Psychological Harm Imposed by Torrance County Detention Facility on Migrants in Its Custody

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Persons who seek asylum at the U.S. southern border are often in flight for their lives, having survived persecution in their countries of origin and violence from cartels they encountered en route. The only hope they can imagine is protection from a government that values human rights. This hope compels them to pursue asylum, even at great personal cost, yet the result for many is detention by U.S. Immigration and Customs Enforcement (ICE) in facilities that evoke memories of torture and trauma in their countries of origin. Our recent study of conditions at Torrance County Detention Facility (TCDF) in Estancia, New Mexico revealed these unhealthy conditions to be rampant there.

Previous Review of TCDF Mental Health Practices

In autumn, 2022, our team of mental health professionals at Humanitarian Outreach for Migrant Emotional Health (H.O.M.E.) completed a series of clinical assessments for nine persons who were then detained by TCDF and one who had been recently released. Our clinical interviews were detailed consultations that reviewed each patient's psychological symptoms, daily functioning, and emotional responses to detention. Experts at H.O.M.E. also reviewed internal health records created by TCDF health professionals employed by CoreCivic, supposedly to provide care for their detained patients. (We understand CoreCivic to be the private, for-profit operator of TCDF and the managing entity for its healthcare professionals.)

We were aghast to discover that *all* TCDF detainees our clinicians met with for mental health assessment reported a dangerous combination of suicidal ideation (suicidal thoughts) and a deep, persistent fear of disclosing those thoughts to facility staff, including mental health staff. The fear these men expressed had developed after TCDF's egregious and punitive responses to disclosure of depression and psychological trauma. Medical records we reviewed were sparse but still revealed pervasive lapses in care, harmful organizational practices, and a culture of dehumanization. At the conclusion of this dual-track review, H.O.M.E. concluded that the TCDF environment posed serious harm, and no person with any level of emotional distress should be detained there. It was alarming to learn these recommendations were ignored.

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Request for Updated Review

Approximately one year later, attorneys from Innovation Law Lab contacted H.O.M.E. again and requested mental health evaluations for several of their detained clients. In December, 2023, and January, 2024, H.O.M.E. clinicians completed ten clinical interviews with asylum seekers who were detained in TCDF or who had been recently released or deported from TCDF. As before, these were detailed clinical interviews that focused on mental health symptoms, functioning, and response to the TCDF environment.

H.O.M.E. experts also reviewed the health records maintained for each patient by TCDF and CoreCivic. As in our previous review, the most striking feature of TCDF healthcare records was their sparsity. Each record consisted of lengthy, formulated templates and minimal personalized information. Mental health records lacked key, standard components such as symptom review, diagnosis, wellness goals, treatment plan, or psychotherapy notes.

This report summarizes our findings from both primary sources (interviews and records), and it provides an analysis based on best practice and scholarly literature. Because it was revealing to complete side-by-side comparisons of H.O.M.E. clinical interview data and TCDF/CoreCivic health records for each person, we include a combined summary organized around areas of concern. Our key findings included pre-detention trauma histories, credible fear interviews that were not trauma sensitive, punitive solitary confinement, deprivation of drinking water, dehumanization, humiliation, discrimination, indefinite detention, fear of officers and staff, and non-therapeutic framing of patient needs.

Pre-Detention Trauma Histories

All ten persons H.O.M.E. clinicians interviewed reported having fled their countries of origin due to violence, with most reporting they had been targeted for political reasons or targeted by a corrupt government. Several reported being victims of violent assault and receiving repeated threats to their lives that led to their escape for what they hoped would be safety in the United States. Some reported serious physical injuries, including broken bones and loss of consciousness. They also reported sexual assault and exploitation at the hands of paramilitary groups in the places they had fled. For this reason, they expressed fear of returning to their countries of origin. One emphasized that he knew of others who had returned and been imprisoned or killed, which he is sure will be his fate as well if he is deported. Some also reported kidnapping and torture by cartel members in northern Mexico, who prey on stateless asylum seekers waiting for appointments at U.S. ports of entry. In some cases, threats of death continue into the present.

