There Is No Safety Here

The Dangers for People with Mental Illness and Other Disabilities in Immigration Detention at GEO Group's Adelanto ICE Processing Center

March 2019

A Disability Rights California Investigation Report

Disability Rights California

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**With thanks to the Physicians for Human Rights Asylum Network for its assistance, and to all the people who shared with us their experiences at the Adelanto Detention Facility.*

This report, a Spanish-language version of the report, and an accessible electronic version of this report, are available at: http://www.disabilityrightsca.org/Reports/Adelanto.

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Cover Photo: Men's Disciplinary Segregation Cell inside the Adelanto West Facility

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EXECUTIVE SUMMARY

The United States' immigration detention population is at an all-time high and continuing to grow. Thousands of people are held in immigration detention facilities in California. The largest of these detention facilities is the Adelanto ICE Processing Center ("Adelanto Detention Center" or "Adelanto") in the City of Adelanto in San Bernardino County. The facility is owned and operated by a private contractor, the GEO Group, Inc., pursuant to an Intergovernmental Service Agreement between the Department of Homeland Security's Immigration Customs Enforcement (ICE) and the City of Adelanto. Adelanto is the largest ICE detention facility in California, and one of the largest in the country, with an average detainee population of almost 2,000 people.

Recent government policy changes regarding immigration enforcement priorities has made a significant increase in the detention of people with disabilities all but certain. Most notable is the January 2017 Presidential order that terminated the exercise of "prosecutorial discretion" for people with disabilities and other special populations. There has also been a dramatic rise in the detention of asylum seekers, who often carry with them experiences of trauma and have significant mental health needs.

When conditions in a detention facility fall below prevailing legal and other standards, it is people with disabilities who are among the most likely to suffer the harms that result.

As the designated protection and advocacy system charged with protecting the rights of people with disabilities in California, Disability Rights California (DRC) opened an investigation into conditions at the Adelanto Detention Center in January 2018. We conducted a tour of Adelanto's facilities and completed interviews with ICE and GEO Group leadership, facility staff, and Adelanto detainees. We have reviewed thousands of pages of relevant policies, procedures, and forms as well as individual detainee records.

Our investigation at Adelanto Detention Center has focused on the treatment of immigration detainees with mental health treatment needs and other disabilities. We provide specific recommendations for systemic improvements.

Disability Rights California's key findings include:

➢ ***People held at Adelanto are subjected to punitive, prison-like conditions that harm people with disabilities.*** Adelanto is infused with unnecessarily harsh – and in effect, punitive – conditions, raising questions as to whether ICE and GEO Group are violating the constitutional rights of the people held there as *civil* detainees. Adelanto looks, feels and operates like a prison, from the extreme idleness and regimented daily schedule to the use of solitary confinement-type housing. In fact, the east side of the facility was constructed to be and was operated as a prison for many years. ICE is underutilizing feasible alternatives to detention for people who can be effectively supervised in the community. The facility's prison-like conditions disproportionately harm people with mental illness and other disabilities.

➢ ***Adelanto has an inadequate mental health care and medical care system, made worse by the facility's counter-therapeutic conditions and practices.*** We identified many people with serious mental health needs who have suffered in detention. They receive inadequate clinical contacts and ineffective, non-individualized treatment. GEO Group fails to provide structured mental health programming to meet Adelanto detainees' clinical treatment needs. GEO Group also restricts people's ability to engage in self-directed activities, including something as simple as reading books that help them cope in detention. Men and women at the facility are further harmed by the facility's harsh and non-therapeutic institutional responses to people in psychiatric crisis. When people are in crisis, they are met with pepper spray and extreme isolation. We also found several examples of deficient medication management practices that are dangerous and harmful. Overall, conditions at Adelanto are antithetical to the therapeutic, trauma-informed approach to treatment that is recommended by mental health professionals and that many people at the facility need.

We found that GEO Group operates administrative and disciplinary segregation units that are extremely restrictive and in some cases reflect solitary confinement-type conditions. These segregation units put people with mental health disabilities at substantial risk of psychological and even physical harm. We found people who had suffered greatly in these units, and even attempted suicide. The specter of being placed in solitary confinement hangs over all Adelanto detainees. More than 50 offenses can result in a detainee's

placement in solitary confinement, including minor infractions like "refusal to clean assigned living area," "refusing to obey a staff member officer's order," "being in an unauthorized area," or "failure to stand [during] count."

Beyond mental health care, we found that serious delays and gaps in the provision of medical care at Adelanto are a pervasive problem, and that such deficiencies disproportionately harm people with disabilities. Denials of medical care have in many cases also caused or exacerbated a person's psychiatric distress.

➢ ***GEO Group significantly underreports data on the number of suicide attempts that occur at Adelanto.*** The frequency with which detainees engage in self-harm or attempt suicide at the facility demands attention. However, we found that GEO Group's reporting practices result in significant underreporting of this information. For example, GEO Group's data, as reported to DHS and ICE, show *zero* suicide attempts at the facility for the first ten (10) months of 2018. Our investigation showed this to be demonstrably false. The underreporting of such data is the result of GEO Group's inappropriately narrow definition of "suicide attempt," one that is inconsistent with the definition used by the federal government.

➢ ***Adelanto's system fails to comply with disability antidiscrimination laws as well as ICE's detention standards regarding the treatment of people with disabilities.*** First, ICE and GEO Group fail to ensure equal access and reasonable accommodations to people with disabilities. Second, they fail to provide for the placement of people with disabilities in the least restrictive and most integrated setting possible. In fact, people with mental illness and other disabilities are regularly placed in restrictive segregation housing *because* of their disability, a practice that likely violates federal law. Third, we found aspects of the Adelanto facility to be physically inaccessible for people with disabilities.

The harmful conditions, practices, and inadequate mental health and medical care at Adelanto result in the abuse and neglect of people with disabilities as defined by federal law. The situation demands action. Access to treatment and disability-related accommodations must improve, and steps to reduce unnecessarily punitive conditions at the facility must be a top priority.

At the same time, given the extraordinary risks and the harms to people with mental illness and disabilities detained at Adelanto, it is essential to ask: Is it *necessary* to imprison this population? Are there less restrictive and less damaging alternatives that better serve the country's constitutional freedoms and commitment to the rights, safety, and dignity of all?

DRC'S KEY FINDINGS

1. People held at Adelanto are subjected to punitive, prison-like conditions that harm people with disabilities.
2. Adelanto has an inadequate mental health care and medical care system, made worse by the facility's counter-therapeutic conditions and practices.
3. GEO Group significantly underreports data on the number of suicide attempts that occur at Adelanto.
4. Adelanto's system fails to comply with disability antidiscrimination laws as well as ICE's detention standards regarding the treatment of people with disabilities.

Disability Rights California
California's Protection & Advocacy System

Disability Rights California protects and advocates for the rights of all people with disabilities in the State of California, regardless of their ethnicity, cultural background, language, or immigration status.

Many people migrating to the United States are forced to leave their countries due to political instability, dangerous conditions, or persecution. Many are seeking asylum. They exhibit high instances of trauma and present numerous mental health needs. Immigration detention facilities are generally ill-equipped, and are not the least restrictive setting to meet the medical, mental health, and other needs of adults and children with disabilities.

Disability Rights California has long fought for the de-institutionalization of people with disabilities and for their right to live and receive services in the community. Immigrants with disabilities deserve this same treatment.

I. INTRODUCTION

Federal immigration enforcement impacts millions of people in California each year, most acutely people with pending immigration proceedings, noncitizens who face potential arrest and deportation, and their families. The number of people subject to immigration detention has grown tremendously in recent years. This trend is likely to continue for the foreseeable future.

In the last two years, federal immigration policy has also dramatically shifted in its handling of people with serious mental health needs and other disabilities. Along with the overall ratcheting up of immigration detention, the federal government in 2017 rescinded DHS policies that sought to avoid the detention of lower-risk people with mental illness, disabilities, and other characteristics that put them at elevated risk harm in immigration detention. The detention of asylum seekers, many with a history of severe trauma and serious mental health needs, is also on the rise.

A series of government investigation reports have identified systemic deficiencies in ICE detention facilities. The DHS Office of Inspector General (OIG) has identified problems – including the mistreatment of detainees by staff, inadequate medical and mental health care, and the misuse of segregation – so serious as to "undermine the protection of detainees' rights, their humane treatment, and the provision of a safe and healthy environment."[1] The DHS OIG recently concluded that ICE is failing to provide adequate oversight of facility conditions, and that "some deficiencies remain[] unaddressed for years."[2]

Media reports have shed further light on harmful conditions in immigration detention facilities – including delayed and inadequate mental health and medical care, use of forced medication and restraints for children and teenagers with mental health needs, sexual abuse and violence, the punitive use of solitary confinement, sanitation deficiencies, and a growing number of avoidable deaths.[3] Human rights and advocacy groups have issued additional reports on the dangerous conditions in immigration detention.[4]

Adelanto Detention Center has been a particular focus of concern. Adelanto is the largest ICE detention facility in California, and one of the largest in the country, with almost 2,000 people held there on a given day. The population at the facility is remarkably diverse, with people from nearly all parts of the world and many languages spoken. The facility's operator, the GEO Group, is among the most prominent for-profit prison companies in the United States. It is also ICE's largest single contractor, having secured $327 million from ICE in 2018.[5] (In California, GEO Group also operates ICE's 400-bed Mesa Verde detention facility in Bakersfield.)

In September 2018, the DHS OIG issued a *Management Alert - Issues Requiring Action at the Adelanto ICE Processing Center,* in which it identified "serious issues" that violate ICE's detention standards and "pose significant health and safety risks at the facility." The OIG highlighted concerns about inadequate suicide prevention practices, improper and overly restrictive segregation units, and untimely and inadequate medical care. The report stated that these issues require immediate attention.[6]

In June 2017, the State of California enacted Assembly Bill 103, which directed the California state attorney general to review and report on county, local, and private locked detention facilities in which noncitizens are housed or detained for purposes of civil

immigration proceedings in California.[7] The law directs the attorney general to conduct a review of the conditions of confinement, the standard of care and due process provided to people held in immigration detention facilities, and the circumstances around their apprehension and transfer to those facilities.[8]

This sort of comprehensive review is important and necessary. At the same time, when conditions in a detention facility fall below prevailing legal and other standards, people with disabilities are among the most likely to be harmed. Focused attention on their particular experience in detention is essential.

Our investigation of conditions at Adelanto Detention Center revealed many individual stories of people with mental health needs and other disabilities experiencing serious psychological and physical harm. These harms are the consequence of harsh and punitive conditions at the facility, and of an inadequate health care treatment system. We also found that Adelanto's disability accommodation system was deficient in a number of ways, with real and damaging consequences for people with disabilities.

Our findings warrant attention and demand action. DHS, ICE, and GEO Group must take steps to address the harmful conditions and treatment failures that affect people with disabilities at Adelanto. Where problems persist, it is the responsibility of government officials, advocacy groups, and the general public to demand that the rights and well-being of people subject to immigration detention are protected.

Ugo: "There Is No Safety Here"

Ugo's search for safety began with the burning down of the school where his mother taught in Nigeria. Ugo was forced to flee his Nigerian village after an extremist group threatened to kill him, his parents, family members and all Christian residents of the village. For the next decade, Ugo moved several times while fleeing religious persecution.

When he arrived at Adelanto in 2018, Ugo struggled with depression due to the trauma of these experiences and the recent death of his uncle. The harsh and regimented conditions of detention made coping nearly impossible. Ugo recalls one incident when he sat down to calm himself while detainees were forming a meal line. Custody staff yelled at him to stand up. The situation escalated to the point where he was pushed against a wall and surrounded by several officers. He recalls trying to explain his circumstances and distress, but not being permitted to do so. The altercation led to Adelanto staff placing Ugo in restraints, pepper spraying him, and sending him to disciplinary segregation.

Ugo's condition deteriorated in disciplinary segregation, where he was confined to a small cell for more than 23 hours per day. His anxiety and desperation increased. He made a noose out of his T-shirt. When staff saw that Ugo was trying to hang himself, they immediately pepper-sprayed him in his face and on his body. Recounting this episode, Ugo wondered, "If I say I am going to hurt myself, why pepper spray me? Why not try to help me?"

Ugo explained that "you cannot house someone with mental illness here, the noise, the lack of nutrition, the crowds, there is no therapy, nothing to do." His voice grew quiet, as he considered his journey from persecution in his home country to the United States and Adelanto Detention Center: "When I arrived here, I thought I was safe, but there is no safety here."

Men's Administrative Segregation Unit Cell (Adelanto West Facility)

II. SCOPE OF INVESTIGATION

A. *DRC Investigation Process*

Disability Rights California (DRC) is the state's designated protection and advocacy system, charged with protecting the rights of people with disabilities.[9] DRC has the legal authority to inspect and monitor conditions in facilities that provide care and treatment to people with mental illness and other disabilities.[10]

Pursuant to this monitoring authority, DRC opened an investigation of Adelanto Detention Center based on troubling accounts from advocacy and community groups, information received from people with disabilities who have been detained at Adelanto, and public reports regarding facility conditions.

