSPECTOR GENERAL, TREATMENT OF IMMIGRATION DETAINEES HOUSED AT IMMIGRATION AND CUSTOMS ENFORCEMENT FACILITIES, No. OIG-07-01 (2006), *available at* <http://trac.syr.edu/immigration/library/P1598.pdf> (henceforth “OIG Report”).

¹¹¹ *Id.*

¹¹² *Id.*

that owns or operates the facility pursuant to an intergovernmental service agreement (“IGSA”) with ICE, or a for-profit company that specializes in correctional healthcare. Still, in all facilities that house immigration detainees, including those in which DIHS does not have on-site presence, DIHS ultimately manages detainee healthcare through a managed care network that must approve or deny certain kinds of medical care pursuant to official DIHS policies, including the Covered Services Package.

Another applicable guideline for medical care is ICE’s Performance Based National Detention Standards (“PBNDS” or “the manual”), first issued in 2008, which mandates that all detainees receive “emergent, urgent, or non-emergent medical, dental, and mental health care that are within the scope of services provided by the DIHS, so that their health care needs are met in a timely and efficient manner.”¹¹³ The standards set forth in the manual apply to most facilities housing ICE detainees including Service Processing Centers; Contract Detention Facilities; and state or local government facilities used by ICE, through IGSA’s, to hold detainees for more than 72 hours.¹¹⁴ The standard for HIV/AIDS care detailed in the PBNDS provides in part:

When current symptoms are suggestive of HIV infection, the following shall be implemented: clinical evaluation shall determine the medical need for isolation... [f]ollowing a clinical evaluation, if a detainee manifests symptoms requiring treatment beyond the facility’s capability, the provider shall recommend the detainee’s transfer to a hospital, or other appropriate facility, for further medical testing, final diagnosis, and acute treatment as needed, consistent with local operational procedures... HIV positive detainees should be hospitalized until any acute treatment deemed necessary is completed. When the attending physician determines that a detainee is in remission from his or her illness and/or no longer requires off-site care, he or she shall be returned to the detention facility. The physician shall recommend whether the detainee should be housed in the general

¹¹³ DEPARTMENT OF HOMELAND SECURITY, 2008 OPERATIONS MANUAL ICE PERFORMANCE-BASED NATIONAL DETENTION STANDARDS (PBNDS) §22 (2008), *available at* <http://www.ice.gov/detention-standards/2008/index.htm>.

¹¹⁴ *Id.*

population or in another location for medical purposes.¹¹⁵

Under the standard for HIV/AIDS care outlined in the PBNDS, if a detainee manifests symptoms requiring treatment unavailable at their current facility, a physician may recommend that the detainee be transferred to a hospital, or other appropriate facility for further testing, final diagnosis, and acute treatment as needed.¹¹⁶

C. Other Applicable Guidelines for Immigration Detainees

Additional standards cited by the PBNDS include the American Correctional Association (ACA) Standards for Adult Detention Facilities, the National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, and the Federal Bureau of Prisons (BOP), Clinical Practice Guidelines.

NCCHC, a monitoring body from which some ICE detention centers are required to seek accreditation, endorses the concept that the medical management of HIV-positive inmates and correctional staff should parallel that offered to individuals in the non-correctional community.¹¹⁷ Specifically, they suggest that HIV-positive detainees receive a thorough physical examination and laboratory tests upon arrival.¹¹⁸ The group also recommends that correctional administrators conduct consistent quality improvement evaluations, which consider patient adherence to antiretroviral treatment, timeliness of referrals, and monitors the number of HIV- positive patients provided medical treatment.¹¹⁹

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, POSITION STATEMENT, ADMINISTRATIVE MANAGEMENT OF HIV IN CORRECTIONS (2005), *available at* <http://www.jdcap.org/SiteCollectionDocuments/Health%20Standards%20for%20Detention.pdf>

¹¹⁸ *Id.*

¹¹⁹ *Id.*

BOP, which also houses some immigration detainees, provides detailed guidance for medical and correctional staff in the treatment and prevention of HIV in prisons.¹²⁰ BOP guidelines require prevention counseling and mandatory testing for inmates at risk of contracting the illness. Even the baseline level of care for BOP inmates requires a comprehensive physical examination and medical history review.¹²¹ Most notably, the BOP guidelines provide direction on HIV treatment for prison medical staff that is in line with acceptable levels of care recognized by HIV practitioners.¹²²

D. Procedures for Accessing HIV Medical Care in Detention Facilities

Information concerning the number of infectious disease specialists employed by immigration detention facilities is unavailable, but it is likely that most facilities do not have an on-site HIV specialist. For this reason, many facilities are unable to offer the specialized care needed by many HIV patients and thus must rely on outside medical providers. In order to provide care that is not offered by the detention center, medical staff must seek prior approval from DIHS in the form of a treatment authorization request (TAR).¹²³ Absent a TAR, DIHS will not reimburse the local detention center for medical care.¹²⁴ According to ICE, more than 40,000 TAR's are submitted each year, the average turnaround time is 1.4 days, and 90% are approved.¹²⁵

Prior to 2005, the Covered Services Package entitled detainees with chronic illnesses, such as HIV, to quarterly medical visits with outside specialists. That year's amendments to the Covered Services Package clarified to providers that DIHS did not mandate the frequent medical

¹²⁰ FEDERAL BUREAU OF PRISONS, CLINICAL PRACTICE GUIDELINES, MANAGEMENT OF HIV (2006), *available at* www.nicic.org/library/021582.

