March 20, 2023

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Re: Re: Relief from Torturous Conditions and Rights Violations at Torrance County Detention Facility

Ms. Murray, Mr. Thurlow, Ms. Doyle, Mr. Hedgpeth, Ms. Mateen, Ms. De Anda-Ybarra, Mr. Shaw, Mr. Tavarez, and Mr. Phillips,

On behalf of individuals currently detained at the Torrance County Detention Facility (TCDF), we write to follow up on our requests submitted to you on February 24, 2023.

Since submission of our previous letter, dire conditions and other abusive and retaliatory tactics against detained individuals persist at TCDF, in violation of law and the 2011/2016 ICE Performance-Based National Detention Standards (PBNDS). We understand that the abuses detailed in our previous correspondence and report have continued, including persistent sleep deprivation caused by CoreCivic staff turning on lights at fifteen-minute intervals throughout the night. We further understand that detained individuals’ access to water throughout the day has been restricted, sometimes for hours at a time. In addition, declining mental health conditions, negligent medical services, and retaliation by CoreCivic staff continue:

- **Harmful Mental Health Services and Repeated Suicide Attempts in TCDF:** Since our last letter, at least one additional individual detained at TCDF has attempted suicide. In response, we understand that CoreCivic staff forcibly placed the individual in solitary confinement in a “cold room” or “torture room,” as detailed in the attached recent report by *The Hill*.1 This practice has been repeatedly condemned by mental health practitioners, including in the attached November 2022 report on “Mental Health Practices in Torrance County Detention Facility,” which has been provided to DHS on multiple occasions.2 We are deeply concerned that declining mental health and problematic mental health services continue to be pervasive at TCDF, and that this latest incident is due to the same abuse and neglect at TCDF that has resulted in at least one death and five other attempted suicides over the past eight months.

- **Negligent Medical Services:** We continue to receive complaints about the quality and availability of medical care inside TCDF. We have been made aware that one detained individual remains at TCDF despite an extreme deformity on his leg that is causing him constant and extreme pain. Although ICE has deemed this individual unfit for travel and TCDF is unequipped to provide the acute medical attention required by his health condition, ICE continues to detain him at TCDF and deny his release on humanitarian grounds.

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Retaliation and Physical Assault by CoreCivic Guards: We continue to receive reports that individuals detained at TCDF are intimidated, threatened, and even physically assaulted for advocating for themselves. We have been told that individuals who speak up about issues highlighted in the February 15, 2023 report have been subjected to denial of services and accommodations, including medical care and recreational time; threatened with rescission of such services and accommodations; and even physically assaulted by CoreCivic staff. Based on these experiences, individuals have expressed that they are afraid to speak freely with advocates for fear of retaliation at TCDF. Additionally, since our last letter, one individual was physically assaulted by a CoreCivic guard in front of several other individuals in ICE custody; when these individuals collectively spoke out against the assault, they were denied access to services, accommodations, and telephonic communication, including with legal advocates and representatives among the organizational signatories of this letter. To date, ICE has not acknowledged this assault and continues to deny the individual’s release on humanitarian parole.

The undersigned have received no substantive response to our letter of February 24, 2023. To date, it is our understanding that none of our requests have been met:

1. By March 3, 2023, ICE provide written instruction to CoreCivic to cease the use of Restrictive Housing Units and other punitive responses to self-reported symptoms of suicidality that, per the PBNDS, increase the risk of unreported symptoms and suicide;
2. By March 3, 2023, DHS cease administering fear interviews at TCDF as TCDF is not equipped to provide a private and confidential setting for individuals conducting their fear interviews;
3. By March 3, 2023, DHS reissue Notices to Appear (NTAs) to all individuals currently detained at TCDF who have been subjected to the egregious due process violations described below and in the attached report, which include the administration of fear interviews over faulty phone lines in a non-private, non-confidential setting; the failure to serve credible fear interview (CFI) notes and notices of hearing on a timely basis; and the failure to ensure that limited-English proficiency (LEP) individuals are provided adequate interpretation to understand the expedited removal process and to meaningfully participate in their fear interviews; and
4. By March 3, 2023, ICE and USCIS begin a formal investigation into the violations detailed in this letter and the attached report, based on interviews with 115 men detained at TCDF from January-February 2023, including the physical conditions of the cells at TCDF.
5. By March 17, 2023, DHS provide a response outlining a plan of action for TCDF, including the disciplinary and remedial measures that may be undertaken in response to any findings of staff misconduct.
It is our understanding that approximately 400 individuals remain detained at TCDF. We remain deeply concerned that these individuals are being subjected to inhumane conditions of confinement; deprived of necessary medical and mental health care; deprived of their legal rights, including due process rights to confidential fear interviews; and retaliated against for exercising their freedom of speech. We request that you immediately remedy these abuses and violations as requested above. Please provide a written response to this letter no later than Friday, March 24, 2023, at 5 PM MST.

Sincerely,

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A series of suicide attempts reported by detainees and officials at a single New Mexico immigration detention facility are underscoring concerns about mental health treatment outcomes in the system.