This trauma history is critical to migrants' mental health while detained because most if not all are still processing the life-threatening experiences that were deliberately inflicted on them by persons in power. Their history makes them especially vulnerable to new stressors or to triggers that prompt involuntary memories of their worst experiences.

Scholars have found that post-migration stressors such as detention can lead to a "building block effect," increasing the risk for mental illness (Neuner et al., 2004; Sidhu & Vasireddy, 2020; Song et al., 2015). Depression, anxiety, and Post-Traumatic Stress Disorder (PTSD) may persist for months or years after release from detention, and the severity of these symptoms and accompanying sadness, hopelessness, and anger are correlated with detention length (von Werthern et al., 2018). There is also emerging, high-quality evidence to suggest that migrants placed in community settings have favorable outcomes compared to those who are detained, even when both groups of study participants have similar burdens of mental health trauma prior to detention (Cleveland & Rousseau, 2013; von Werthern et al., 2018).

Neither our review of TCDF records nor our interviews with migrants offered any acknowledgement that TCDF practices strive to accommodate torture survivors. Asylum seekers are particularly vulnerable to the types of interpersonal mistreatment we heard about consistently from people detained at TCDF. Dehumanization, humiliation, aggressive mistreatment, and discrimination were all pervasive in the experiences of the men we interviewed, yet these interactions are the exact opposite of what these men need in order to heal.

Credible Fear Interviews Not Trauma-Informed

For asylum seekers, the credible fear interview (CFI) is a life-or-death event in which they are required to describe the traumatic events that forced them to flee their countries of origin. Government decisions based on this interview will determine whether the person is granted permission to apply for asylum protection, or if rejected, quickly removed to the places they fled. As mental health experts, we are regularly astounded that interviews focused on severe trauma events are often conducted without regard to trauma effects on the person's ability to tell their story.

Multiple TCDF interviewees reported irregularities during their credible fear interviews that elicited significant anxiety and continued fear that their trauma histories were neither heard nor understood. One reported that during his CFI, he was frequently interrupted and was not allowed to fully respond to questions. About halfway through, officers removed and replaced his interpreter without explanation and without restarting the process. The client fears that his first interpreter might not have understood him, and his testimony might not have been accurately recorded.

An interviewee reported that his interpreter and the officer laughed with each other several times during the interview, despite the client's attempts to describe life-threatening trauma events. More than once, he asked for clarification of the interview questions, but neither the officer nor the interpreter provided it.

Another detainee reported he was unable to disclose his torture history during the credible fear interview because he was in a cubicle, rather than a private room. He feared someone with

connections to his country of origin might overhear and report his credible fear testimony to officials there. He is frightened that his government might use his testimony as a reason to harm his mother, who remains in the country of origin, or if he is deported, that they would use it as a reason to imprison, kill, or disappear him.

Medical records for one interviewee documented his attempt to disclose to a CoreCivic mental health professional that he had not been able to tell his full story during his credible fear interview. The mental health professional refused to discuss this with the client, apparently per organizational policy.

Continuation of Punitive Solitary Confinement

In our previous report, we noted consistent, pervasive fear of solitary confinement as a punishment for the disclosure of suicidal thoughts. In 2022, H.O.M.E. interviewees describe conditions in solitary that include deprivations, humiliation, and extreme cold. Despite the cold, migrants reported that their clothing was taken and replaced with a thin gown that was open on both sides. They were given no blankets or bedding of any kind, and some reported a diet consisting only of raw carrots, raw celery, and garlic cloves. Regrettably, our interviews with current and recently released detainees revealed many of these same conditions – and sometimes worse.