¹²¹ *Id.*

¹²² *Id.*

¹²³ Homer D. Venters, Jennifer McNeely, Allen S. Keller, *HIV Screening and Care for Immigration Detainees*, 11 HEALTH & HUMAN RIGHTS J. (No. 2) 91 (2009) <http://www.hhrjournal.org/index.php/hhr/article/view/177/261>.

¹²⁴ *Id.*

¹²⁵ SISKIN, *supra* note 99, at 9.

visits or the type of testing conducted by on-site physicians. Rather, treatment and testing were to be limited to instances where it was recommended based on a clinical evaluation and deemed necessary by the medical provider.¹²⁶

ICE cites cost-effectiveness and efficiency as reasons for providing detention centers with more discretion over the management of detainee health care. However, studies conducted by the Congressional Research Service suggest that cutting medical costs may be more of a priority than ICE maintains. Between 2003 and 2007, ICE medical costs nearly doubled, from \$51 million to \$92 million.¹²⁷ Seemingly, this represents a commitment by ICE to increase spending on detainee health care.¹²⁸ But in fact, this is more representative of an increase in the population of detainees in ICE facilities. During the same time period, the amount of funded bed space increased by 49%.¹²⁹ Combined with the rising costs of medicine, this dramatic population increase provides ICE with a clear incentive to increase the number of TAR refusals. And given the staggering costs of HIV treatment, it comes as no surprise that patient's requests are frequently denied. An internal ICE memo documenting medical cost savings due to TAR refusals lists "HIV" amongst the most frequently refused TAR's.¹³⁰ In fact, HIV refusals represent the greatest category of cost savings, totaling nearly \$130,000 out of a total of \$1.37 million saved because of TAR refusals.¹³¹

ANALYSIS

IV. CHALLENGES TO PROVIDING MEDICAL TREATMENT IN IMMIGRATION DETENTION FACILITIES

¹²⁶ *Id.*

¹²⁷ *Id.* at 18.

¹²⁸ *Id.*

¹²⁹ *Id.*

¹³⁰ *Id.* at 9.

¹³¹ *Id.*

Francisco Castaneda, a detainee housed at a San Diego detention facility, spent eleven months in immigration custody suffering from extremely painful lesions on his penis that were increasing in size and were continuously infected.¹³² While detained he complained to the medical staff about his problems and occasionally showed correctional officers blood and discharge in his underpants in order to get medical attention.¹³³ Eventually, Castaneda received authorization to meet with one oncologist and several urologists who concluded that he required a circumcision to alleviate his pain and a biopsy to determine whether he was suffering from penile cancer.¹³⁴ Despite these conclusions, the procedures were denied by USPHS and DIHS on the grounds that they were simply “elective” in nature.¹³⁵ Several weeks later, with the help of immigration advocates, he was released from the detention facility and able to visit an emergency room for diagnosis and treatment.¹³⁶ One week after his release from ICE custody he was diagnosed with penile cancer and admitted to the hospital to have nearly his entire penis surgically removed.¹³⁷ Approximately one year after his penis was amputated, Castaneda died.¹³⁸

A. Inconsistent and Discontinuity of Care

While Castaneda’s story illuminates the problems faced by all detainees with serious medical conditions, HIV-positive detainees face a unique set of challenges while in ICE custody. Since the effectiveness of antiretroviral therapy (“ART”) depends on continual viral suppression, consistent care is particularly important for those living with HIV. Inconsistent adherence to

¹³² Castaneda v. United States, 538 F. Supp. 2d 1279, 1298 (C.D. Ca. 2008), *rev’d*, 130 S.Ct. 1845 (2010).

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.* at 1298.

¹³⁸ FLORIDA IMMIGRANT ADVOCACY CENTER, DYING FOR DECENT CARE: BAD MEDICINE IN IMMIGRATION CUSTODY (2009), available at <http://www.tallahassee.com/assets/pdf/CD131100321.PDF>.

drug therapy enables the virus to develop resistance to the medication and may make the prescribed treatment regimen ineffective.¹³⁹ According to HHS, adherence to HIV treatment strongly correlates with HIV viral suppression, reduced rates of resistance, increased mortality rates, and improved quality of life.¹⁴⁰

Statements from HIV-positive detainees demonstrate the substandard continuity of treatment in ICE facilities. One detainee spent five years in detention during which time he was bounced around between facilities in New Jersey and Louisiana.¹⁴¹ He described delays in transfers of medical records, frequent lapses in his medication regimen, and what one HIV/AIDS specialist called “substandard medical attention.”¹⁴² Due to the improper medical attention, he contracted several conditions while in detention, including conjunctivitis, a throat infection, a lymph node infection, two upper respiratory infections, five skin infections, three ear infections, and a tonsil infection.¹⁴³