DRC conducted on-site monitoring of the Adelanto facility on February 1 and 2, 2018, and again on August 13 and 14, 2018. We viewed areas accessible to people in detention, including the intake area, health care treatment areas, recreation areas, visitation areas, and housing units. During the visit, staff provided information and answered questions about the facility and programs. Staff and representatives from GEO Group and ICE cooperated with DRC's monitoring work.

We spoke with well over one hundred people detained at the facility, through interviews in housing unit common areas, in confidential visiting rooms, or at cell-front. The stories of some of these people are included in this report. (To protect the privacy of the people who we interviewed, the report uses pseudonyms rather than real names.)

We reviewed publicly available documents as well as documents and data provided by ICE and GEO Group. We also obtained records for individual detainees with their authorization.

B. *Expert Analysis*

DRC retained two experts to conduct detailed evaluations of people detained at the Adelanto facility. These experts, Altaf Saadi, M.D., M.S.H.S., and Erica Lubliner, M.D. (the "DRC Experts"), have experience and expertise as treatment providers, and have considerable experience evaluating and treating immigrants who have been held in detention facilities.

Dr. Saadi is a physician who is board certified in Neurology. She has served as an expert evaluator for immigrants seeking asylum in the United States. She regularly conducts psychological and medical evaluations of immigrants in the community and in detention. She is an expert volunteer and member of the Physicians for Human Rights Asylum Network. She has worked in underserved communities domestically and internationally, including in Zambia, in Tanzania, at the Navajo Medical Center in New Mexico, and at the Boston Healthcare for the Homeless. Her expertise extends to working with survivors of rape and sexual assault. Dr. Saadi is a graduate of Harvard Medical School and completed her training at Massachusetts General and Brigham and Women's Hospitals in Boston, where she served as chief resident. She is a Health Sciences Clinical Instructor of Medicine at UCLA, with a research focus on health inequities among minority and immigrant populations.

Dr. Lubliner is chief resident at the UCLA/Greater Los Angeles-VA Psychiatry Residency Training Program. She has extensive practical and research experience with Latino/a and immigrant communities. Her research explores the intersection of health care, immigration, and culture. She is a graduate of the David Geffen School of Medicine at UCLA. She is a native Spanish speaker.

The DRC Experts evaluated ten (10) men and four (4) women detained at Adelanto who have a mental illness and/or a history of suicidal thoughts or self-harm. The DRC Experts reviewed individual records and conducted confidential interviews in each detainee's preferred language, with the assistance of an interpreter when needed. The DRC Experts focused their assessments on the detainees' experience and psychological health in immigration detention, while also gathering information on their pre-detention experiences and health histories.

The DRC Experts provided their findings, which are incorporated in this report, in their personal capacities. Their opinions do not represent the official views of their employers or affiliated institutions.

III. THE GROWTH IN DETENTION OF ICE DETAINEES, INCLUDING PEOPLE WITH DISABILITIES AND ASYLUM SEEKERS

A. *A Rapidly Growing ICE Detention System*

In the last two decades, the United States' immigration detention system has ballooned. In 2017, DHS reported a record-high ICE detainee population – more than 38,000 people on a given day.[11] The number continues to rise, with ICE reporting an average daily detention population of 44,631 as of October 2018.[12] For Fiscal Year 2019, DHS submitted a budgetary request for 52,000 ICE detention beds.[13]

Private prison companies like GEO Group dominate ICE's immigration detention system, with approximately 70% of detained people held in private facilities that operate pursuant to federal government contracts.[14]

B. *Government Policies Are Driving Increased Detention of People with Disabilities*

Although we were unable to obtain systemwide population data on immigration detainees with disabilities, it is apparent that the number is substantial and very likely increasing. Such an increase is the result of both the overall increase in ICE detention as well as the federal government's rescission, in 2017, of policies designed to divert people with disabilities from immigration detention.

Though aggressive federal government efforts to detain and deport people accused of violating United States immigration laws is not new,[15] the government for several years had procedures intended to avoid or mitigate the harms of immigration detention for people with disabilities.

These procedures followed a DHS report, *Immigration Detention Overview and Recommendations*, authored by Dora Schriro, the founding Director of the ICE Office of Detention Policy and Planning. Based on a comprehensive evaluation of ICE's immigration detention system, the report provided detailed recommendations to meet the health care and other special needs of people subject to immigration proceedings and detention, and to expand community-based supervision programs as alternatives to detention.[16]

In the wake of that report, DHS took steps toward reducing the detention of "special populations." In 2011, the Director of ICE issued a memorandum stating that the detention of "individuals who suffer from a serious mental or physical disability" and "individuals with serious health conditions," among other groups, warrant "particular care and consideration."[17]

In 2014, DHS further articulated its immigration enforcement priorities to reflect heightened consideration for people with disabilities and other special needs. These priorities focused enforcement efforts on people who pose "threats to national security, border security, and public safety," including those with serious criminal histories.[18] DHS directed that, as a general matter, ICE should not detain individuals "who are known to be suffering from serious physical or mental illness, who are disabled, elderly, pregnant, or nursing, who demonstrate that they are primary caretakers of children or an infirm person, or whose detention is otherwise not in the public interest."[19]

In early 2017, the government rescinded this policy guidance by Presidential Executive Order 13,768, ending the exercise of "prosecutorial discretion" for special populations.[20] The termination of such prosecutorial discretion made an increase in the detention of people with disabilities all but certain.

Our investigation revealed a considerable number of Adelanto detainees with mental health needs and other disabilities. According to ICE's data, there are approximately 300 people on the mental health caseload, representing about 15% of the facility's population. We identified many more Adelanto detainees with physical, sensory, and other types of disabilities, as well as with acute and chronic medical needs.

Cristina: A Dreamer's Nightmare at Adelanto

Cristina has lived most of her life in California, arriving when she was a toddler. She qualified as a "Dreamer" under the Deferred Action for Childhood Arrivals (DACA) program and attended college in Northern California. After her DACA status expired, she was apprehended by immigration officials and detained at Adelanto. At the time of our interview, Cristina had been detained for approximately four months.

Cristina had a history of mental illness and had attempted suicide two months prior to her detention. She was experiencing auditory hallucinations when she arrived at Adelanto. She was initially evaluated at an off-site health care facility, where staff found her to have acute mental health needs requiring treatment and placement on suicide watch. The following day, she was sent to Adelanto. (Under DHS's pre-2017 prosecutorial discretion guidelines, it is likely that Cristina would have been diverted from detention.)

During her first session with mental health staff at Adelanto, Cristina disclosed her history of abuse, depression, and suicidality. The clinician suggested breathing exercises and did not see her again for five weeks.

Cristina's condition grew worse. She had difficulty breathing and a rapid heart rate. But she also feared telling mental health staff about how she was feeling, knowing that they could put her back in the suicide watch cell and, regardless, would provide little, if any, treatment.

After a few months at Adelanto, Cristina sliced her wrists, injuries that required hospitalization for five days. Mental health staff wrote: "[Cristina] has been hesitant to tell myself and other providers about her cutting and how severe her [suicidal ideation] is because she doesn't want to be placed in a suicide smock and made to sit alone in a cell."

Suicide watch cells are discussed in Section V.A.3, below.

C. *Detention of Asylum Seekers with Serious Mental Health Needs*

The growing number of asylum seekers, many with mental health treatment needs, in immigration detention is striking and troubling. As the number of people seeking asylum in the United States rises (growing by as much as 20 percent annually),[21] the rate of detention of people seeking asylum has also dramatically increased.[22] According to ICE data, between 2011 and 2013, five major ICE Field Offices, including the office in Los Angeles, paroled 92% of arriving asylum seekers.[23] In contrast, the asylum seeker parole rate fell to *below 4%* across the same offices for the period of February 2017 to September 2017.[24]

While mental illness is by no means limited to asylum seekers in ICE detention facilities, the asylum seeker population has a disproportionately high incidence of psychological and physical trauma, as well as serious mental health treatment needs. People seeking asylum are often fleeing horrific violence, abuse, or persecution in their country of origin. Some may be seeking to escape persecution based on their mental illness or other disabilities.[25] Detained asylum seekers experience very high rates of anxiety, depression, post-traumatic stress disorder (PTSD), and thoughts of suicide.[26] One study found that 77% of detained asylum seekers showed clinically significant symptoms of anxiety, 86% suffered from depression, 50% showed signs of PTSD, and 26% had thoughts of suicide.[27]

I thought I would die from the beating, and they [gang members] threatened to kill me next time. So I left.

– Honduran asylum seeker at Adelanto

The number of asylum seekers at Adelanto is substantial. According to ICE, as of March 2018, there were 445 detainees who were seeking asylum (27% percent of the facility population). More than 50% of women held at the facility were seeking asylum.

The DRC Experts interviewed many Adelanto detainees who described "traumatic experiences before immigration, including rape, childhood sexual assault, and targeted political violence such as home burnings or police violence." Multiple female asylum seekers reported having witnessed their children and/or husbands tortured or killed. We encountered one young asylum seeker with visible scars and trouble swallowing due to a severe beating he endured in his home country.

The federal government has itself recognized that asylum seekers are among the special populations with an elevated need for treatment and services as they await resolution of their immigration proceedings.[28] DHS has acknowledged that the "indefinite nature of immigration detention may trigger a profound sense of powerlessness and loss of control, contributing to additional severe and chronic emotional distress for asylum seekers."[29]

The DRC Experts found that asylum seekers held at Adelanto face an extremely high risk of psychological and other harms. The risks are particularly acute given the severe, prison-like living conditions at the facility. (Read Ugo's story, p. 8; Sofia's story, p. 22.)

Many of the asylum seekers we interviewed would likely have avoided detention under DHS's pre-2017 enforcement priorities given their mental and physical care needs and their low security risk classification.

IV. ADELANTO'S PUNITIVE, PRISON-LIKE CONDITIONS RESULT IN SIGNIFICANT HARM TO PEOPLE WITH DISABILITIES

A. *The United States Constitution Prohibits Subjecting Civil Immigration Detainees to Punitive Conditions*

People held in immigration detention are civil, not criminal, detainees. Courts have recognized that people held in civil detention should *not* be subjected to conditions that amount to punishment when less harsh alternatives exist, particularly when it comes to access to health, mental health, and other services. While this constitutional principle, based on rights guaranteed under the Fifth and Fourteenth Amendments to the Constitution, has been recognized by the United States Supreme Court for decades,[30] it has recently received renewed attention.

In 2018, the Court of Appeals for the Ninth Circuit reaffirmed the constitutional limitations on subjecting people in civil detention to punitive conditions. In *King v. County of Los Angeles*, the court explained that detention conditions "are presumptively punitive if they are identical to, similar to, or more restrictive than, those in which [a civil detainee's] criminal counterparts are held," and that such conditions violate a detainee's constitutional rights unless they are necessary to achieve legitimate, non-punitive objectives that cannot be achieved through alternative and less harsh methods. [31]

DHS's 2009 report, *Immigration Detention Overview and Recommendations,* was critical of ICE's detention practices in this regard, noting the distinct impact on people with mental health, medical, and disability needs. The report noted that "with only a few exceptions, the facilities that ICE uses to detain aliens were built, and operate, as jails and prisons."[32] The report found that ICE's detention standards were largely informed by criminal facility-based standards, and that they "impose more restrictions and carry more costs than are necessary to effectively manage the majority of the detained [immigrant] population."[33] The report recommended that ICE modernize its system of detention to more appropriately meet the needs of the civil immigration detainee population, drawing a clear distinction to the management of criminal prisoner populations.[34] It recommended that ICE pursue less restrictive detention strategies as well as alternatives to detention for people with disability and other needs who can be supervised in the community.[35]

The constitutional prohibition against punitive conditions for civil detainees is in fact reflected in Adelanto's Intergovernmental Service Agreement. The Adelanto service agreement recognizes that "ICE detainees are not charged with criminal violations and are only held in custody to assure their presence throughout the administrative hearing process and ... removal from the United States."[36] The Adelanto service agreement states that "ICE is reforming the immigration detention system to move away from a penal model of detention."[37]

B. *Adelanto Looks, Feels and Operates Like a Prison*

In spite of the constitutional mandate against punitive civil detention and the government's findings and contract language, conditions at Adelanto are largely equivalent to those in prisons, and amount to the unnecessary and possibly unlawful punishment of civil detainees. For most people detained at the facility, the conditions are like nothing they have experienced before, and are deeply jarring. The punitive, prison-like conditions disproportionately harm people with mental illness and other disabilities.