Brazilian national Kelsey Vial killed himself at the Torrance County Detention Facility in Estancia, N.M., on Aug. 24, according to the official Immigration and Customs Enforcement (ICE) detainee death report.

Vial’s death came a month before a Department of Homeland Security (DHS) Office of Internal Investigations (OIG) report recommended the facility’s closure due to poor conditions.
In a complaint to federal oversight agencies, advocates with Innovation Law Lab detailed another suicide attempt at the facility on Nov. 30 based on former detainee Rafael Oliveira do Nascimento’s personal account.

Oliveira do Nascimento, also a Brazilian national, has since been released from immigration detention.

“F.,” another detainee at Torrance, which currently holds around 400 people, told The Hill he attempted suicide last month but was stopped by his fellow inmates as he climbed over a railing to jump off a ledge.

F., whose name is being withheld at his request to avoid affecting his immigration process, said the facility’s response to his attempt was to put him in isolation.

“When I was in the cell I told them, ‘Why won’t you turn off the lights?’ That they were treating me worse than el Chapo. ‘Why won’t you turn off the lights?’ and they would leave them on. ‘Why won’t you turn off the lights?’”

**Mental care in detention environments**

Craig Haney, a social psychologist and an expert on the impacts of isolation in detention, said American prisons and detention centers often use isolation as a response to inmate depression, self-harm and suicide attempts.

“This is a way to solve a short-term problem: ‘What do we do with this mentally ill detainee?’ But in a way that is very likely to be damaging to [detainees] in the long run. And that’s just not an equation that [detention centers] pay much attention to,” Haney said.

Ryan Gustin, a spokesman for CoreCivic, the private company that operates the Torrance facility for ICE, pushed back against F.’s claim.

“The safety of those entrusted to our care at [Torrance] is our number one priority. If a detainee exhibits or expresses self-harm or suicidal ideations, they are not met with punitive measures, rather they are provided with a high-level of appropriate medical and mental health care,” Gustin said.

“This includes transitioning the detainee to a cell designed with safety in mind. A thorough mental health and physical assessment is performed by our medical staff, and staff can intensively monitor the individual to ensure their safety. The individual would continue to receive monitoring and assessment no longer than necessary to mitigate the risk of imminent self-harm,” added Gustin, noting that CoreCivic uses neither the term nor the practice of “solitary confinement.”

Still, Vial’s death and the two other suicide attempts marked a turn for the worse for ICE detention generally after the agency reported no detainee suicide deaths in fiscal 2021.

That decrease followed a grim fiscal 2020, when six people died by suicide in immigration detention. In fiscal 2019, ICE registered two deaths by suicide, as well as one in fiscal 2018.
According to a 2021 study published in AIMS Public Health, a journal for peer-reviewed papers, the overall suicide rate per every 100,000 people admitted into ICE detention was 0.3 from 2010 to 2019. In 2020, that rate skyrocketed to 3.4 suicides per 100,000 admissions.

That study, authored by academics from Harvard and Stanford universities, theorized that a possible cause for the spike was “increasing lapses in mental health care in ICE detention,” based on a 2020 congressional report that found “major issues in mental health care inside detention centers” which “may result from chronic staffing shortages, as vacancy rates of 37–50% for psychiatrists and social workers have been previously reported in immigration detention.”

Though September’s OIG report praised the quality of health care at Torrance, it found understaffing in the medical office was causing an array of problems.

“In addition to several staff expressing that the low staffing levels were problematic, we observed empty watch rooms and understaffed medical units. Our medical contractors concluded that these medical unit vacancies impacted the level of care detainees received for suicide watch, dental care, and chronic care,” wrote the OIG.

And despite the OIG’s praise, detainees report bleak consequences of seeking mental health care for depression, thoughts of self-harm or suicidal ideation.

“W.,” another detainee at Torrance whose name is being withheld to avoid affecting his immigration case, relayed a harrowing experience after seeking medical help for thoughts of self-harm.

“They put me in a cold room, they took all my clothes, they only gave me a little robe and I lasted Friday, Saturday, Sunday and Monday. Four, five days there. Then they took me out of there, put me for a week in a room, in a tank by myself stuck there. I would send letters [asking] them to let me out of there, to transfer me with more people, but they didn’t want to. It was ‘no’ and all ‘no,’ that they couldn’t do anything for me and things like that.”

“I didn’t have anything to do but to cry and read the word of God and so on. And it was all very, very sad.”

While conditions like those described by W. appear cruel, they may adhere to ICE’s suicide prevention procedures.

W.’s “little robe,” for instance, was likely a “suicide smock,” a tool prescribed by ICE’s National Detention Standards manual that can be used, with or without underwear, if a medical professional determines a detainee could use regular clothing to attempt acts of self-harm.

ICE’s manual describes in detail “suicide-resistant cells,” prohibits excessive deprivations for detainees in those cells, and mandates one-to-one observation and a medical treatment plan.

Advocates, however, say the ICE manual’s regulations are often not followed.