Other detainees report receiving two out of three of their required medications; receiving no medication at all for several weeks while waiting for ICE officials to re-order their prescriptions; and being prescribed drugs contraindicated for use together and contrary to U.S. HIV treatment guidelines.¹⁴⁴ Another detainee, housed at the San Pedro Detention Facility, testified that when he arrived at the detention center his HIV medication was confiscated.¹⁴⁵

¹³⁹ Judith A. Aberg, et al., *Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus: 2009 Update by the HIV Medicine Association of the Infectious Diseases Society of America*, 49 *CLINICAL INFECTIOUS DISEASES* 6511, 678 (2009), available at www.aphs.upenn.edu/bugdrug/.../idsahivprimarycare2009.pdf.

¹⁴⁰ HHS PANEL ON ANTIRETROVIRAL GUIDELINES FOR ADULTS AND ADOLESCENTS, *GUIDELINES FOR THE USE OF ANTIRETROVIRAL AGENTS IN HIV-1-INFECTED ADULTS AND ADOLESCENTS* 21 (2011), available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>.

¹⁴¹ Aslyn Loder, *Ex-detainees Rip Treatment: AIDS-Infected men got Sicker in Jail*, *HERALD NEWS*, August 24, 2005, at A1.

¹⁴² *Id.*

¹⁴³ *Id.*

¹⁴⁴ *Chronic Indifference*, 19 *HUMAN RIGHTS WATCH* 5(G) at 37.

¹⁴⁵ *Id.*

When he was finally provided with treatment, ICE medical staff did not give him a medical examination.¹⁴⁶ The medical workers simply accepted his word.

B. Systemic Failures

The substandard conditions within ICE detention centers are well documented. In December 2006, OIG issued a report on whether immigration detention facilities were living up to the minimal standards in ICE's Detention Operation Manual (the predecessor to PBNDS) and the Covered Services Package. According to the report, OIG observed instances of non-compliance with the detention standards at four of the five facilities it reviewed. The following year, the United States Government Accountability Office (GAO) issued a report that similarly identified violations of the detention standards at various detention facilities across the country. The GAO report specifically highlighted deficiencies in the provision of medical care to detainees in treatment.

Other reports note overcrowding, inadequate medical and dental care, inappropriate use of force, lack of access to telephone services, and frequent transfers that disrupt access to legal counsel.¹⁴⁷ In a 2008 Washington Post series, Neil Sampson, a former DHCIS director, admitted that ICE treated detainee health care "as an afterthought," and that "[t]hey do not have a clear idea or philosophy of their approach to health care [for detainees]." He went on to conclude, "It's a system failure, not a failure of individuals."¹⁴⁸

Expectedly, DHS's standards for medical care have drawn criticism from advocates from both the legal and medical communities. Medical advocates contend that despite DHS's acknowledgment of the substantial burden of chronic diseases among the detained population,

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 43-4.

¹⁴⁸ *Careless Detention: Medical Care in Immigrant Prisons*, WASH. POST, http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d1p2.html (last visited April 10, 2013).

their medical guidelines are centered on an acute care model, and are not crafted for a population with significant chronic medical needs. Furthermore, immigrants in detention, especially long-term residents that have health insurance, are unable to use it. Other advocates allege that officers frequently view ICE detainees as criminals, even when they do not have a criminal record, and as such, are sometimes quick to assume that detainees are faking their illnesses. Additional problems noted include reports of detainees being transferred without their medical records. ICE does not have a system to track the transfer of medication and medical records of detainees. And some lawyers described difficulties getting access to medical records on their client's behalf.¹⁴⁹

Another common complaint amongst detainees suffering from chronic illnesses is access to grievance procedures and redress of detainee complaints. In their report, OIG found a lack of proper record keeping for detainee complaints and in many instances; detainees were never even informed about the grievance procedure.¹⁵⁰ A series of detainee complaints regarding grievance procedures made to the American Bar Association Immigration Commission between January 2006 and June 2007, revealed that detainees consistently complained of written and oral grievances going unanswered, grievance forms being unavailable, and jail officials being dismissive of complaints.¹⁵¹ Many detainees acknowledged hesitancy in filing complaints, fearing retaliation or that their concerns would go unanswered.¹⁵²

C. Arguments in Support of the Existing ICE Health Care Standards

While there are strong arguments in support of improving care in ICE detention centers, the status quo is not without its supporters. Proponents of maintaining the existing ICE health

¹⁴⁹ *Id.*

¹⁵⁰ DEPARTMENT OF HOMELAND SECURITY, *supra* note 109, at 20-1.

¹⁵¹ SUNITA PATEL AND TOM JAWETZ, CONDITIONS OF CONFINEMENT IN IMMIGRATION DETENTION FACILITIES 5-6 (2007), http://www.aclu.org/pdfs/prison/unsr_briefing_materials.pdf (henceforth "UNSR Briefing").