The prison-like conditions at Adelanto are obvious from the moment one enters the detention center complex. In fact, the East facility was constructed to be a prison, which it was for many years.[38]

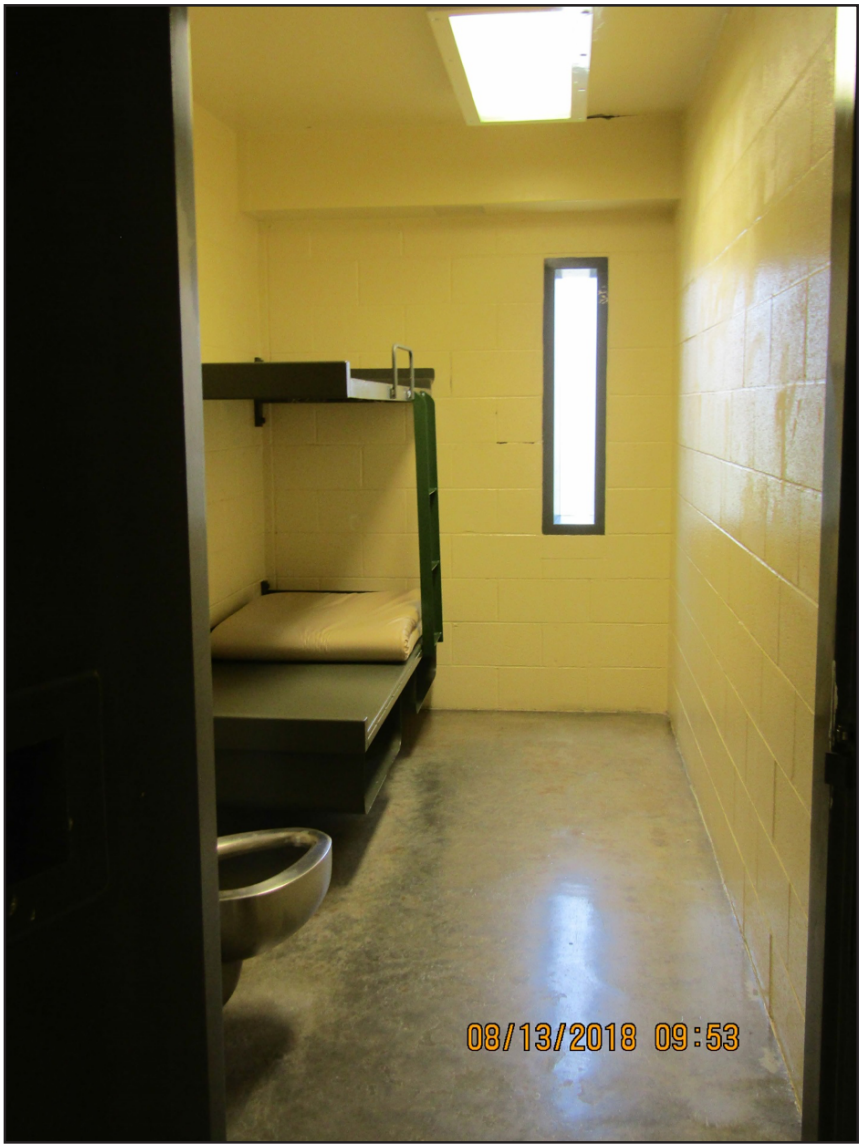
The large greyish buildings that hold ICE detainees have small windows and are surrounded by tall barbed wire fencing.

Detainees are made to wear color-coded uniforms based on their classification and housing location. The majority of detainees at Adelanto sleep in cells, with some sleeping in crowded dormitory-style units. They are closely monitored at all times and must follow a strict schedule. They are not free to leave their housing units without specific authorization by staff. They spend the majority of their day confined inside their housing unit or their cells. Access to showers is limited. When detainees are permitted to go outdoors, the exercise areas available to them are often made entirely of concrete, though some have artificial grass. For much of the year, the largely unshaded outdoor areas can be unbearable under the hot desert sun.

We heard many reports about meals that lacked sufficient nutrition, did not comply with religious and medical dietary needs, and were often spoiled.[39]

Detainees have limited phone access to communicate with their families or legal counsel, and essentially no physical contact with the outside world beyond limited visitation hours.

Detainees are subject to prison-like solitary confinement, whether for disciplinary or administrative reasons. (*See* Section V.B, below.)



Women's Disciplinary Segregation Cell (Adelanto East Facility)

Meanwhile, the profiles and records of many Adelanto detainees – with no criminal or violent history, and having disabilities and related needs – strongly suggest that (1) Adelanto is imposing unnecessarily harsh – and in effect, punitive – conditions, and (2) ICE is underutilizing feasible alternatives to detention for people who can be effectively supervised in the community.[40] These facts raise serious questions as to whether ICE and GEO Group are violating the constitutional rights of Adelanto's civil detainees, and in particular those people with disabilities.

RECOMMENDATIONS TO ADDRESS THE PUNITIVE TREATMENT OF CIVIL IMMIGRATION DETAINEES, INCLUDING PEOPLE WITH DISABILITIES

DHS and ICE

1. Reinstate and build upon the pre-January 2017 exercise of prosecutorial discretion for special immigrant populations, to reduce or eliminate the detention of people with serious mental illness and other disabilities.
2. Implement immigration enforcement policies to reduce or eliminate the detention of people with histories of trauma, particularly those seeking asylum in the United States.
3. Implement and require less restrictive ICE detention practices that better reflect the nature of civil immigration detention and prevent the violation of detainees' constitutional right not to be subjected to punitive conditions of confinement, which disproportionately harm people with disabilities.
4. Increase oversight of Adelanto operations and practices and ensure that conditions are consistent with the Adelanto Intergovernmental Service Agreement's directive to "move away from a penal model of [immigration] detention."
5. Terminate service agreements with contracted operators of immigration detention facilities that fail to maintain conditions that meet the constitutional and legal requirements for civil detention.

GEO Group

1. Ensure that conditions at Adelanto are not punitive, are no more restrictive than necessary, and are conducive to the psychological and physical well-being of detainees, in particular people with disabilities.
2. Take immediate steps to normalize Adelanto's living environment for detainees to the maximum extent feasible based on individualized risk assessments, including: expanded access to the outdoors, exercise, and recreation; provision of nutritious meals and fresh foods consistent with religious observance and medical needs; and significantly expanded access to visitation and telephone communication with legal counsel and family.

V. ADELANTO'S INADEQUATE MENTAL HEALTH AND MEDICAL TREATMENT, AND COUNTER-THERAPEUTIC CONDITIONS

Adelanto's mental health care system does not meet the needs of the detainee population, and facility conditions are counter-therapeutic, all of which places people with mental health disabilities at a significant risk of harm. We found that the conditions and practices at Adelanto result in the abuse and neglect of detainees with mental health disabilities as defined in federal law.[41]

There are several steps that ICE and GEO Group can take right now to improve mental health care and conditions at Adelanto. At the same time, the seriousness of the harms we found strongly suggest that it may be impossible to safeguard the rights and well-being of people with serious mental health needs in such a prison-like facility.

A. *Inadequate Mental Health Treatment*

The mental health treatment program at Adelanto fails to meet the needs of the facility's population. Key deficiencies include:

1. Cursory clinical contacts and non-individualized treatment;
2. A lack of structured programming and activities;
3. Harmful institutional responses to patients in psychiatric crisis; and
4. Deficient medication management practices.

In addition, the traumatic backgrounds and mental health needs of many people held at Adelanto – including people seeking asylum – demand the implementation of a robust trauma-informed care system that addresses the distinct needs of this population.

1. Cursory Clinical Contacts and Non-Individualized Treatment

In nearly each case reviewed by the DRC Experts, the mental health treatment provided was not individualized to the patient's psychological profile and needs. Detainees described how their encounters with mental health staff are brief and marked by a rapid checklist assessment. Review of detainee records confirm the lack of individualized care. For example, clinical staff repeatedly recommend "breathing techniques and physical exercise," even for detainees in highly restrictive units with extremely limited out-of-cell recreation time, and thus almost no opportunity to engage in "physical exercise." (Read Sofia's story, p. 22; Cristina's story, p. 13.)

Mental health staff also recommend "religious coping," even for detainees who explain that they do not have religious beliefs. Other detainees who received this clinical recommendation reported that they do not have access to religious texts related to their faith or in their language.

Mental health staff document the same recommendations month after month, even as patients experience worsening symptoms or develop thoughts of self-harm or suicide.

The repeated use of boilerplate clinical recommendations suggest that mental health staff may not be meaningfully engaging with patients. Our finding is consistent with the DHS OIG's September 2018 report that GEO Group clinical staff were recording the completion of patient encounters without making contact with the patient.[42]

Ultimately, the lack of individualized treatment means that detainees are not getting the care they need and are unlikely to seek help when they need it.

2. Lack of Structured Mental Health Programming and Activities

A related deficiency is the lack of structured mental health programming and opportunity to engage in any meaningful activities. Even in jails and prisons, contemporary standards require "basic on-site outpatient [mental health] services," including "individual counseling, group counseling and psychosocial/psychoeducational programs."[43] GEO Group fails to provide such services to meet the needs of its population.

An example of this failure is the near non-existence of structured group treatment. We spoke with GEO Group mental health staff who recognized the value of and need for group treatment programming for his patients. But when we first toured the facility in February 2018, GEO Group offered no structured therapy groups due to the lack of clinical staff to provide such programming. When we returned to the facility in August 2018, staff reported that they were offering two therapy groups, though exclusively in Spanish and only for women. For male and non-Spanish-speaking detainees, no structured group treatment programming was available at all. (Even within the female Spanish-speaking population, many women reported to us that they were not aware of therapy groups or how they could participate.) Nor were there classes or vocational programs offered at the facility to engage people's minds or provide structure to their days.

Sofia: An Asylum Seeker Brought to the Brink of Suicide at Adelanto

Sofia sought asylum in the United States due to persecution she faced in Russia. She and her husband, Aleksei, were both detained at Adelanto Detention Center starting in 2017. (Read Aleksei's story, p. 26).

During our first interview, Sofia spoke in a whisper as she described her experiences in detention. A thick bandage covered her wrist. She had recently been hospitalized following an attempted suicide by cutting herself.

Sofia explained how visits with her husband were rare and how requests to send him a letter or speak with him on the phone were denied. In addition to the distress caused by not being able to communicate with her husband, Sofia described feeling anxious and depressed based on her living conditions and lack of medical treatment at Adelanto. When she experienced intense headaches, her requests for medical care went unanswered. Other requests for small sources of comfort, such as a book in Russian or a sweater, were also denied.

She requested to see mental health staff but found that "they make me feel worse." She explained: "Their advice or therapy are not suitable for my case . . . they tell us to exercise or breathe." Sofia, like her fellow detainees, has very limited and inconsistent access to outdoor recreation time, making it difficult to exercise regularly. Clinical staff also directed Sofia to use "religious coping" even though she is not religious. A review of her medical records reveals that mental health staff persisted with these ill-fitting recommendations even as Sofia reported worsening mental health, had suicidal thoughts, and finally reached the point of wanting to kill herself.

Approximately four and a half months into her detention, Sofia attempted suicide. She had no history of suicidal thoughts or self-harm prior to her detention at Adelanto. She recalled: "I was tired of being here, of being detained. It was just too stressful."

There is also severely limited opportunity for detainees to engage in self-directed activities, including something as simple as reading books. Detainees reported significant barriers to obtaining books, a right protected even for people imprisoned under the First Amendment.[44] We spoke with multiple detainees with mental health needs who, concerned about the lack of treatment and support at the facility, had unsuccessfully attempted to order self-help books from outside vendors to help them endure during their detention. We reviewed a written detainee request for self-help books that facility staff had rejected, with a note that the detainee must go through mental health staff to request such materials. The detainee reported that he had spoken with mental health staff and was told that such requests were outside mental health staff's responsibilities. Other detainees reported that the facility had denied their requests to order books in their native language, vocational books, and dictionaries.

Many detainees also complained about the limited availability of reading material in the housing units. We observed "library" areas within the units consisting of one or two carts of books. Book selection was quite limited. It included a noticeably large number of Bibles and other Christian literature, but few or no books related to other religions. Additionally, the majority of books were in English only, despite Adelanto's significant non-English speaking population.

With no meaningful structured therapeutic activities, the lack of books, and days spent largely confined in crowded dorms and solitary confinement-type cells, detainees face an enforced idleness that worsens their mental health.

3. Harmful Institutional Responses to Detainees in Psychiatric Crisis

We interviewed many people who had developed suicidal thoughts, engaged in self-harming behaviors, or attempted suicide at the Adelanto facility. They described reaching a point of wanting to die due to the intense stress of prison-like detention, and the harsh responses they faced when they manifest a psychiatric crisis. Their accounts speak to a system that fails to provide treatment to prevent decompensation, and that instead relies on a severe, non-therapeutic crisis response system.

Similar to what we have observed in prisons and jails with inadequate mental health care systems, GEO Group regularly relies on suicide watch cells when detainees experience a psychiatric

I told the doctor, [the suicide watch cell] makes me want to kill myself quicker. It will happen faster this way, being in this room. The doctor just said, 'this is the process we have to go through here.' I told him, I am going to hurt myself, please send me back otherwise I am afraid I will hurt myself. The doctor said that 'the only way I can send you out is if you tell me you won't hurt yourself,' so I did that and they let me out.