One client we interviewed reported being assaulted by officers, sustaining severe injuries, and being left in solitary confinement without medical care for approximately two and a half days. His time in solitary was marked by TCDF's refusal to provide medical care, extreme cold, continuous bright lighting, and unhygienic conditions due to blood from a previously isolated migrant that remained on the walls, sink, and toilet. He was not returned to the general TCDF population but was instead swiftly removed to his country of origin, despite ongoing threats to his life there.

Two other migrants, in separate interviews with H.O.M.E. clinicians, both described being placed in solitary confinement for approximately three days, apparently as punishment for requesting drinking water. (This and other drinking water incidents are detailed below.) Both clients separately reported that while in isolation, they continued to request drinking water, but it was refused. In each case, when they resorted to drinking the water used for washing, officers laughed at them. One of the two migrants reported ongoing PTSD symptoms related to this confinement, including intrusive re-experiences of his confinement and extreme fear of TCDF officers. The second reported worsening of pre-existing trauma symptoms, coupled with a new fear of TCDF officers and intrusive rumination about his time in solitary.

An interviewee whose PTSD diagnosis has its roots in TCDF solitary confinement, reported the intermittent feeling that he is back in solitary. During these episodes, he experiences acute escalations in fear, heart and respiratory rates, and gastrointestinal distress. As a result of his confinement, he now views the world as mostly dangerous, and he identifies himself as a target for persecution.

Per internal mental health records, it appears that CoreCivic mental health professionals routinely ignore the effects of solitary confinement on their patients. At best, they may complete a short blank on a form. One such form posed the question, "Why are you in restrictive housing?" The noted response was simply "Ad-Seg" (administrative segregation). No other information was provided: no explanation for the isolation, no indication the mental health professional asked about potential psychological harm, and no therapy notes regarding any discussion of the solitary confinement experience.

As noted in our previous report, migrants have good reason to fear solitary confinement, which is associated with significant mental health deterioration, including depression, PTSD, psychosis, suicidality, and mortality (Luigi, et., 2020). Even a few days in solitary can result in sleep disorder, panic attacks, appetite disturbance, hallucinations, and increased suicidal ideation (Patler, et al., 2018). Repeated confinement worsens the psychological harm of solitary confinement, and its impacts can persist well past release from detention. These effects are widely known and were clearly delineated in our previous report, yet TCDF continues its practice of punitive solitary confinement.

Deprivation of Drinking Water and Humiliation in Response to Thirst

Lack of access to drinking water was a consistent concern among interviewees. One reported that water is not available to detainees between 10:00 a.m. and 4:00 p.m., even if they request it. Another also reported hours-long periods of water deprivation, adding, "When we say something, they tell us they don't speak Spanish." In response to their thirst, detainees collectively developed a strategy of resistance by refusing to return to their cells after recess until officers provided them with drinking water. But as noted above, for at least two detainees, this resistance was met with punitive solitary confinement, rather than water.

TCDF medical records confirmed problems related to drinking water. In the chart of a patient with kidney pain and history of kidney stones, the medical provider wrote "Patient is drinking 1-4 cups of water per day. Instructed to drink 1-2L." But there was no discussion of *why* the patient's water intake was meager or *how* the patient might accomplish the directive to drink more. In his interview with H.O.M.E., this patient reported water deprivation, humiliation, and solitary confinement in response to his attempts to access drinking water, as was medically directed.

An important concern of detained migrants is that officers frequently order them to drink from the same water they use for washing. Detainees fear the safety of this water and only drink it as a last resort. More than one detainee also reported that when they do resort to drinking from the wash water, officers laugh at them. Medical records revealed a brief note regarding a patient who requested a mental health visit to address his lack of access to water. The mental health professional wrote, "It was explained to the patient that the water in the jugs and the water from the sink was the same water." However, the mental health professional did not indicate whether he discussed the patient's safety concerns about TCDF tap water, nor whether the patient felt less safe upon learning that even his drinking water was nothing more than "water from the sink." In

fact, despite migrants' frequent and serious concerns about the lack of drinking water, there was no notation in any of the charts we reviewed as to whether TCDF tap water (or 'the water in the jugs') is potable.