¹⁵² *Id.*

care standards remind us that many U.S. citizens lack health insurance and face barriers in accessing health care.¹⁵³ In fact, many poor HIV-positive citizens, especially those in rural areas, lack adequate treatment and access to HIV care providers. They also point out that patient safety issues exist in many medical settings - not just in correctional facilities.¹⁵⁴ Moreover, a proportion of detained non-citizens are not authorized to be in the country – for this reason alone, they reason, American taxpayers should not bear the responsibility of paying for their medical care.

Even more convincing, ICE has argued that some immigrants receive better health care in detention centers than they would have in their home countries or than they had received earlier in their lives. Julie Meyers, a senior ICE official, testified that in FY2007, 34% of detainees screened were diagnosed with, and treated for, preexisting chronic conditions (e.g., hypertension, diabetes), and that many of these detainees would not have known of their medical condition or received treatment if not it were not for the comprehensive health screening they obtained when entering the detention system.

Finally, from a medical perspective, some health care decisions need to be made with the consideration that the non-citizen is going to be removed to a country where he or she may not receive be able to get any follow-up care.

V. LEGAL AND POLICY SOLUTIONS

A. Litigating Detention Conditions

Litigants have seen mixed results in claims brought against DHS officials and medical staffs at detention facilities.¹⁵⁵ The plaintiffs in *Baires*, discussed *supra*, brought suit in federal

¹⁵³ SISKIN, *supra* note 99, at 17-23.

¹⁵⁴ *Id.*

¹⁵⁵ *See Baires v. United States*, No. C 09-5171 CRB, 2010 WL 3515749, at *3 (N.D. Ca. 2010).

court against DHS Secretary Janet Napolitano, senior level ICE officials, and DIHS director Timothy Shack, alleging Eighth and Fourteenth Amendment violations and liability under the Federal Torts Claims Act.¹⁵⁶ The Government officials moved to dismiss the action, arguing that the Plaintiff's complaint was not "plausible on its face" and thus warranted dismissal under *Ashcroft v. Iqbal*.¹⁵⁷ The Court determined that the Plaintiffs failed to meet *Iqbal*'s facial plausibility requirement because the facts alleged in their complaint indicated "that the federal government has no day-to-day operational oversight of the county facilities where they were held."¹⁵⁸ Further, the facts undermined Baires' and Miranda's attempt at imposing liability on the federal defendants because ICE detains thousands of people and high-ranking officials cannot be thought to be "aware, at all times, of the status of each and every detainee."¹⁵⁹ Without factual allegations that these individual defendants were aware of Baires' and Miranda's conditions, "their simple failure to correct those conditions [was] not sufficient to state a claim for relief."¹⁶⁰

Regarding the Plaintiffs tort liability claims, the Court stated:

[t]he law is clear that the United States is not liable under the FTCA for torts committed by independent contractors. However, where a third party acts as the agent of a Federal Agency, the Government can be held liable under the FTCA... the third party will be considered an agent of the federal government where the Government is able 'to control the detailed physical performance of the contractor' and supervise its 'day-to-day operations.'¹⁶¹

The Government introduced a copy of a contract that DHS entered into with the San Diego detention facility to show that it did not control the prison officials or medical providers who saw

¹⁵⁶ *Id.* at 3-4.

¹⁵⁷ Under *Iqbal*, a claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662 (2009)

¹⁵⁸ *Baires*, 2010 WL 3515749 at *6.

¹⁵⁹ *Id.* at *7.

¹⁶⁰ *Id.*

¹⁶¹ *Id.* at 10.

Baires and Miranda.¹⁶² Combined with the lack of an allegation in the complaint “of day-to-day supervision or detailed oversight of detention operations,” this was sufficient to defeat the Plaintiff’s tort liability claims.

Claims against individual medical staffers have seen a similar result. After his death, Castaneda’s estate filed constitutional and wrongful death actions against ICE, DIHS, individual medical staffers, and the San Diego detention facility.¹⁶³ In a scathing decision, the district court determined that the ICE medical staff demonstrated “deliberate indifference” to Castaneda’s medical needs. Denying the Government’s motion to dismiss, the court stated:

[I]f Plaintiff’s evidence proves true, from the first time Castaneda presented with a suspicious lesion in March 2006 through his release in February 2007, the care afforded him by Defendants can be characterized by one word: nothing. The evidence that Plaintiff has already produced at this early stage in the litigation is more thorough and compelling than the complete evidence compiled in some meritorious Eighth Amendment actions... [Defendants] assertion that Plaintiff’s claim is not even cognizable is, frankly, frivolous.¹⁶⁴

The Ninth Circuit affirmed the district court’s ruling,¹⁶⁵ but it was later reversed and remanded by the Supreme Court, which held that the Public Health Service Act preempted actions against the DIHS staff for constitutional violations arising out of their official duties.¹⁶⁶

While cases such as *Baires* and *Castaneda* have been unsuccessful, a class action brought against the San Diego Detention Center resulted in a settlement agreement establishing standards for ICE detainees’ health care at the facility. In *Woods v. Morton*, a class of plaintiffs alleging that they suffered health consequences due to the denial of care at an ICE facility, brought Fifth Amendment claims against officials at ICE and the Correctional Corporation of America – the

¹⁶² *Id.* at 11.