-Adelanto Detainee

crisis. The suicide watch cells are barren and extraordinarily isolating settings. They are small rooms that prevent any sort of normal interaction with another human being. People placed in these cells at Adelanto are often stripped naked and given only a "safety smock" made from heavy tear-proof material. They generally receive no books or other personal property while in one of these cells.

Mental health staff have acknowledged the damaging effects of placing Adelanto detainees in a suicide watch cell. One GEO Group clinician recorded that a patient had stopped sharing information about her suicidal thoughts with staff for fear of being placed on suicide watch and noted that such a placement could "completely ruin the therapeutic alliance" between clinician and patient. (Read Cristina's story, p. 13.)

Suicide Observation Cell (Adelanto West Facility)

Beyond the reliance on suicide watch cells, GEO Group's response to detainees in acute mental health crisis can be violent or punitive, lacking in appropriate therapeutic intervention, and ultimately psychologically damaging.

I cannot ask for help because they will put me on suicide watch by myself and I get more depressed. It does not help. I don't trust them. So I suffer in silence.

-Adelanto Detainee

Aleksei: "They Treat Us Like Animals"

Aleksei was apprehended by immigration agents along with his wife, Sofia. (Read Sofia's story, p. 22). He has diagnoses of pancreatitis and gastroesophageal reflux disease, a condition that causes intense abdominal and chest pain. His medications were discontinued when he arrived at Adelanto. Within a few weeks, his pain had become so severe that he could not walk or stand. Staff provided him Ibuprofen repeatedly, which according to the DRC Experts is inappropriate for a patient with his condition and could lead to dangerous internal bleeding. After more than a year in detention with worsening symptoms, including symptoms of internal bleeding, Aleksei still had not received clinically indicated follow-up, such as an endoscopy ordered by medical staff. Records show that Aleksei had filed repeated grievances, and that the facility's responses were inadequate.

Aleksei described how he and other detainees felt that staff "treat us like animals." They were summarily punished for minor violations of facility rules. On one occasion, facility staff forced his entire housing unit to get up in the early hours of the morning and stand outside in the cold because some detainees had complained about one officer's behavior towards them. Many of the men had no shoes and wore only underwear.

After being unable to receive updates on his immigration case, Aleksei's distress became unbearable and he began a hunger strike. He was placed in a suicide watch cell for two days. Aleksei recalled his time there as "torture, I could not sleep, they keep the lights on at all times, I had no water or food, no clothing."

Aleksei's trauma in the suicide watch cell lingered, and his depression worsened. He attempted suicide by lacerating a vein in his arm. The razor was too dull to inflict fatal harm, but he was again placed in the suicide watch cell. Aleksei recalls being so distraught that he yelled for someone to end his life. He was allowed no time outside the cell, no contact with his wife, and no clothes other than a heavy, tear-proof smock. After four days in the suicide watch cell, health care staff told him that the only way he would be released is if he said he was OK. So he did.

After this second experience in the suicide watch cell, Aleksei withdrew from Adelanto's mental health staff. He explained, as his hands visibly shook, "I am afraid of being sent back to the suicide room, I do not tell the doctor how I feel, I say everything is fine because I don't want to go back . . . but I can't sleep, there's nightmares and I shake, I do not want to do anything but lay in bed."

We witnessed one incident firsthand that illustrated GEO Group's punitive and counter-therapeutic response to a detainee's psychiatric crisis. The detainee was being discharged from suicide watch when he suddenly ran down the hallway, an act that clinical staff described to us as related to his still unstable mental health condition. Notwithstanding this assessment, custody staff treated the incident as an "Attempted Escape" and immediately placed the detainee in disciplinary segregation. Things got worse in the segregation unit. The man started banging his head against the wall and kicking his legs at custody staff who tried to restrain him. After some time, clinical staff directed that he be taken to an inpatient psychiatric hospital. A clinician who had evaluated this man told us that disciplinary segregation was not an appropriate placement for him.

Another detainee reported that he was immediately pepper sprayed after staff saw him attempting to commit suicide by hanging himself. (Read Ugo's Story, p. 8).

The DRC Experts described these types of responses to a person's psychiatric crisis as "reflective of a penal rather than healing attitude toward addressing mental health distress."

4. Deficient Medication Management Practices

The DRC Experts found that medication practices at Adelanto do not meet standards of care. They noted a number of cases of medication management failures.

In one case, a detainee stopped receiving his psychiatric medications for ten days "pending ICE approval," a gap in medication that the DRC Experts found "quite dangerous" for the patient, who had a history of serious mental illness involving suicidal ideation and hallucinations.

Another young Adelanto detainee required psychiatric hospitalization after experiencing hallucinations, anxiety, and insomnia, and becoming suicidal. Hospital staff attributed his decompensation in part to the fact that "his medication was inexplicably stopped 3 days ago at Adelanto." (Read Luis's story, p. 32.)

In another case, the DRC Experts found that a prescribed medication to address a patient's anxiety was contraindicated given the patient's cognitive condition and gait instability. According to the DRC Experts, the medication risked worsening the patient's cognitive functioning and increasing the likelihood of a fall.

Our findings of medication management deficiencies at Adelanto are generally consistent with the findings of the DHS OIG and recent investigative reports.[45]

5. The Need for Trauma-Informed Care

The DRC Experts found that the mental health care system at Adelanto failed to meet the needs of detainees who have experienced trauma. They recommend the implementation of a trauma-informed approach for immigrants held at Adelanto and similar immigration detention facilities. At the same time, serious effort should be made to keep people who are coping with past trauma and serious mental illness out of detention altogether.

A trauma-informed approach to mental health care requires an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. The Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health & Human Services has articulated a detailed framework for a trauma-informed approach.[46]

SAMHSA identifies four key assumptions for a trauma-informed approach to care (referred to as the "four R's"): (1) Realizing the prevalence of trauma; (2) Recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; (3) Responding by putting this knowledge into practice; and (4) Resisting re-traumatization.[47] SAMHSA recommends that a trauma-informed approach adhere to six key principles: 1) safety (emotional and physical); 2) trustworthiness and transparency; 3) peer support; 4) collaboration and mutuality; 5) empowerment, voice and choice; and 6) attention to cultural, historical and gender issues.[48]

In 2016, a DHS Advisory Committee recommended that DHS and ICE take a variety of steps to "holistically implement a trauma-informed approach" and services in DHS's Family Residential Centers.[49] There is a compelling need for trauma-informed care in ICE detention facilities like Adelanto as well.

A trauma-informed approach requires the provision of meaningful treatment and an environment defined by safety, support, and individual agency. It must go beyond interactions between clinical staff and detainees. As the DRC Experts explained, trauma-informed care requires the participation of "all staff, from the receptionist to guards to escort staff, who must be trained on how violence

and trauma impact the lives of people being served, so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization."

GEO Group fails to maintain an environment where detainees feel safe. We heard multiple reports from detainees about staff addressing them with derogatory and demeaning language. Detainees reported the use of racial slurs by facility staff and being mocked for not speaking English fluently. They described staff making derisive comments directed at people with mental illness. The DHS OIG similarly documented a report of Adelanto "guards laugh[ing] at [people who attempt to hang themselves] and call[ing] them 'suicide failures' once they are back from medical."[50] Improved training and better accountability at Adelanto is necessary in this regard.

Overall, Adelanto – with its prison-like conditions, tightly regimented schedule with little freedom of movement or individual agency, and the dearth of programming and stimulating activity – is a setting antithetical to a trauma-informed approach. As the DRC Experts found, the adoption of a "trauma-informed care approach appears inconsistent with the nature of detention conditions" as they are at Adelanto.

B. *Housing People with Mental Health Disabilities in Segregation*

GEO Group operates administrative and disciplinary segregation units for both men and women held at Adelanto. These units are much more restrictive than the general population units. The conditions in these segregation units put people with mental health disabilities at substantial risk of psychological and even physical harm. (In fact, we found evidence that GEO Group houses people with mental illness and other disabilities in segregation *because* of their disability, a practice that likely violates federal law, as discussed in Section VII.B, below.)

Adelanto's administrative segregation units are generally utilized as "protective custody" units – that is, with the purpose of protecting the safety of a detainee who may not feel safe in general population housing areas. But the significantly more restrictive nature of these administrative segregation units in many cases inflicts psychological harm on detainees whom the facility claims to seek to protect. Men held in administrative segregation are permitted out of their cells for just 3-4 hours each day, including about one hour outdoors.

(In contrast, people in the general population units are allowed to be in common areas for most of the day.) Women held in administrative segregation face even more isolating conditions than their male counterparts. The women are confined alone in their cell for as many as 22 hours per day, and are rarely permitted to go outdoors for fresh air or exercise. With the restricted out-of-cell time comes limitations on access to the telephones to communicate with family and legal counsel.

Adelanto's disciplinary segregation units closely mirror solitary confinement units in prisons and jails. Men held in disciplinary segregation are placed in single cells with no windows to the outside and only a small window in the cell door that looks into a hallway. There is no common area in the men's disciplinary segregation unit. Men are confined to their cells for about 23 hours per day. The outdoor "recreation area" for men held in disciplinary segregation consists of small cage-like spaces that are constructed entirely with concrete.

Women held in disciplinary segregation are placed in the same unit as those held in administrative segregation. An additional cage-like fence separates their cells from the rest of the housing area. They are confined to their cell for about 23 hours each day.

People held in disciplinary segregation have restricted access to telephones and to visits with family and legal counsel.

Concrete, Fenced-In Recreation Area for
Disciplinary Segregation Unit (Adelanto West Facility)

The specter of being placed in solitary confinement hangs over all Adelanto detainees. GEO Group's Adelanto ICE Processing Center Supplemental Detainee Handbook lists more than 50 offenses that can result in a detainee's placement in disciplinary segregation, including minor infractions like "refusal to clean assigned living area," "refusing to obey a staff member officer's order," "being in an unauthorized area," or "failure to stand [during] count." (GEO Group's policy appears to track the applicable 2011 ICE Performance-Based National Detention Standards, which explicitly permit disciplinary segregation for these behaviors.[51])

There is extensive research on the damaging effects of restrictive solitary confinement-type conditions, finding that they exacerbate symptoms of mental illness and even cause mental illness in those who previously did not have such a condition.[52]

Such damaging effects are evident in the segregation units at Adelanto, particularly among detainees with a history of trauma or mental health needs. Multiple detainees at Adelanto have decompensated and engaged in self-harm or attempted suicide after spending time in these segregation units. (Read Ugo's story, p. 8; Luis's story, p. 32.) In March 2017, Osmar Epifanio Gonzalez-Gadba committed suicide while in detention at Adelanto after spending several weeks in disciplinary and administrative segregation. The External Reviews and Analysis Unit (ERAU) of the ICE Office of Professional Responsibility documented Mr. Gonzalez-Gadba's psychiatric deterioration in those units, where he began refusing meals, became psychotic and delusional, and stated a desire to die.[53] (The ERAU report details multiple deficiencies in how Mr. Gonzalez-Gadba was treated.)[54]

A 2017 DHS OIG report on segregation practices at several ICE detention facilities, including Adelanto, recognized that "placing detainees with mental health conditions in segregation is a serious step that requires careful review and oversight to ensure it is necessary, protects staff and detainees, and is in detainees' best interest."[55] The report was critical of ICE's practices in reviewing detainees' segregation placements, which according to the OIG, meant that "ICE may be missing opportunities to use alternatives that may be better for those with mental health conditions."[56]

The continued use of restrictive segregation housing remains a problem at Adelanto. The DRC Experts found that the conditions in Adelanto's segregation units were damaging well beyond the period

Luis: A Teenager with Unmet Mental Health Needs, Trapped in Segregation

Luis is 19 years old and was raised by a single parent in a Salvadorian community that was inundated with gang violence. He immigrated to the United States at the age of 17 because of threats to his life after he refused to join a local gang. Luis is also a survivor of sexual assault and was raped as a child.

Luis has a history of mental illness and has taken psychiatric medication since childhood. When he arrived at the United States border, he was sent to a children's shelter but was later released to live with a family member. Luis attended high school for a period of time, but later dropped out and became homeless. He was arrested and taken to juvenile hall, and was then transferred to ICE custody.

Luis arrived at Adelanto in 2017. During his initial mental health evaluation, Luis reported auditory hallucinations and other mental health history. He was placed in the administrative segregation unit. Luis's symptoms grew worse in Adelanto's segregation units, and he repeatedly raised concerns about his medication regimen. He engaged in acts of self-harm and at least once attempted suicide.

Luis has required at least two acute psychiatric hospitalizations while at Adelanto. Hospital staff documented his deteriorated condition and inadequate care at Adelanto, noting that Luis "is here after experiencing worsening voices, anxiety, and insomnia after his medication was inexplicably stopped 3 days ago at Adelanto."

When we last spoke with Luis, he was still in administrative segregation. He continued to struggle with the unit's restrictive nature and lack of activity. He told us: "I wish I could be out there [in the facility's general population]. I wish I could have more time outside."