It is clear that detainees do not perceive TCDF tap water as safe to drink. Furthermore, from a cultural perspective, no record indicates awareness that tap water in Central and South American countries, where most detainees are from, is rarely safe to drink and is not consumed without filtration and or boiling. Even if TCDF tap water is potable, there is no indication this was discussed with detainees, despite their frequent requests for drinking water and their willingness to risk solitary confinement for those requests.

Indefinite Detention with Life-and-Death Uncertainty

One factor critical to the psychological health of detained persons is the knowledge that their time in detention will end, and hopefully, that it will end in their protection. Persons detained for their immigration status are often given no information, despite the life-or-death consequences of decisions about their future. Scholars have labeled such practices as "the violence of uncertainty" (Grace, Bais, & Roth, 2018; Phillimore & Cheung, 2021), and this uncertainty poses psychological harm to migrants' loved ones as well (Martinez-Aranda, 2020).

Our TCDF clients described stark psychological outcomes in the wake of this silence. Many of our interviewees expressed certainty that they will be imprisoned or killed if they are deported to the places they fled. The lack of information regarding outcomes of their credible fear interview increases their fear and makes the daily stressors of detention more difficult to endure.

One detainee who met with H.O.M.E. is certain that if his asylum petition is denied, he will be imprisoned or killed in his country of origin. He now feels trapped between threats to his life – and a long, deliberate silence as to whether he will be granted protection. He finds the silent waiting period unbearable. "*Nos estan matando psicologicamente*," he said. "They are killing us psychologically."

Dehumanization, Racism, and Discrimination

Interviewees reported being "treated like animals." They note dehumanizing conditions such as punitive cold, deprivation of basic needs, solitary confinement, and officers who categorize detainees as "delinquents." They reported that officers justify poor treatment with statements such as, "you wanted to come here (U.S.), then you have to tolerate it!" They described these humiliations as "constant," and some detainees fear officers will physically assault them. Most or all interviewees reported a constant sense of humiliation.

They further reported that officers make racist insults, curse, and "flip them (detainees) off." Most TCDF officers do not speak Spanish, forcing detainees to guess what they are demanding,

yet blaming detainees for not responding as officers wanted. One interviewee reported that officers slam doors on detainees and yell at them for not understanding English.

Fear of Officers and Staff

Our interviews revealed that detainees fear TCDF officers and, in some cases, CoreCivic health professionals. One manifestation of this fear is reluctance to disclose needs. A client who reported medical conditions to his H.O.M.E. evaluator stated that he avoids reporting medical problems to staff because he fears his health information will be used to increase his detention time. Another client reported that he once requested a mental health appointment to discuss the distress of detention, but the counselor scoffed at the detainee's request, rejected his ID card, and threw it back to him. The detainee told his H.O.M.E. evaluator that he no longer feels safe with mental health staff and will no longer request appointments.

As torture survivors, many detainees experience detention as a reminder of earlier persecution by their own governments, and detention triggers their PTSD symptoms. These survivors desperately need an environment that is safe, calm, and supportive, but within the confines of TCDF, they find the opposite. For many of our interviewees, the combination of triggered trauma memories and current harm result in heightened symptoms and reduced ability to function.

One interviewee stated he is terrified of being tortured by TCDF officers. His persistent, intense distrust of staff sometimes results in panic attacks, during which he suffers intense fear of being verbally or physically assaulted. That patient's H.O.M.E. evaluator reported that her client was unable to respond to other topics without connecting them, again and again, to his deep and constant fear of TCDF officers.

In light of the assault report noted in the solitary confinement discussion above, detainees' fear of physical harm seems well-founded. The injured interviewee stated that an officer pressed his hand onto the detainee's throat, making it difficult for him to breathe. A second officer forcefully squeezed the detainee's testicles, and a third twisted his ankle enough to impair his ability to walk. He was next placed in solitary confinement (described above) and then quickly removed to his country of origin, where he feels unsafe, worries about threats to his life, and remains impacted by the trauma of detention.