¹⁶³ *Id.*

¹⁶⁴ *Castaneda*, 538 F. Supp. 2d at 1295.

¹⁶⁵ *See Castaneda v. United States*, 546 F.3d 682, 686-87 (9th Cir. 2008).

¹⁶⁶ *Hui v. Castaneda*, 130 S.Ct. 1845, 1853-54 (2010).

private contractor that managed the detention center.¹⁶⁷ The district court denied class certification, but allowed the plaintiffs' primary claims to move forward.¹⁶⁸ Later, the Ninth Circuit referred the case to mediation, where the parties eventually reached a settlement agreement.¹⁶⁹ Although the settlement was only binding on the San Diego facility, it produced modifications to the DIHS medical benefits package, including expanding coverage beyond emergencies to those of "serious medical needs."¹⁷⁰ It also expedited consideration of TARs, grievances, and appeals; increased medical staff; and designated monitoring and evaluation procedures.¹⁷¹

These cases highlight the difficulty confronted by attorneys litigating medical conditions within ICE facilities. While federal courts have recognized the horrific circumstances facing detainees with medical conditions, such as AIDS, they have been hesitant to conclude that such claims meet the "deliberate indifference to a serious medical need" standard required to find an Eighth Amendment violation. Claims brought against detention facilities for failure to provide HIV medication are likely to fall short of the subjective "serious need" prong of the *Estelle* analysis, due to the short length of time that most non-citizens are detained. Furthermore, given the slow progression of the illness, many inmates will have trouble proving adverse effects or physical injury caused by delayed treatment while in detention. For similar reasons, mistreatment that "shocks the conscience" or is "intolerable to fundamental fairness" is also difficult to find in the immigration detention context, because for most detainees symptoms will not show immediately. Even when a constitutional violation is found under a less restrictive

¹⁶⁷ See discussion *supra*, Fifth Amendment rights of immigrant detainees.

¹⁶⁸ AMERICAN CIVIL LIBERTIES UNION, PRACTICE ADVISORY: HEALTH CARE FOR ICE DETAINEES AFTER THE *WOODS V. MORTON* SETTLEMENT (2009), www.aclusandiego.org/article.../Woods%20Practice%20Advisory.pdf

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

Fifth Amendment standard, plaintiffs face the difficult task of overcoming statutory and procedural protections, such as the FTCA and the PHSA, discussed *supra*, afforded to federal defendants.

Advocacy on behalf of individual clients has also proved difficult. DIHS must approve all medication requests; ICE officials have no control over the approval process. Since attorneys are not in close contact with DIHS, they can do little to expedite the process beyond aggressively contacting the detention facility to ensure that medical requests are processed.

Still, given the success of the parties in *Woods* and the well-documented insufficiency of care for HIV-positive detainees in many ICE facilities, advocacy strategies to improve access to AIDS care seem promising. Especially in cases involving detention facilities where substandard conditions have been documented. These cases, along with recent news reports, have increased national awareness of the problems faced by detainees with serious medical conditions, providing an opening for systemic policy change.

B. Adoption of DHS Medical Standards as Federal Regulations

In the absence of aggressive oversight, facilities have no incentive to improve medical practices. Interest groups, including Human Rights Watch and the American Civil Liberties Union, have recommended the adoption of DHS's Medical Standards as federal administrative regulations.¹⁷² Many of the instances noted by GAO and OIG involved violations of existing ICE guidelines.¹⁷³ A legal mandate to enforce these guidelines could help improve medical practices across ICE facilities. In 2007 and 2009, the National Lawyers Guild - National Immigration Project submitted a proposal for the codification of ICE detention standards in the form of petition for rulemaking to DHS explaining:

¹⁷² See generally *Chronic Indifference*, 19 HUMAN RIGHTS WATCH 5(G).

¹⁷³ Homer D. Venters, Jennifer McNeely, Allen S. Keller, *HIV Screening and Care for Immigration Detainees*, 11 HEALTH & HUMAN RIGHTS J. (No. 2) 91 (2009) <http://www.hhrjournal.org/index.php/hhr/article/view/177/261>.