Men's Disciplinary Segregation Unit
(Adelanto West Facility)

of a detainee's confinement: "The pernicious impact of isolation and solitary confinement on detainees' mental health is not limited to their time in isolation," they noted. "It is compounded by living under constant threat and fear of the facility's penal philosophy."

C. Beyond Mental Health Care Deficiencies: Delays and Gaps in Medical Care

We found that serious delays and gaps in the provision of medical care at Adelanto are a pervasive problem, and that they disproportionately – though not exclusively – harm people with disabilities. Denials of medical care have in many cases also caused or exacerbated a person's psychiatric distress.

We identified multiple cases of acute and chronic medical treatment needs that were not timely addressed. In many cases that we requested the facility review, ICE and GEO Group acknowledged that there had been significant delays in the delivery of care.

- A man who was taking prescribed medication for a gastrointestinal disorder had his medication discontinued when he arrived at Adelanto. Without his medication, he experienced pain so severe that he could not walk. Facility staff referred him for an endoscopy, which was scheduled to occur in April 2018. That procedure did not occur as scheduled. It was reportedly provided nearly six months later, after DRC contacted ICE and GEO Group about the case. (Read Aleksei's story, p. 26.)
- A woman who was raped multiple times during her journey to the United States requested and was provided HIV and pregnancy testing when she arrived at Adelanto. However, staff failed to provide the test results to her for more than three months. Dealing with her recent traumas and unable to find out whether she was pregnant or if she had contracted HIV, she became suicidal and required placement on suicide watch.
- A man was evaluated for hemorrhoids causing severe pain and bleeding, and was referred for a colonoscopy in or about June 2018. ICE and GEO Group acknowledged the delay in providing the procedure, which as of November 2018 still had not occurred. In October 2018, the man was placed on suicide watch for five days after becoming suicidal.

- A woman with cataracts who entered ICE detention needing surgery went without such treatment for the approximately one year she was detained. ICE and GEO Group acknowledged a lengthy delay in completing necessary labs and arranging the surgery. By the time of her release in late 2018, the surgery still had not been provided. Her vision had greatly deteriorated.

The 2018 DHS OIG report, *Management Alert - Issues Requiring Action at the Adelanto ICE Processing Center,* found a significant number of detainees who faced delays in the provision of urgent care, appointments for ongoing medical conditions, and prescribed medications.[57] The report cited a 2017 internal investigation at Adelanto that "identified 60 to 80 clinic appointments that were canceled because contract guards were not available to take detainees from their cells to their appointments."[58] The report also pointed to a 2017 external medical care review finding that "wait times to see a provider for both acute illness/injury and chronic care needs are often excessively long."[59] The OIG stated that "ICE must take these continuing violations seriously and address them immediately."[60]

Our investigation reveals that these delays and treatment failures persist, causing real harm to people detained at the facility.

RECOMMENDATIONS TO ADDRESS ADELANTO'S INADEQUATE HEALTH CARE TREATMENT SYSTEM AND COUNTER-THERAPEUTIC CONDITIONS

DHS and ICE

1. Conduct a comprehensive review of Adelanto's mental health treatment system to ensure adequate clinical staffing, individualized treatment, structured therapeutic programming and unstructured activities, and medication management practices that meet prevailing standards of care.
2. Review and revise standards to ensure that ICE detention facilities' institutional response to detainees in psychiatric crisis is humane, non-punitive, driven by individual clinical need, and consistent with prevailing standards of care.
3. Review and revise standards to end the use of solitary confinement and similarly restrictive segregation housing for ICE detainees, most urgently for detainees with mental health needs or other disabilities. Where detainees require separation from a facility's general population, they should be placed in a separate "protective housing" unit with equivalent programming, activities, and privileges.
4. Review and revise standards to ensure that ICE detention facilities implement a trauma-informed approach to treating people with mental health needs, following SAMHSA's framework for trauma-informed care.
5. Conduct a comprehensive review of Adelanto's medical care system to ensure that detainees with acute, urgent, or chronic care needs receive timely and adequate evaluation and treatment.

GEO Group

1. Increase mental health staffing and significantly enhance mental health programming at Adelanto, including individualized counseling and group therapy to meet the clinical needs of the detainee population.
2. Revise Adelanto's policies and procedures to allow detainees to order books and other reading materials, and increase reading materials available to detainees at the facility, including appropriate religious texts and materials written in detainees' primary language.
3. Implement a trauma-informed approach to care at Adelanto, and provide all Adelanto clinical, custody, and program staff with relevant training.
4. Conduct a comprehensive review of medication management policies and practices at Adelanto and take corrective action to ensure medication continuity and safe prescription practices.
5. Convert Adelanto's administrative segregation units to "protective housing" units with programming, activities, and privileges equivalent to what is offered in general population.
6. End the use of solitary confinement as a disciplinary or administrative housing option at Adelanto, most urgently for detainees with mental health needs or other disabilities.

VI. GEO GROUP'S UNDERREPORTING OF SUICIDE ATTEMPTS

We found that GEO Group's data collection practices lead to the underreporting of suicide attempts among Adelanto detainees. The frequency of suicide attempts and the circumstances of such incidents shed considerable light on the conditions and risks faced by people in immigration detention. GEO Group's lack of transparency regarding these incidents undermines public oversight and accountability.

Data regarding suicide attempts at Adelanto Detention Center is difficult to extract from existing records. The ICE Office of Detention Oversight reported eight (8) suicide attempts at the facility in 2013.[61] A *Los Angeles Times* investigation of 911 call logs found at least five (5) suicide attempts at the facility between December 2016 and July 2017.[62]

DRC requested data and records on suicide attempts at the facility. In response, ICE produced data indicating that Adelanto had just one (1) suicide attempt in 2016, three (3) in 2017, and zero in 2018 through mid-November.

We found evidence that this data represents a *significant undercounting* of suicide attempts among Adelanto detainees. In the course of DRC's monitoring, and without conducting anything close to a comprehensive review of all detainees, we encountered several people who, as documented by Adelanto health care staff and confirmed by the DRC Experts' assessment, attempted suicide between January 2018 and September 2018. For example:

- In one case from early 2018, facility records document that the detainee was found "in the shower in fetal position, fully dressed, crying and holding left bleeding wrist," leading to a five-day hospitalization. Medical records referred to the incident as a "suicide attempt," noting that the detainee had suicidal thoughts and plans to commit suicide. The detainee confirmed in an interview that her actions were made in an attempt to die.

- In another case from August 2018, medical records describe a man experiencing auditory hallucinations and expressing plans to hang himself. A few days later, he attempted to strangle himself with clothing. The clinician documented the incident as a "suicide attempt," and ordered that the patient's clothing and mattress be taken away.

Neither of these incidents, nor others we found that strongly suggest that detainees had attempted to kill themselves, are reflected in the data produced by ICE, which (again) indicated *zero* suicide attempts during the time period when they occurred.

When we raised this discrepancy, ICE noted that the data came from the facility and pointed to GEO Group's definition of "suicide attempt." ICE informed us that "according to GEO's corporate policy and procedures, a suicide attempt is defined as 'serious self-harm intended to cause death.'"

GEO Group's definition, requiring that some kind of "serious self-harm" occur, is inconsistent with – and far narrower than – the federal government's definition of "suicide attempt." The Centers for Disease Control and Prevention defines "suicide attempt" as a "non-fatal self-directed *potentially* injurious behavior with any intent to die as a result of the behavior." It explains that "a suicide attempt *may or may not* result in injury."[63]

When suicide attempts are not counted or tracked due to the inappropriately narrow definition of a private government contractor like GEO Group, it undermines public oversight and systemic quality improvement efforts. This finding is particularly troubling in the context of the September 2018 DHS OIG report regarding Adelanto, which identified suicide prevention deficiencies at the facility and noted reports of attempted suicides by hanging.[64]

The 2017 suicide of Osmar Epifanio Gonzalez-Gadba also exposed numerous deficiencies in suicide prevention practices at Adelanto Detention Center. A government review of his death found that custody staff had not been conducting timely or adequate safety checks, including immediately preceding Mr. Gonzalez-Gadba's death.[65] The report also documented failures with respect to emergency response procedures and the maintenance of emergency response equipment.[66]

DHS and ICE must demand greater transparency and accurate reporting from its contractor to ensure adequate oversight and accountability.[67]

RECOMMENDATIONS TO ADDRESS UNDERREPORTING OF SUICIDE ATTEMPTS AND NEED FOR ADEQUATE PUBLIC OVERSIGHT

DHS and ICE

1. Require GEO Group to adopt the definition of "suicide attempt" employed by the Centers for Disease Control and Prevention and to report all suicide attempts at Adelanto and other GEO Group-operated ICE detention facilities, to ensure appropriate oversight.
2. Conduct a comprehensive audit of GEO Group's suicide prevention practices and procedures, including as to whether deficiencies found in the Gonzalez-Gadba death review and the 2018 DHS OIG report, *Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California,* have been remedied.

VII. DISCRIMINATION AGAINST ADELANTO DETAINEES WITH DISABILITIES

Under Section 504 of the Rehabilitation Act of 1973, DHS and ICE are prohibited from discriminating against people with disabilities. In addition, DHS has adopted a regulation guaranteeing that "[n]o qualified individual with a disability in the United States, shall, by reason of his or her disability, be excluded from the participation in, be denied benefits of, or otherwise be subjected to discrimination under any program or activity conducted by the Department [of Homeland Security]."[68] People with disabilities in immigration detention facilities like Adelanto have legal rights to equal access to programs, activities, and services, and to reasonable accommodations and modifications as necessary to ensure such equal access. It is the responsibility of DHS, ICE and their contractors – GEO Group and the City of Adelanto – to ensure against disability discrimination at the Adelanto Detention Center.[69] California State disability law also applies to the treatment of individuals with disabilities who are detained in this privately operated facility.[70]

Men's Disciplinary Segregation Unit Cell with Wheelchair (Adelanto West Facility)

Federal disability antidiscrimination law is reflected in the ICE/ERO Performance-Based National Detention Standards ("ICE National Detention Standards") that GEO Group and the City of Adelanto must follow in operating the Adelanto Detention Facility. These standards make clear that GEO Group and the City of Adelanto have a duty to "act affirmatively to prevent disability discrimination" against detainees. This duty includes the provision of:

> (a) "processes to ensure that detainees with a disability will have an equal opportunity to participate in, access, and enjoy the benefits of the facility's programs, services, and activities";
>
> (b) placement in the "least restrictive and most integrated setting possible"; and
>
> (c) "physically accessible" facilities.[71]

Our investigation revealed a system that fails to meet legal requirements and the ICE National Detention Standards regarding the treatment of detainees with disabilities. Specifically, we found that Adelanto (a) does not ensure equal access and reasonable accommodations to people with disabilities, (b) does not provide for the placement of people with disabilities in the least restrictive and most integrated setting possible, and (c) has facilities that are not physically accessible for detainees with disabilities. Such failures lead to situations in which people with disabilities suffer abuse and/or neglect, as those terms are defined by law.[72]

A. *Failures to Identify, Track, and Provide for Disability Accommodation Needs*

Adelanto detainees with disability-related needs are not timely identified, nor are they timely provided with reasonable accommodations. We found a disability program that is fractured, *ad hoc*, and poorly managed. The failures in this regard have real and harmful consequences for people with disabilities.

There are a number of systemic deficiencies that appear to contribute to the failure to provide equal access and accommodations to Adelanto detainees with disabilities, including: (1) an inadequate system for identifying disability-related needs; (2) an inadequate system to reliably track identified disability needs in a way that ensures that accommodations are provided; (3) an accommodation request and grievance system is confusing and ineffective; (4) instances of disability-related assistive devices and equipment in

disrepair; and (5) inadequate training and involvement of the facility Disability Compliance Manager, as well as poor coordination with ICE field office staff regarding disability-related issues.

1. Inadequate Disability Identification System

The intake and screening protocols at Adelanto fail to appropriately identify the disabilities and disability-related needs of detainees.

The initial intake screening process is unlikely to elicit information necessary for the proper identification of people with disabilities. The intake screening form contains insufficient inquiry into disability-related information.

Subsequent medical screening complicates the problem further by limiting the number of recognized disabilities and potential accommodations. In the screening, the list of recognized disabilities is random and incomplete. Many disabilities – including those related to vision, hearing, and communication – are missing entirely. The types of physical disabilities are inappropriately limited to "para/quadriplegia," "stroke," "amputation," and "cardiac condition."

A second screening form inquiry, entitled "Assistive Devices," is also incomplete. It reads as follows:

> Assistive Devices: ☐ Glasses/Contacts ☐ Hearing aid(s) ☐ Denture(s)/Partial(s)
> ☐ Orthopedic brace ☐ Prosthetic ☐ Cane

This screening form fails to identify whether an individual *has* an assistive device or *needs but does not have* such a device. It also omits a number of common accommodations – most notably, a wheelchair – that should be considered and available. That some detainees end up with a wheelchair, in spite of it not being an option on the screening form, speaks to the *ad hoc* nature of Adelanto's system.

There is no screening for housing accommodation needs – *i.e.,* placement in a lower bunk or on a lower tier without stairs for people with mobility impairments.