When an organization tolerates serious harm, however covertly, stakeholders sense the lack of safety. Considering the gravity of the above client's assault, as well as the many abuses reported by other detained migrants, it appears the pervasive fear our clients described is warranted. The closest descriptor for their fear in the American Psychological Association (APA) diagnostic manual would be hypervigilance, generally seen as fear that remains long after a traumatic event is past (APA, 2020). Meanwhile, it may be a misnomer to label detainees' fear response as hypervigilance while they remain in danger and as a post-traumatic stress symptom when trauma and immense stressors are ongoing.

Non-Therapeutic Framing and Refusal to Address Patient Needs

A striking feature of TCDF healthcare records was their framing of the expectation that healthcare staff manage "inmates," rather than care for patients. Health records are completed on templates that were apparently designed for prisons and include references to "time served," length of sentence, and number of "incarcerations." In their brief notations, healthcare professionals, including mental health staff, acquiesce to this expectation, sometimes referring to their patients as "inmates" and appearing to base their approach to care on TCDF norms, rather than professional standards.

Medical templates include the intake question: "Are you currently experiencing any serious problems (i.e., bad news, significant loss, close friend/family committing suicide) you would like to talk to mental health staff member?" Yet when a patient attempts to speak with a mental health professional about immigration trauma, the mental health professional turns them away.

In one case, a mental health professional noted that the client expressed concern about omissions in the trauma events he had reported during his credible fear interview. Rather than assisting the client with trauma disclosure, the mental health professional determined that the client's needs were "non-mental health." The professional noted, "He was under the impression that if he needed to talk about something with someone the place to go was Mental Health. He was advised that only ICE could talk with him about immigration." In response to another template prompt, the same professional wrote, "Explained Mental Health was for mental health and could not solve non-mental health." He then labeled the patient's concern as "Ineffective coping r/t (related to) incarceration." *Ineffective coping* is a common label in these records, one that blames detainees for the trauma caused by TCDF conditions.

Refusal to discuss immigration concerns appears to be CoreCivic's policy for mental health professionals, and the professionals' notes indicate they are more in tune with those company directives than with the professional standards for ethical practice. Well-trained and empathetic mental health professionals understand that in the face of traumatic circumstances, their role is to enter their patient's frame of reference, attempt to understand it, and offer compassionate guidance. Good clinicians acknowledge their inability to solve external problems, but they discuss those problems in detail with the patient, offer treatment, and help the patient move toward mutually agreed upon personal goals.

In contrast, the apparent protocols for CoreCivic mental health professionals deny their patient's experiences, diminish their humanity, discourage them from acknowledging trauma, and fail to account for the reality that they may be forced to return to a place where they will face life-threatening circumstances.

Medical Review

Most H.O.M.E. clinicians are psychologists, clinical social workers, and professional counselors, and our primary perspective is psychological. In addition, two members of the H.O.M.E. evaluation team are Doctors of Medicine, one a psychiatrist and the other a psychiatry resident. We asked them to review the TCDF medical records from a medical perspective, and their observations are outlined below.

Non-Therapeutic Environment

- Patients frequently described feeling invalidated by staff in regard to their physical pains.

- Patients describe an environment where they feel degraded by officers who interact in an adversarial manner with detainees and who do not consistently use interpreters to communicate with detainees. This environment has culminated in physical assault, according to one detainee, including strangulation and pressure applied to his testicles; the assault has caused him lasting physical damage and impairment to his functioning. This environment of significant psychosocial and interpersonal stress is not only detrimental to emotional healing and rehabilitation, but also to physical health and wellness, as stress prompts hormonal dysregulation, which has multisystemic effects throughout the body. The detainees' experiences with solitary confinement would be expected to create a similar deleterious stress response in the body.

- This hostile environment further impedes care as patients describe struggles to share vulnerable physical and psychiatric symptoms, due to fear of being further invalidated, given inadequate care, and/or placed in solitary confinement.