Codification of the standards into regulations would provide much-needed consistency and enforceability and allow ICE to achieve its goal of providing “safe, secure, and humane confinement of persons detained in accordance with immigration law.” Critically, promulgating regulations would make the detention standards binding upon all immigrant detention facilities, including the contract IGSA facilities, which would be bound through the doctrine of preemption.¹⁷⁴

Other benefits of promulgated standards noted by the petition include uniformity and consistency, decreased risk of legal liability and adverse publicity, better monitoring, and assurance of quality control.¹⁷⁵

In 2009 DHS rejected the petition, concluding that rulemaking would prove laborious, time consuming, inflexible, and could impede the department’s ability to respond to changed conditions, emergencies, and crises.¹⁷⁶ The agency’s response also cited its recent adoption of the PBNDS, which they believe addresses many of the monitoring and evaluation concerns addressed by the petitioners.¹⁷⁷ Along with the PBNDS, ICE created the Detention Standards Compliance Unit, a group of officials charged with evaluating facilities based on interviews with staff and detainees, observations, and documentary reviews.¹⁷⁸ Notably, however, the PBNDS does not articulate specific penalties for facilities that fail to comply with the standards. Rather, ICE “reserves the right to discontinue using any facility that fails to comply” with the standards.¹⁷⁹

DHS’s concerns are not without merit. As mentioned *supra*, most detention facilities are subcontracted to local agencies via IGSA. In these facilities, immigrant detainees are housed alongside inmates and pre-trial detainees. Each facility operates differently, largely dependent

¹⁷⁴ NAT’L LAWYERS GUILD, NAT’L IMMIGRATION PROJECT, DETENTION PETITION FOR RULEMAKING (2009), available at <http://www.nationalimmigrationproject.org/legalresources.htm>.

¹⁷⁵ *Id.*

¹⁷⁶ DHS DENIAL, PETITION FOR RULEMAKING TO PROMULGATE REGULATIONS GOVERNING DETENTION STANDARDS FOR IMMIGRATION DETAINEES (2009), available at <http://www.nationalimmigrationproject.org/legalresources.htm>.

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ DHS DENIAL, PETITION FOR RULEMAKING TO PROMULGATE REGULATIONS GOVERNING DETENTION STANDARDS FOR IMMIGRATION DETAINEES (2009), available at <http://www.nationalimmigrationproject.org/legalresources.htm>.

on state and local laws and the number of detainees housed. Implementation of a new set of regulations would prove difficult for correctional staffs as they would have to enforce one set of guidelines for ICE detainees and another set of guidelines for the rest of the population. Forcing local jail and prison officials to comply with new federal rules would override local codes and deny officials the ability to run facilities as they deem necessary.¹⁸⁰

Further, despite the contentions of advocates, regulations may increase operational costs for the agency. Even if the agency were to regulate the existing standards, they would still incur costs for administrative oversight and staff training. The most costly repercussion of regulating ICE medical standards is possibly the increased litigation expenses. One can imagine a myriad of frivolous lawsuits filed by disgruntled former detainees. Consequentially, these increased litigation expenses have the potential to debilitate the agency.

C. Independent Monitoring Agencies.

Congressional action provides another means of improving conditions in ICE facilities. Congressional oversight of ICE is currently housed within a subcommittee dedicated to immigration policy – the Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law. The Subcommittee could propose adoption of the Detentions Operating Manual or other effective medical standards as federal regulations, binding ICE to amend its guidelines and practices. The Subcommittee could also introduce legislation providing for increased oversight of ICE facilities, especially those found to consistently violate medical guidelines.

Recognizing that ICE's internal checks have failed to address problems, proponents of detention reform have also recommended that Congress create an independent monitoring

¹⁸⁰ Kelsey E. Papst, *Protecting the Voiceless: Ensuring ICE's Compliance with Standards that Protect Immigration Detainees*, 40 UNIV. PAC. MCGEORGE L. REV. 261, 283 (2009).

agency that could oversee both ICE detention centers and county jails with which ICE contracts.¹⁸¹ Monitors could conduct thorough investigations of health and hygiene, mental health, and environmental conditions at each facility.¹⁸²

States or counties could also institute facility-based inspection teams to receive and investigate individual and system-wide allegations.¹⁸³ Alternatively, ombudspersons or legislative committees could be created to monitor conditions on an on-going basis. Ombudspersons could monitor and report grievances to ICE, track complaints, and issue reports on facilities that do not comply with DHHS standards.¹⁸⁴ Each of these oversight bodies should be required to report to the U.S. Congress, as well as the public, and all reports and investigations should be made publicly available and open to external scrutiny.¹⁸⁵

D. Improving HIV/AIDS Medical Services in ICE Facilities

Advocates from the medical community propose that at minimum, ICE's medical standards should align with those of NCCCHC and the BOP.¹⁸⁶ Specific suggestions include routine, non-mandatory screening for all detainees, counseling and evaluation for treatment, and discharge planning for those leaving ICE custody.¹⁸⁷ Other recommendations include regular exams, laboratory tests, and administration of antiretroviral medications. To measure effectiveness of treatment, ICE should also record, monitor, and report information about individual HIV tests and health statistics across facilities to an agency outside of DHS, such as

¹⁸¹ SUNITA PATEL AND TOM JAWETZ, CONDITIONS OF CONFINEMENT IN IMMIGRATION DETENTION FACILITIES 16-7 (2007), http://www.aclu.org/pdfs/prison/unsr_briefing_materials.pdf.

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ *Id.*

¹⁸⁶ Homer D. Venters, Jennifer McNeely, Allen S. Keller, *HIV Screening and Care for Immigration Detainees*, 11 HEALTH & HUMAN RIGHTS J. (No. 2) 91 (2009) <http://www.hhrjournal.org/index.php/hhr/article/view/177/261>.