The facility's screening lacks a reliable or valid tool to identify individuals with intellectual or developmental disabilities.

There is also no reference in the screening protocol to the potential needs of people who have hearing or vision impairments.

Juan: Isolation of a Deaf Detainee Denied Communication Assistance

Juan is a 22-year-old deaf asylum seeker from Central America. He was abandoned by his biological mother when she found out that he was deaf. He was taken in by another woman and taught Guatemalan Sign Language. Juan was isolated in his community due to his disability. He was also victimized by a step-father who beat him and removed him from school. Juan fled to the United States to escape the discrimination and abuse he faced.

Juan arrived in the United States in June 2018, and was sent to Adelanto while his asylum case was pending. For months, he had no way to communicate with staff. He describes how staff did not provide him a sign language interpreter, including for medical appointments. He had to point at the area of his body that was hurting and hope medical staff understood.

Meanwhile, the facility staff ignored Juan's need for an interpreter proficient in Guatemalan Sign Language, and assumed, incorrectly, that he could not sign at all, noting: "Detainee is deaf but does not sign in American or Spanish Sign Language. Per signing interpreters in the past, detainee is using 'made up' signs. Detainee is only able to write a few words in Spanish including 'mama' and 'papa.' Detainee is only able to sign using gestures."

GEO Group staff should have arranged for a Guatemalan Sign Language interpreter or Certified Deaf Interpreter who could assist in communication through gestures. Just recently, facility staff began using a Video Relay Service to facilitate effective communication for Juan in Guatemalan Sign Language, but only sparingly and only when the circumstances are extremely serious – for example, when he was experiencing debilitating stomach pain. Because he still cannot communicate regularly with others, Juan described to us feelings of extreme isolation and helplessness.

COMMUNICATION SYSTEMS FOR DEAF DETAINEES

Adelanto acquired a Video Relay Service device in 2018. Staff explained that the device would be available to facilitate contacts between deaf detainees and health care staff. Staff stated that the device is not available for detainee calls to family or legal counsel – that is, deaf detainees would have to use the Text Telephone (TTY), a communication system that is more than fifty years old and largely obsolete in today's world.

The limitation on access to Video Relay Services discriminates against deaf people. A court recently found that a detention facility must provide deaf people access to a Video Relay Service, recognizing that "TTYs are not a practical or effective communication tool for deaf and hard of hearing persons, and that video-based communication is today's standard mode of remote communication for such persons who communicate through sign language."[73]

ICE and GEO Group should update their protocols to ensure that deaf detainees who use sign language to communicate have access to video-based communication methods for personal and legal counsel contacts.

These disability screening deficiencies have real consequences for Adelanto detainees with disabilities. One legally blind detainee reported that he was denied a walking cane for four months after arriving at the facility, making it nearly impossible for him to safely navigate his housing unit and other areas of the facility on his own.

We received reports from detainees regarding inappropriate housing and bed assignments for people with disabilities. Detainees recalled a woman with epilepsy being assigned a top bunk. Only after she had a seizure and fell from her top bunk to the floor, causing physical injury, did the facility make a bottom bunk available to her.

Our findings are consistent with the DHS OIG's 2018 report regarding failures to provide assistance to Adelanto detainees with disabilities. That report described, for example, a "blind, limited English proficient detainee in disciplinary segregation" who was provided "no auxiliary aids or translated materials" so that he could read and understand documents he was given.[74]

2. Inadequate Disability Tracking System

The Adelanto records system does not reliably track detainees' disability accommodation needs. This creates a situation where health care and security staff are often not aware of, and do not provide for, detainees' accommodation needs.

Facility staff reported that disability information is currently printed on a "housing card" that travels with each detainee. While such a practice is well-intended, it is not a substitute for a reliable, electronic system that informs all relevant staff of disability accommodation information. A paper "housing card," which we learned many staff do not ever look at, does not ensure that all relevant facility staff receive timely notification and instructions for implementation of needed accommodations, as required by the ICE National Detention Standards.[75]

In addition, because detainees are frequently moved from one facility to another, DHS must ensure that there is an effective system across ICE detention facilities and immigration enforcement agencies to ensure the consistent provision of reasonable accommodations and assistance for people with disability needs. Again, ICE and its sister federal agencies have a legal duty to ensure detainees are provided the reasonable accommodations they require.[76]

DHS has recognized the need for an electronic records system. A 2016 report refers to the deployment of an ICE "electronic health records system to capture information about detainees' needs" in 2014.[77] ICE must ensure that its system effectively tracks the disability needs of detainees and that all relevant actors timely receive that information. Without such a system, DHS and ICE fail to comply with federal law.[78] Their legal duty extends to when detainees are transferred from the custody of one federal agency to another, and from one detention facility to another. It is a duty that cannot be delegated away.[79]

3. Deficiencies in Accommodation Request Procedures

Disability law requires detention facilities to provide a system by which people with disabilities may request accommodations for their disability-related needs.[80] Adelanto's accommodation request system is disorganized, *ad hoc*, and ineffective.

The ICE National Detention Standards require that the detainee orientation program and handbook "notify and inform detainees about the facility's disability accommodations policy, including their right to request reasonable accommodations and how to make such a request."[81]

At the time of our on-site monitoring, the GEO Group Adelanto Supplemental Detainee Orientation Handbook did not satisfy this requirement because it did not adequately inform detainees about their disability-related rights or facility procedures.[82] The handbook contains a passing reference to detainees' ability to possess "health care items issued by or authorized by facility medical staff" as well as "eyeglasses, hearing aids, dentures, or other authorized prostheses."[83] But there is no reference to the kinds of accommodations that people with disabilities often need – such as wheelchairs or walkers, a housing placement that does not require navigating stairs or climbing onto a top bunk, sign language interpretation, staff assistance with daily activities, and more.

The detainee handbook's sole reference to a process for people with disabilities to request an accommodation is a section entitled "Grievance Procedure for Detainees with Disabilities."[84] However, this section addresses only the need for an "appropriate accommodation to be provided *in the grievance process."* It does not address the detainee's right to request an accommodation outside of the grievance process, or a procedure for how to make such a request.

The various detainee request forms in the housing units compound the problem. Staff did not have a consistent response to our questions about which form is appropriate for a detainee to make an accommodation request. We obtained four forms available to detainees – two entitled "Detainee Request Form," one entitled "Patient Health Services Request Form," and one entitled "Detainee Grievance Form." None make reference to disability-related needs or requests.

Not surprisingly, we found that detainees were confused and frustrated by the process for seeking disability-related assistance. They often wait weeks to get a response to an accommodation request. Several detainees recounted a staff member collecting grievance forms from the housing unit. She read one form that requested an accommodation and a medical assessment, and immediately returned the form to the detainee, telling him he was "wasting everyone's time." Other detainees recalled an incident in which a staff member ripped up a submitted grievance form. One detainee reported that he was awaiting responses to five grievances, the oldest dating back almost three months.

Staff acknowledged that their practice is in fact to return grievance forms with disability accommodation-related requests to the detainee

Form Submission Boxes for Detainees (Adelanto East Facility)

without investigation or action, directing the detainee to submit a medical request form instead. This practice is inconsistent with the ICE National Detention standards requirement that "detainees shall be permitted to raise concerns about disability-related accommodations and/or the accommodations process *through the grievance system.*"[85]

4. Assistive Devices in Disrepair

We discovered a number of cases in which a person with a disability had been provided a broken or dysfunctional assistive device, and had raised the issue with staff without result. For example, we observed two people with wheelchairs in a clear state of disrepair, with damaged seating and wheels. We learned of another person whose wheelchair was missing multiple screws, making it difficult to safely use. In each case, they had submitted requests for a repair or replacement that had gone unanswered.

Another detainee, who has a significant disability related to an injury that permanently damaged his left leg, waited nine months to get a replacement for a broken orthotic shoe. He described how, without proper footwear, he was extremely unstable and afraid of falling every time he walked. Records show that he made at least five written accommodation requests over several months. In one request, he wrote: "I can't walk . . . I am afraid to . . . fall because the bottom[s] are coming off. Please help with my problem I am handicap[ped] and its very important to have my orthopedic shoes." (DRC raised the issue with ICE and GEO Group representatives following our monitoring visit. ICE representatives reported to us that replacement footwear was provided to this man approximately five weeks later.)

5. Problems with GEO Group Disability Compliance Manager Role and Poor Coordination with ICE

The ICE National Detention Standards require the Adelanto facility to designate at least one staff member as the "Disability Compliance Manager" to "assist in ensuring compliance with [ICE National Detention Standards] and all applicable federal, state and local laws related to accommodations for detainees with disabilities."[86] We identified several shortcomings with respect to GEO Group's Disability Compliance Manager's training and day-to-day involvement with disability-related compliance issues.

We spoke with the GEO Group on-site staff member assigned to this role. He explained that he served as both the facility Fire Safety Manager and the Disability Compliance Manager. He stated that he did not have prior disability-related experience. His disability training for the position entailed a four-hour online training that was targeted to firefighters and did not address detention-specific issues.

He described his Disability Compliance Manager role as reviewing any disability requests that are routed to him, but it was clear that an extremely small percentage of such requests ever reach him. In contrast to the dozens of written accommodation requests we observed during our monitoring visit and in individual records, the Disability Compliance Manager stated that he had received just two accommodation requests in the previous month.

(ICE recently reported to us new practices at the facility relating to the Disability Compliance Manager – specifically, weekly Disability Compliance Manager rounds to monitor detainees with accommodation needs and monthly multi-disciplinary meetings to discuss Disability Compliance Manager findings and needed actions and/or updates. In addition, ICE reported to us that the detainee handbook was recently updated to include contact information for the facility's Disability Compliance Manager.)

Relatedly, there is poor coordination between GEO Group facility staff and the regional ICE Field Office regarding disability accommodation issues. Such coordination is required by the ICE National Detention Standards for each review of a detainee with disability needs, and for any a denial of a detainee's accommodation request.

We spoke with the ICE Regional ADA Coordinator from the local ICE Field Office. He explained that his job is to review any denial of an accommodation request at the facility, and that he is unaware of *any* denial ever having occurred. Such a statement is inconsistent with our investigation, which revealed several accommodation requests that were denied or significantly delayed. More active oversight by ICE is necessary.

B. *Segregation Practices Violate Legal Requirements to Place People with Disabilities in the Least Restrictive, Most Integrated Setting Possible*

Disability law and the ICE National Detention Standards require that people with a disability have an "equal opportunity to participate in, access, and enjoy the benefits of the facility's programs, services, and activities," and that "[s]uch participation ... be accomplished in the least restrictive and most integrated setting possible."[87]

We found that GEO Group's management of people with disabilities resulted in a violation of this requirement. Most notably, people with mental health and other disabilities who are at risk of exploitation and other harms in the general population housing units are placed in the facility's "administrative segregation" units. We observed segregation unit rosters that identify a mental illness or medical condition as the "Reason for Placement" in administrative segregation. Administrative segregation placement means more cell confinement and less access to outdoor exercise and other activities, as discussed in Section V.B, above. A number of people housed in the administrative segregation units due to their mental health or medical condition shared with us that they feel like they are being punished for their disability.

In some cases, people with disabilities are placed in the even more restrictive disciplinary segregation unit, where detainees are confined to their cells for at least 23 hours each day. One facility housing roster we reviewed showed a person held in disciplinary segregation for two weeks, not for any misconduct but rather because of safety concerns related to his medical condition.

We spoke with another individual with mental illness who had become suicidal while housed in the administrative segregation unit. After three days on suicide watch and four days on enhanced mental health observation, he was moved to the disciplinary segregation unit because there was no longer space for him in administrative segregation. He described how his time in disciplinary segregation, more than a week, was extremely isolating.

The DHS OIG also recently found Adelanto detainees with disabilities being placed in inappropriately restrictive housing units. The OIG reported on a detainee who uses a wheelchair and had requested removal from the general population. The OIG found that GEO Group inappropriately held this man in disciplinary segregation

for nine (9) days, until OIG inspectors raised the issue. The OIG's findings as to this man's placement in segregation and staff's neglectful treatment of him are troubling:

> [I]n those 9 days, the detainee never left his wheelchair to sleep in a bed or brush his teeth. During our visit, we saw that the bedding and toiletries were still in the bag from his arrival. We also observed medical staff just looking in his cell and stamping his medical visitation sheet rather than evaluating the detainee, as required by ICE standards.[88]

While it may be appropriate to place people in protective housing settings to ensure their safety, the facility may not legally place them in *more restrictive* settings because of their disabilities.[89] They should have equivalent access to out-of-cell time, outdoor time, and other programs and activities as compared to what is provided in general population housing areas. Placement in isolation-type settings in the name of "safety" misses the reality of the harm that such settings can inflict on people with mental illness and other disabilities.

C. *Inadequate Physical Accessibility*

Several aspects of the Adelanto facility that we observed were not physically accessible to detainees with disabilities. For example, some recreation areas lacked accessible toilet facilities. There were a number of gravel paths that created physical access barriers for people in wheelchairs trying to reach outdoor seating areas, exercise areas, and shaded locations (which is notable given the extremely hot temperatures many months of the year). Staff were not aware of whether there had ever been an ADA physical accessibility assessment of the facility.