- Particularly concerning are multiple reports of limited accessible drinking water throughout the day.

- Cold temperatures and bright lights at night are described by multiple patients. Such conditions increase stress by increasing physical discomfort and impairing sleep. One patient described an exacerbation of their chronic asthma due to the cold environment.

Medical Care & Documentation Often Inconsistent with Standards of Care

- Patients describe that medical care was not provided in a responsive, timely manner, even after significant injury, which standard of care indicates would have required emergency evaluation and treatment.

- Patient history, physical exams, and workup including labs and imaging are often less than would be expected for similar presenting complaints in other settings, such as

emergency departments or urgent care centers. Missing in some medical records are basic features of a clinical assessment such as describing the quality or duration of a symptom, in addition to physical exams that omit examinations relevant to the chief complaint.

- Multiple patients were instructed to increase hydration for various complaints, from asthma to flank pain, for which oral hydration is not first line treatment.

In most aspects, the findings of our medical professionals parallel the findings of our psychologists, counselors, and clinical social workers.

***Necroharm* – Community Level Trauma Based in Devaluation**

In too many cases, conditions reported by TCDF detainees are traumatic, even by the narrow definition of the American Psychiatric Association, a personal encounter with "actual or threatened death, serious injury, or sexual violence" (APA, 2022, p. 271). Denial of trauma-sensitive credible fear interviews threatens lives. Deprivation of basic needs such as drinking water, adequate food, sleep, and healthcare pose serious physical harm. Assault such as that described by one interviewee and feared by many, clearly meets the APA definition of trauma, and it can be assumed that the person whose blood was discovered on the walls, sink, and toilet of a solitary confinement cell suffered trauma as well.

In addition to suffering individual trauma, migrants detained by TCDF also face collective psychological harm that permeates the entire community. They sense that officers, like U.S. policies, are indifferent to their survival. Their lives do not matter. The clearest descriptor for this level of collective trauma is necroharm (Iliadou, 2023), shared trauma that comes from knowing one's entire community has been dehumanized to the point that no one's survival matters. It brings humiliation, abandonment, and a sense of being disposable (Wilson, Burnstan, Calderon, and Csordas, 2023). This concept contributes to understanding the psychological harm imposed by TCDF confinement. Migrants detained there recognize that their suffering exists because TCDF authorities do not value their lives.

Conclusion

As mental health professionals, our core value is wellbeing for individuals, communities, and society. Mental health best practices begin with respect for individual personhood and with ensuring that patients are in a safe and caring environment. Conversely, a threatening environment in which trauma is continuously perpetrated and patients are overtly devalued will not only preclude patients' ability to heal but will induce new trauma, significantly increase symptoms, and cause new diagnoses, even among those who had managed resilience after torture and persecution in their countries of origin.

As in 2022, the clinical interviews that H.O.M.E. mental health professionals conducted with TCDF detainees and our review of TCDF healthcare records revealed that many organizational practices are harmful and contribute to the emotional suffering and deteriorating mental health of persons in their custody. Many decisions that promote and sustain these practices are clearly at the organizational leadership level, including choice of health record templates, policies that forbid mental health discussions of immigration trauma, and organizational framing of detained persons as “inmates” or even as less than human.

At the conclusion of our previous report, H.O.M.E. recommended the release of TCDF detainees experiencing mental health symptoms to a safe and stable environment, participation in normal home and community life, and the opportunity to seek appropriate care. We are troubled that, more than one year later and even after its abusive practices were publicly revealed, TCDF has not remedied its punitive and dehumanizing culture. The TCDF organizational culture poses substantial psychological risk for *all* persons detained there and also poses risk of perpetration induced traumatic stress for staff and officers. Its failure to address abuses of the past decrease the likelihood it will do so in the future. For these reasons, H.O.M.E. recommends the release of current detainees to safe communities and the closure of the TCDF facility to prevent additional abuses.

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