¹⁸⁷ *Id.*

the CDC.¹⁸⁸ ICE's goal of ensuring the health of detainees would also be assisted if the agency were to track patients receiving medication until their release and during transfers, parole, or deportation, to ensure that treatment is uninterrupted.¹⁸⁹ Finally, medical providers recommend that ICE provide training to medical and security staffs to minimize the harassment of HIV-positive detainees and ensure confidentiality.¹⁹⁰

As this Note has argued, ICE's detention guidelines and stated goals are not conducive to managing the medical needs of those living with HIV or AIDS. While less serious illnesses are manageable during the thirty-three-day average residency in ICE detention facilities, these facilities appear unfit to handle chronic illnesses requiring constant medical attention. In response to comparisons between ICE medical standards and those by BOP, DHS points to several differences. While those housed in BOP facilities are confined incident to punishment, ICE detainees are confined only for the period necessary to effectuate their removal or release from custody.¹⁹¹ As mentioned *supra*, the average stay for ICE detainees is less than forty days. The average time spent in a BOP prison is approximately forty months.¹⁹² According to DHS, this fundamental difference evidences the need for different health care goals between ICE and BOP. Typically, DHS provides medical services during a brief period of confinement for most detainees. BOP, on the other hand, provides health care over an extended period of imprisonment.

Subcontracting with local AIDS Services Providers (ASPs) may offer a plausible solution to inadequate HIV care offered in ICE facilities. Staffed by HIV specialists in the medical and

¹⁸⁸ *Id.*

¹⁸⁹ *Id.*

¹⁹⁰ *Id.*

¹⁹¹ DHS DENIAL, PETITION FOR RULEMAKING TO PROMULGATE REGULATIONS GOVERNING DETENTION STANDARDS FOR IMMIGRATION DETAINEES (2009), available at <http://www.nationalimmigrationproject.org/legalresources.htm>.

¹⁹² *Id.*

human services professions, ASPs offer medical treatment that include: physical and laboratory examinations, access to clinical trials, and free or low-cost ART medications; psychological counseling; and other services for poor and low-income people living with HIV. Many providers are community organizations and health centers funded through the federal government's Ryan White Care Program, a multimillion-dollar funding source for AIDS-related services.¹⁹³ ICE facilities could also contract with ASPs to provide regular visits to centers housing HIV-positive detainees. Services offered by ASPs could, in the end, help alleviate the exorbitant cost of HIV treatment on detention facilities and the administrative burden facing current medical staffs.

Many HIV-positive detainees, especially those with lawful permanent residence status, have health insurance but are unable to use it while in ICE custody. Discretionary medical releases offer another option for improving care for HIV-positive detainees. ICE has the authority to release non-citizens due to medical and psychological concerns.¹⁹⁴ Yet, the frequency by which this authority is exercised is unknown.¹⁹⁵ Releasing detainees, especially those with medical insurance, could save medical costs associated with HIV treatment. It could also relinquish DHS of the responsibility for the detainee's health should the non-citizen become ill while waiting for the adjudication of his removal proceedings.

Alternatively, ICE could release HIV-positive detainees into Alternative to Detention Programs (ADPs), which use tools such as electronic monitoring devices, home visits, and reporting by telephone, to monitor non-citizens released on bond during their immigration proceedings.¹⁹⁶ In most instances, the decision to exercise this option is case specific and exercised only when a medical or psychiatric evaluation makes the non-citizen's detention

¹⁹³ *About the Ryan White HIV/AIDS Program*, HRSA, <http://hab.hrsa.gov/abouthab/aboutprogram.html> (last visited April 10, 2013)

¹⁹⁴ SISKIN, *supra* note 99, at 18.

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

problematic or if removal from the United States is unlikely.¹⁹⁷ ICE, however, does not keep records of how often this discretion is exercised. Like discretionary medical releases, this option relieves DHS of the burden of attending to the medical care of an HIV-positive detainee.

Nevertheless, ADP has its own detractors within the advocacy community. The American Immigration Lawyers Association (AILA), a bar association of immigration attorneys, criticizes the restrictive nature of most ADPs. They favor community-based alternative programs run by nongovernmental, state, or local agencies, which use less restrictive means to ensure program compliance. According to AILA, programs that provide “case management services, legal orientation for participants, and facilitate access to counsel have been shown to substantially increase program compliance without the extensive use of electronic monitoring.”¹⁹⁸

Other questions arise when considering the implementation of ADPs, including how immigration officials should decide when to exercise discretion, factors that should be considered in making a determination, and repercussions for those that disobey their release orders. The answers to these questions are necessarily case specific, but it is the opinion of this author that discretion should be considered when it is likely that a detainee’s removal proceedings will take longer than thirty days, when the detainee is at a stage of the illness that requires constant medical attention, or when a local facility does not have access to the detainee’s ART regimen. Other factors measured may include the flight risk associated with releasing the non-citizen and the specific relief the non-citizen is seeking in immigration court.