Steps to achieve compliance with technical accessibility standards throughout the facility should be taken through affirmative and proactive efforts. ICE recently informed us that, since our site visit, the facility has taken steps to construct accessible pathways to recreation yards and to install accessible handrails to outdoor restroom areas. A complete audit of physical accessibility at the facility is a next important step to ensure compliance.

RECOMMENDATIONS TO ADDRESS DISABILITY DISCRIMINATION

DHS and ICE

1. Conduct a comprehensive review of the system across ICE facilities and immigration enforcement agencies to ensure effective tracking of detainee disabilities and accommodation needs and timely communication of such information to all relevant actors.
2. Complete a comprehensive audit of Adelanto's compliance with ICE National Detention Standard 4.8, *Disability Identification, Assessment, and Accommodation,* and require GEO Group to implement a Corrective Action Plan regarding any identified deficiencies.
3. Implement a process to ensure that the ICE Regional ADA Coordinator independently verifies the accuracy of GEO Group reports regarding accommodation requests and is proactively involved in ensuring accommodations.

GEO Group

1. Provide appropriate disability training to the Disability Compliance Manager and other security and health care staff that interact with detainees with disabilities.
2. Revise detainee screening protocols and forms to ensure identification of people with disabilities and disability-related needs.
3. Implement an effective system for tracking of Adelanto detainees' disabilities and accommodation needs, such that all security and health care staff that provide services to detainees are made aware of this information.
4. Develop a policy and procedure, with appropriate documentation and clear timelines, to ensure that disability accommodation requests and grievances are logged, tracked and addressed.
5. Develop a process to ensure that assistive devices are in working order.
6. Revise policies and procedures to ensure that deaf detainees who communicate with sign language have access to video-based communication technology for personal and legal counsel contacts, and ensure access to interpretation services in the appropriate sign language that the person uses.
7. Clarify the duties of the Disability Compliance Manager to ensure a proactive role in addressing disability-related issues.
8. End the practice of placing detainees with mental illness, medical conditions, and any other disabilities in restrictive segregation housing units, especially for non-disciplinary "safety" reasons.
9. Ensure that detainees with mental illness, medical conditions, and any other disabilities who cannot be housed in general population units are housed in the most integrated setting appropriate to their needs and receive equal access to facility programs, including outdoor recreation and dayroom time.
10. Complete a comprehensive physical accessibility assessment throughout the Adelanto facility and implement a remediation plan to address any deficiencies.

VIII. CONCLUSION

Conditions at Adelanto pose serious risks to people with mental illness and other disabilities. The situation demands action. Access to treatment and disability-related accommodations must improve, and steps to reduce unnecessarily punitive conditions at the facility must be a top priority. At the same time, given the extraordinary risks and the harms to people with mental illness and disabilities detained at Adelanto, it is essential to ask: Is it *necessary* to imprison this population? Are there less restrictive and less damaging alternatives that better serve the country's constitutional freedoms and commitment to the rights, safety, and dignity of all?

[1] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *Report 18-32, Concerns About ICE Detainee Treatment and Care at Detention Facilities* (Dec. 2017), https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf.

[2] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *Report 18-67, ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained Compliance or Systemic Improvements* (June 2018), https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf.

[3] *See, e.g., Lisa Riordan Seville, Hannah Rappleye, & Andrew W. Lehren, 22 immigrants died in ICE detention centers during the past 2 years*, NBC News – Immigration and the Border, Jan. 6, 2019, https://www.nbcnews.com/politics/immigration/22-immigrants-died-ice-detention-centers-during-past-2-years-n954781; Molly Hennessy-Fiske, *Lawsuit alleges improper medication of migrant children in federal shelters*, L.A. Times, Jun. 21, 2018, https://www.latimes.com/nation/la-na-immigrant-shelters-medicated-20180620-story.html; Jess Bidgood, *et al., Restraint Chairs and Spit Masks: Migrant Detainees Claim Abuse at Detention Centers*, N.Y. Times, Aug. 4, 2018, https://www.nytimes.com/2018/08/04/us/migrant-children-detention-centers.html; Chantal Da Silva, *Thousands of Migrants Have Reported Sexual Abuse While in ICE Custody*, Newsweek, Jul. 23, 2018, https://www.newsweek.com/thousands-migrants-have-reported-sexual-abuse-while-ice-custody-1036580; Jeanne Kuang, *Immigration Detention Deaths Reach the Highest Total Since 2009*, , Houston Chronicle, Jan. 12, 2018, https://www.houstonchronicle.com/news/houston-texas/houston/article/Immigration-detention-deaths-reach-the-highest-12494624.php; Paloma Esquivel, 'We don't feel OK here': *Detainee deaths, suicide attempts and hunger strikes plague California immigration facility*, L.A. Times, Aug. 8, 2017, https://www.latimes.com/local/lanow/la-me-In-adelanto-detention-20170808-story.html.

[4] Human Rights First, *Prisons and Punishment: Immigration Detention in California* (2019), https://www.humanrightsfirst.org/sites/default/files/Prisons_and_Punishment.pdf; Human Rights Watch, *et al., Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention* (2018), https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-care-immigration#; American Civil Liberties Union, *et al*., *Fatal Neglect: How ICE Ignores Deaths in Detention* (2016), https://www.aclu.org/report/fatal-neglect-how-ice-ignores-death-detention; Southern Poverty Law Center, *et al*., Shadow Prisons: Immigrant Detention in the South (2016), https://www.splcenter.org/20161121/shadow-prisons-immigrant-detention-south.

[5] Nick Schwellenbach, *Locking In Profits: Top ICE Officials Leave Agency to Serve Its Top Contractor,* Project on Government Oversight, Dec. 18, 2018, https://www.pogo.org/investigation/2018/12/locking-in-profits-top-ice-officials-leave-agency-to-serve-its-top-contractor/.

[6] Office of Inspector Gen., U.S. Dep't of Homeland Sec., Report 18-86, *Management Alert - Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California* (Sept. 2018), https://www.oig.dhs.gov/sites/default/files/assets/2018-10/OIG-18-86-Sep18.pdf ["DHS OIG 2018 *Adelanto Management Alert*"].

[7] Cal. Gov't Code § 12532.

[8] *Id.* at § 12532(b).

[9] Cal. Welf. & Inst. Code § 4900; 42 U.S.C. §§ 10802(1) & (5); 42 C.F.R. § 51.2; Cal. Welf. & Inst. Code § 15610.07.

[10] 42 U.S.C. § 10805(a)(3); 42 C.F.R. § 51.42 (b); Cal. Welf. & Inst. Code § 4902(b)(2).

[11] U.S. Dep't of Homeland Sec., *Immigration and Customs Enforcement, Budget Overview, Fiscal Year 2019 Congressional Justification at* 5, https://www.dhs.gov/sites/default/files/publications/U.S.%20Immigration%20and%20Customs%20Enforcement.pdf.

[12] Spencer Ackerman, *Trapped Under Ice: ICE Is Imprisoning a Record 44,000 People,* Daily Beast, Nov. 11, 2018, https://www.thedailybeast.com/ice-is-imprisoning-a-record-44000-people.

[13] U.S. Dep't of Homeland Sec., FY 2019 BUDGET-IN-BRIEF at 4, 36, https://www.dhs.gov/sites/default/files/publications/DHS%20BIB%202019.pdf.

[14] Tara Tidwell Cullen, *ICE Released Its Most Comprehensive Data Yet. It's Alarming,* NATIONAL National Immigrant Justice Center, Mar. 13, 2018, https://immigrantjustice.org/staff/blog/ice-released-its-most-comprehensive-immigration-detention-data-yet.

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[16] U.S. Dep't of Homeland Sec., *Immigration and Customs Enforcement, Immigration Detention Overview and Recommendations* at 27-28 (2009), https://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf ["DHS 2009 *Detention Overview and Recommendations"*].

[17] Memorandum re: *Exercising Prosecutorial Discretion Consistent with the Civil Enforcement Priorities of the Agency for the Apprehension, Detention and Removal of Aliens,* from John Morton, Director of U.S. Immigration and Customs Enforcement at 5 (June 17, 2011), https://www.ice.gov/doclib/secure-communities/pdf/prosecutorial-discretion-memo.pdf.

[18] Memorandum re: *Policies for the Apprehension, Detention and Removal of Undocumented Immigrants,* from Jeh Charles Johnson, Secretary of Dep't of Homeland Security at 1 (Nov. 20, 2014), https://www.dhs.gov/sites/default/files/publications/14_1120_memo_prosecutorial_discretion.pdf.

[19] *Id.* at 5.

[20] Exec. Order No. 13,768, 82 Fed. Reg. 8799 (Jan. 25, 2017); Memorandum re: *Enforcement of the Immigration Laws to Serve the National Interest*, from John Kelly, Secretary of Dep't of Homeland Security (Feb. 20, 2017), https://www.dhs.gov/sites/default/files/publications/17_0220_S1_Enforcement-of-the-Immigration-Laws-to-Serve-the-National-Interest.pdf.

[21] *Continued Rise in Asylum Denial Rates: Impact of Representation and Nationality,* TRACIMMIGRATION (Dec. 16, 2016), http://trac.syr.edu/immigration/reports/448/.

[22] Human Rights First, *Life on Lockdown: Increased U.S. Detention of Asylum Seekers* at 11-12 (2016), http://www.humanrightsfirst.org/sites/default/files/Lifeline-on-Lockdown_0.pdf (documenting a three-fold increase in the number of asylum seekers in immigration detention from 2010 to 2014 and increased detention rates of asylum seekers).

[23] *Damus v. Nielsen,* Case No. 1:18-cv-00578-JEB (D.D.C.), Declaration of Anne Daher, Docket No. 11-12, ¶ 9 (Mar. 20, 2018) (analyzing ICE data produced pursuant to Freedom of Information Act Request).

[24] *Id.* ¶ 10.

[25] Disability Rights International, *Our Reports & Publications*, https://www.driadvocacy.org/media-gallery/our-reports-publications/.

[26] United Nations High Comm'r for Refugees, *Refugee Resettlement: An International Handbook to Guide Reception and Integration 233 (2002),* https://www.unhcr.org/3d98623a4.html (citing clinical studies that found rates of PTSD in refugees ranged from 39-100%, compared to 1% in the general population, and rates of depression in refugees ranged from 47-72%); Allen Keller, et al., *Pre-Migration Trauma Exposure and Mental Health Functioning among Central American Migrants Arriving at the US Border*, PLoS ONE 12(1) (2017), https://doi.org/10.1371/journal.pone.0168692 (32% of study participants reported symptoms indicative of PTSD, 24% reported symptoms of major depressive disorder); Dermot A. Ryan, et al., *Mental Health Among Persons Awaiting an Asylum Outcome in Western Countries: A Literature Review,* Int'l Journal of Mental Health 88, 105-07, Vol. 38, No. 3 (Fall 2009) (asylum seekers are at risk of experiencing high levels of stress and poor mental health, including high rates of depression, anxiety, and PTSD); Physicians For Human Rights, *et al.*, *From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers* at 55-56, 83-85 (2003), https://s3.amazonaws.com/PHR_Reports/persecution-to-prison-US-2003.pdf.

[27] Allen S. Keller, *et al., Mental Health of Detained Asylum Seekers*, 362 Lancet, 1721-23 (2003) (finding that detention of asylum seekers worsens symptoms of depression, anxiety, and PTSD); *see also* Janet Cleveland, *et al., Psychiatric Symptoms Associated with Brief Detention of Adult Asylum Seekers in Canada*, Canadian Journal of Psychiatry 409, 414, Vol. 58, No. 7 (July 2013), https://www.researchgate.net/profile/Cecile_Rousseau2/publication/250922350_Psychiatric_Symptoms_Associated_With_Brief_Detention_of_Adult_Asylum_Seekers_in_Canada/links/54ef449f0cf2495330e1cffe/Psychiatric-Symptoms-Associated-With-Brief-Detention-of-Adult-Asylum-Seekers-in-Canada.pdf (finding that "for asylum seekers, incarceration is a serious stressor involving sever disempowerment, loss of agency, and uncertainty," raising risk of psychiatric disorders after even brief periods of detention).

[28] DHS 2009 *Detention Overview and Recommendations, supra* note 16, at 27-28.

[29] U.S. Dep't of Homeland Sec., *Report of the DHS Advisory Committee on Family Residential Centers* at 109 (2016), https://www.ice.gov/sites/default/files/documents/Report/2016/ACFRC-sc-16093.pdf ["DHS *Report on Family Residential Centers"*].

[30] *See, e.g., Zadvydas v. Davis*, 533 U.S. 678, 690 (2001); *Bell v. Wolfish*, 441 U.S. 530, 536 (1979); *Youngberg v. Romeo*, 457 U.S. 307, 321-22 (1982).