Arguably, with the Obama administration’s repeal of the HIV travel ban in 2009, some HIV-positive non-citizens without legal status, including asylum seekers, should not be detained

¹⁹⁷ *Id.*

¹⁹⁸ *Position Paper: Alternatives to Detention*, American Immigration Lawyers Association (2012), available at <http://www.aila.org/content/default.aspx?docid=25874>.

at all.¹⁹⁹ Asylum seekers often have medical issues that the detention system is unequipped to address. The United Nations High Commission on Refugees posits that detaining asylum seekers is “inherently undesirable.” It argues that detention may be psychologically damaging to an already fragile population, such as those who are escaping from imprisonment and torture in their countries. Often, the asylum seeker does not even understand why he or she is being detained, which, in turn, can increase the detainee’s psychological stress.

E. Separate Facilities for those Living with HIV

A more controversial approach taken by some state and local authorities is segregation of HIV- positive detainees.²⁰⁰ Prisoners’ rights advocates generally admonish policies in Alabama, South Carolina, and Mississippi that place inmates with this chronic illness in separate living facilities, apart from the general prison population.²⁰¹ An ACLU report cites abusive and discriminatory treatment at the hands of prison and jail officials at facilities in these states.²⁰² According to the report, prisoners with HIV are placed in different lodging and eating facilities, are ineligible to participate in many of the vocational and recreational activities enjoyed by other inmates, and are ineligible for many of the programs that enable inmates to qualify for early relief.²⁰³ Even worse, inmates are subject to verbal and physical abuse at the hands of prison guards.²⁰⁴

The ACLU first challenged this policy in the early years of the AIDS epidemic.²⁰⁵ In

¹⁹⁹ See 8 U.S.C.A. § 1101(a)(42) (2010). An asylum seeker is a person who, from fear of persecution for reasons of race, religion, social group, or political opinion, has crossed an international frontier into a country in which he or she hopes to be granted legal status.

²⁰⁰ AMERICAN CIVIL LIBERTIES UNION & HUMAN RIGHTS WATCH, SENTENCED TO STIGMA: SEGREGATION OF HIV POSITIVE PRISONERS IN ALABAMA AND SOUTH CAROLINA (2010), available at <http://www.aclu.org/files/assets/health0410webwcover.pdf>.

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ *Id.*

1987, the group challenged Alabama's segregation policy for HIV- positive prisoners on constitutional grounds.²⁰⁶ The Eleventh Circuit Court of Appeals held that the segregation policy did not violate the prisoners' constitutional rights to privacy and confidentiality as it was reasonably related to the legitimate correctional goal of preventing the spread of disease.²⁰⁷ Since the beginning, the state's rationale for this policy has been to ensure adequate treatment for those with the illness and to prevent the spread of HIV amongst the broader prison population. Advocates challenge this notion, asserting that segregation is by no means the only way to provide adequate treatment to HIV- positive prisoners, nor is it an effective prevention strategy.²⁰⁸

While this author shares the advocates' sentiment in regard to the effectiveness of segregation in the prison context, the differences between the two systems of confinement make a discussion of segregation worth entertaining in the immigration context. Unlike prison inmates, immigration detainees are not sentenced to a definite period; they are detained until the completion of their removal proceedings – that is, indefinitely. Therefore, they are not expected to engage in vocational activities or exercise good behavior in hopes of early release. Additionally, while prisons that integrate HIV- positive inmates provide permanent on site medical care, immigration detention centers do not. Hence, as discussed *supra*, detainees often either rely on offsite medical visits, if granted, or have their medical needs ignored never addressed at all. Moreover, reports of detention center's medical personnel disclosing a detainees' HIV status publicly demonstrates a lack of training on confidentiality and other HIV disclosure issues.

Since immigration detention is supposed to be non-punitive, detention facilities that

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ *Id.*

replicate a nursing home environment may provide a more effective means of caring for those with chronic illnesses. These facilities could be established regionally at a significant distance from existing ICE facilities, thus reducing the risk of disclosure amongst a broader prison population. Most importantly, medical professionals could staff these facilities with fewer security guards, representing a true “civil” detention model.

CONCLUSION

Although DHS has made significant strides over the last few years to improve medical care at ICE detention facilities, the plight of HIV- positive immigration detainees still warrants concern. Until someone addresses the structural problems within the detention system, including the wide array of applicable guidelines, the lack of medical staff experience with HIV patients, the inefficient process for requesting medications, and the insufficient grievance procedures, it is likely that treatment for HIV- positive detainees will remain inadequate. And until detainees are afforded legal recourse for medical mistreatment, these challenges will likely continue.

It is the opinion of this author that DHS should establish enforcement mechanisms that ensure that all facilities housing detainees meet an acceptable level of medical care. DHS should also consider creative solutions, such as alternatives to detention programs and specialized medical facilities, to ensure that the needs of those living with HIV and other chronic illnesses are provided a level of care equivalent to the standards outlined in other correctional bodies’ guidelines.