[31] *King v. County of Los Angeles,* 885 F.3d 548, 557-58 (9th Cir. 2018) (citing *Jones v. Blanas*, 393 F.3d 918, 932 (9th Cir. 2004); *see also Doe v. Kelly*, 878 F.3d 710 (9th Cir. 2017) (discussing the rights of immigrants in Customs and Border Patrol detention).

[32] DHS 2009 *Detention Overview and Recommendations, supra* note 16, at 1.

[33] *Id.* at 1-2.

[34] *Id.* at 21.

[35] *Id.* at 19-21.

[36] Intergovernmental Service Agreement Between the Dep't of Homeland Security, U.S. Immigration and Customs Enforcement, Office of Enforcement and Removal Operations and the City of Adelanto at 2, signed May 27, 2011 (amended May 24, 2013).

[37] *Id*.

[38] Civic & Detention Watch Network, *Abuse in Adelanto: An Investigation into a California Town's Immigration Jail* at 6 (2015), http://www.endisolation.org/wp-content/uploads/2015/11/CIVIC_DWN-Adelanto-Report_old.pdf.

[39] Such food-related deficiencies in immigration detention facilities are not isolated to Adelanto, as confirmed by recent reports from the DHS OIG and watchdog organizations. *See, e.g.*, Office of Inspector Gen., U.S. Dep't of Homeland Sec., *Report 17-43, Management Alert on Issues Requiring Immediate Action at the Theo Lacy Facility in Orange, California* (Mar. 2017), https://www.oig.dhs.gov/sites/default/files/assets/2017/OIG-mga-030617.pdf; Detention Watch Network, *Expose & Close: Theo Lacy Detention Center* at 5 (2012), https://www.detentionwatchnetwork.org/sites/default/files/reports/DWN%20Expose%20and%20Close%20Theo%20Lacy.pdf.

[40] Fatma E. Marouf, *Alternatives to Immigration Detention*, 38 Cardozo L. Rev. 2141, 2155-70 (2017); *see also* 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 Law 392, 396-97 (2010) (discussing cost-effective alternatives to immigration detention of people with serious mental illness).

[41] "Abuse" is defined as an act or failure to act that was knowing, reckless, or intentional, and that may have caused injury to an individual with a mental illness. "Neglect" is defined as a negligent act or omission that may have caused injury to an individual with a mental illness. Cal. Welf. & Inst. Code § 4900; 42 U.S.C. §§ 10802(1) & (5); 42 C.F.R. § 51.2; Cal. Welf. & Inst. Code § 15610.07.

[42] DHS OIG 2018 *Adelanto Management Alert, supra* note 6, at 7 (observing two doctors stamping their name on the detainee records indicating that they visited with the detainee, without having any contact with 10 of the 14 detainees in the unit).

[43] National Commission on Correctional Health Care, *Standards for Health Services in Jails*, Standard J-G-04.

[44] *See, e.g., Parnell v. Waldrep*, 511 F. Supp. 764, 768 (W.D.N.C. 1981) ("[P]rohibition of virtually all reading materials deprives the inmates of their First Amendment right to receive information and ideas."); *Mann v. Smith*, 796 F.2d 79, 82 (5th Cir. 1986) (striking down jail's ban on magazines and newspapers); *Payne v. Whitmore*, 325 F.Supp. 1191, 1193 (N.D. Cal. 1971) (striking down jail's prohibition on receiving newspapers and magazines by mail).

[45] *See, e.g.*, DHS OIG 2018 *Adelanto Management Alert, supra* note 6, at 8; U.S. Gov't Accountability Office, *Immigration Detention: Additional Actions Needed to Strengthen Management and Oversight of Detainee Medical Care* at 12 (Feb. 2016), https://www.gao.gov/assets/680/675484.pdf ["GAO *Report, Oversight of Detainee Medical Care"*]; Human Rights Watch, *Systemic Indifference: Dangerous & Substandard Medical Care in U.S. Immigration Detention* at 24 (2017), https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_0.pdf.

[46] U.S. Dep't of Health & Human Services, *SAMHSA Trauma and Justice Strategic Initiative, SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (2014), https://store.samhsa.gov/system/files/sma14-4884.pdf.

[47] *Id.* at 9-10.

[48] *Id.* at 10-11; Meryl Schulman & Christopher Menschner, *Laying the Groundwork for Trauma-Informed Care, Center for Health Care Strategies* (2018), http://www.traumainformedcareproject.org/resources/Laying-the-Groundwork-for-TIC_012418.pdf.

[49] DHS *Report on Family Residential Centers, supra* note 29, at 138.

[50] DHS OIG 2018 *Adelanto Management Alert, supra* note 6, at 3.

[51] 2011 Performance-Based National Detention Standards (PBNDS) Standard 3.1, *Disciplinary System*.

[52] *See, e.g.,* Craig Haney, *Restricting the Use of Solitary Confinement*, 1 Annu. Rev. Criminal Law 285 (2018); National Research Council, *The Growth of Incarceration in the United States: Exploring Causes and Consequences* at 183-87 (2014); Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in US Prisons: A Challenge for Medical Ethics*, J. Am. Acad. Psychiatry Law 38(1),104-108, (2010); Stuart Grassian, *Psychopathological Effects of Solitary Confinement,* 140 Am. J. of Psychiatry 1450, 1451-53 (1983); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 Crime & Delinquency 124, 130-45 (2003), https://www.researchgate.net/publication/249718605_Mental_Health_Issues_in_Long-Term_Solitary_and_Supermax_Confinement.

[53] ICE Office of Professional Responsibility, External Reviews and Analysis Unit, *Detainee Death Review of Gonzalez-Gadba* at 8-9 (2017), https://www.ice.gov/doclib/foia/reports/ddrGonzalez.pdf ["2017 *Detainee Death Review of Gonzalez-Gadba*"].

[54] *Id.*

[55] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *Report 17-19, ICE Field Offices Need to Improve Compliance with Oversight Requirements for Segregation of Detainees with Mental Health Conditions* at 8 (2017), https://www.oig.dhs.gov/sites/default/files/assets/2017-11/OIG-17-119-Sep17.pdf ["DHS *Report, Segregation of Detainees with Mental Health Conditions*"].

[56] *Id.* at 4-5, 8.

[57] DHS OIG 2018 *Adelanto Management Alert, supra* note 6, at 8.

[58] *Id.*

[59] *Id.*

[60] *Id.*

[61] U.S. Dep't of Homeland Sec., OFFICE OF DETENTION OVERSIGHT (ODO), ADELANTO COMPLIANCE INSPECTION, (2014), https://www.ice.gov/doclib/foia/odo-compliance-inspections/2014AdelantoJuly.pdf.

[62] DHS OIG 2018 *Adelanto Management Alert, supra note 6, at 4 (citing Paloma Esquivel, 'We don't feel OK here': Detainee deaths, suicide attempts and hunger strikes plague California immigration facility*, LA Times (Aug. 8, 2017), http://www.latimes.com/local/lanow/la-me-ln-adelanto-detention-20170808-story.html).

[63] Centers for Disease Control and Prevention, *Self-Directed Violence Surveillance: Uniform Definitions and Recommended Data Elements* at 21, (2011), https://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf (emphasis added).

[64] DHS OIG 2018 *Adelanto Management Alert, supra* note 6, at 3.

[65] 2017 *Detainee Death Review of Gonzalez-Gadba, supra* note 53, at 21.

[66] *Id* at 15-16.

[67] This failure in the reporting and review of suicide attempts is symptomatic of larger, systemic deficiencies in DHS and ICE oversight and accountability processes. For example, the DHS OIG found oversight deficiencies regarding the segregation of ICE detainees with mental health conditions. It found that ICE field offices were not properly recording segregation data and reporting such data to ICE headquarters, and that they failed to assess the accuracy of data provided by individual ICE detention facilities. DHS *Report, Segregation of Detainees with Mental Health Conditions, supra* note 55, at 4-5; see also GAO *Report, Oversight of Detainee Medical Care, supra* note 45, at 21 (criticizing ICE's limited data analysis of medical care compliance data as part of its oversight of individual detention facilities).

[68] 6 C.F.R. § 15.30; *see also* U.S. Dep't of Homeland Sec., Directive No. 065-01 (2013), https://www.dhs.gov/sites/default/files/publications/dhs-management-directive-disability-access_0.pdf; U.S. Dep't of Homeland Sec., Instruction No: 065-01-001 (2015), https://www.dhs.gov/sites/default/files/publications/dhs-instruction-nondiscrimination-individuals-disabilities_03-07-15.pdf; U.S. Dep't of Homeland Sec., *Self-Evaluation and Planning Reference Guide 065-01-001-01* at 23-24 (2016), https://www.dhs.gov/sites/default/files/publications/disability-guide-component-self-evaluation.pdf.

[69] *Hernandez v. Cnty. of Monterey*, 70 F. Supp. 3d 963, 973 (N.D. Cal. 2014) (finding that public and private entities acting jointly each must ensure compliance with disability anti-discrimination law in jail detention facility); *Wilkins-Jones v. Cnty. of Alameda*, 859 F. Supp. 2d 1039, 1047 (N.D. Cal. 2012).

[70] *Wilkins-Jones*, 859 F. Supp. 2d at 1050; Cal. Civ. Code § 51 et seq. (Unruh Civil Right Act); Cal. Civ. Code § 54 et seq. (California Disabled Persons Act).

[71] 2011 Performance-Based National Detention Standards (PBNDS) Standard 4.8, Disability Identification, Assessment, and Accommodation (revised Dec. 2016).

[72] 42 C.F.R. § 51.2; 45 C.F.R. § 1326.19.

[73] *McBride v. Michigan Dep't of Corrs.*, 294 F.Supp.3d 695, 707 (E.D. Mich. 2018); id. at 714 (granting summary judgment for plaintiffs and finding that "TTYs do not enable [deaf individuals] to communicate effectively with persons outside of prison, much less provide them with telecommunications access equal to that provided to hearing prisoners"); *see also* FCC Report Rates for Interstate Inmate Calling Services, 80 FR 79136-01, 2015 WL 9195269 (Dec. 18, 2015) (reaffirming "existing policy of strongly encouraging correctional facilities to provide inmates with communication disabilities with access to TTYs, as well as equipment used for advanced forms of [Telecommunications Relay Services], such as videophones" and noting that "[a]ccess to more advanced forms of TRS, including VRS . . . may be necessary to ensure equally effective telephone services for these inmates" and "strongly encourage[ing] other facilities to continue this trend voluntarily, without the need for further litigation").

[74] DHS OIG 2018 *Adelanto Management Alert, supra* note 6, at 6.

[75] 2011 Performance-Based National Detention Standards (PBNDS) Standard 4.8 at 351.

[76] 6 C.F.R. § 15.30.

[77] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *Report 16-113-VR, ICE Still Struggles to Hire and Retain Staff for Mental Health Cases in Immigration Detention at 6* (July 2016), https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VR-Jul16.pdf

[78] *See, e.g., Armstrong v. Davis*, 275 F.3d 849, 876 (9th Cir. 2001); *Pierce v. D.C.*, 128 F. Supp. 3d 250, 268-72 (D.D.C. 2015).

[79] 6 C.F.R. § 15.30(b)(1) (General prohibition on Department of Homeland Security and its agencies engaging in disability discrimination either "directly or through contractual, licensing, or other arrangements"); A*rmstrong v. Schwarzenegger*, 622 F.3d 1058, 1074 (9th Cir. 2010).

[80] *Updike v. Multnomah Cty.*, 870 F.3d 939, 954 (9th Cir. 2017) (citing *Duvall v. Cty. of Kitsap*, 260 F.3d 1124, 1139 (9th Cir. 2001)).

[81] 2011 Performance-Based National Detention Standards (PBNDS) 4.8 at 353.

[82] There is a short section in the Handbook entitled "Equal Access to Program and Services For Hearing and Visibly Impaired," containing a single sentence that is difficult to decipher: "Detainees with communication-related disabilities including activities such as seeing, hearing, speaking, reading and communicating will be provided equal access to programs and services." *Adelanto Supplemental Detainee Handbook* at 16. This matter-of-fact statement is of little use to a person with a disability who needs (and is legally entitled to) reasonable accommodations and modifications necessary to ensure equal access to programs and services.

[83] *Adelanto Supplemental Detainee Handbook* at 6.

[84] *Id.* at 32.

[85] 2011 Performance-Based National Detention Standards (PBNDS) 4.8 at 345.

[86] *Id.* at 347.

[87] *Id.* at 345; *see also* 28 C.F.R. § 35.152(b)(2) (detention facility "shall ensure that … detainees with disabilities are housed in the most integrated setting appropriate to the needs of the individuals. Unless it is appropriate to make an exception, a public entity … (iii) Shall not place . . . detainees with disabilities in facilities that do not offer the same programs as the facilities where they would otherwise be housed[.]").

[88] DHS OIG 2018 *Adelanto Management Alert, supra* note 6, at 6.

[89] 28 C.F.R. § 35.152(b)(2).

Illustration by an Artist in Immigration Detention
Adelanto Detention Center, 2018

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