According to a November report by Humanitarian Outreach for Migrant Emotional Health, (H.O.M.E.), which reviewed the health care records of seven Torrance detainees, the files lacked
detailed descriptions of symptoms, wellness goals, treatment plans and psychotherapy notes for interactions between patients and caregivers.

“The most striking feature of these records was their sparseness,” wrote Jenifer Wolf-Williams and Judy Iwens Eidelson, executive director and clinical adviser at H.O.M.E, respectively.

CoreCivic says its medical staff follows ICE regulations, earning Torrance’s health services accreditation from the National Commission on Correctional Health Care (NCCHC), an independent agency supported by an assortment of medical, law enforcement and corrections associations.

“All detainees have daily access to sign up for medical care, including mental health services. Our clinic is staffed with licensed, credentialed doctors, nurses and mental health professionals who contractually meet the highest standards of care as verified by multiple audits and inspections,” Gustin said.

Whether or not regulations are consistently followed in dealing with depressed or at-risk detainees, they say a perception of punitive treatment has created a culture of distrust at Torrance.

‘Critically important symptom’

Another detainee, “B.,” told The Hill that veteran detainees will advise newcomers not to seek institutional help for depression, thoughts of self-harm or suicidal ideation or risk being put into the “cold rooms” or “torture rooms.”

B. has since been deported, according to advocates — his name was withheld for fear of persecution in his home country.

“Without exception, when a detained migrant disclosed suicidal thoughts to a H.O.M.E. evaluator, they also noted their unwillingness to discuss these thoughts with [Torrance] staff, including internal healthcare professionals,” reads the H.O.M.E. report.

“Their consistent reason for hiding this critically important symptom was fear of the inevitable detention center response: solitary confinement and its associated humiliations.”

Reached for comment, Jenny Burke, a spokesperson for ICE, said first-hand accounts can provide an unreliable metric to measure whether protocol is being followed.

But Burke said ICE “is committed to ensuring that all those in its custody reside in safe, secure, and humane environments under appropriate conditions of confinement.”

“There are multiple avenues available for detainees to report allegations of substandard care or misconduct — all allegations are taken seriously as agency personnel are held to the highest standards of professional and ethical behavior. When a complaint is received, it is investigated thoroughly to ensure comprehensive standards and policies are strictly maintained and enforced,” she said.
In late February, a coalition of human rights advocates led by Innovation Law Lab, New Mexico Immigrant Law Center, Las Americas Immigrant Advocacy Center and the Santa Fe Dreamers Project delivered a letter and a report to officials within DHS, detailing the conditions described to them in conversations with more than 100 detainees at Torrance.

That report details the accounts of at least 50 men who said they had been put in the “torture rooms,” and, upon exit, isolated from their previous acquaintances and friends.

Isolation can be devastating for any individual in such a setting, but for those experiencing a mental illness, it often aggravates their existing conditions.

“It is an extra layer, and it could not be more inappropriate,” Haney said.

“In a mental hospital, for example, people are not in isolation. In fact, quite the opposite. … One of the things you do as a form of treatment for having mental health problems is engage in various forms of socialization.”

**Loss of self**

Haney added that isolation can cause or aggravate depression and lead to anxiety in detainees, including social anxiety that can make it hard for formerly isolated individuals to interact with other people, even years after the fact.

A third effect is a loss of self, which Haney compared to an experience many people had while living in lockdown during the pandemic.

“And what happens is, it destabilizes people’s identity. They can’t ground themselves and their feelings in their connectedness to other people and in the reactions that other people have to them. And it loosens people’s grip on reality. Even normal healthy people will report that they begin to wonder who they are,” Haney said.

The effects of detention and isolation are also aggravated by the uncertainty faced by non-criminal immigration detainees, according to advocates and mental health experts.

A majority of ICE detainees nationwide are not charged with a crime and do not have a criminal record, and detention times for immigration proceedings are indeterminate — detainees can remain in ICE facilities for days or years.

That uncertainty and last-minute changes to deportation plans or transfers between different detention facilities often take a toll on detainees’ mental health.

Advocates say those stress factors have existed for decades — essentially, that they are a feature, not a bug, of U.S. immigration policy.
“It’s part of an overall framework of U.S. immigration policy that is oriented around policies that are cruel and intended to, quote, unquote, ‘deter’ future migration,” said Heidi Altman, director of policy at the National Immigrant Justice Center.

“You cannot speak to one person who has gone through immigration detention, but doesn’t have the scars of dehumanizing treatment, of having been harassed by guards, of having been strip searched, of having been thrown in solitary because of their mental illness. The list goes on.”

—Updated at 11:44 a.m.
Mental Health Practices in Torrance County Detention Facility as Reported by Detainees to Humanitarian Outreach for Migrant Emotional Health (H.O.M.E.)

Jenifer Wolf-Williams, Ed.D., LPC-S, LPA  
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Judy Iwens Eidelson, Ph.D.  
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Persons seeking asylum in the United States face daunting legal hurdles and emotional challenges in overcoming the traumatic events that pushed them to leave their homes. Parents and children flee cartels that have threatened them with kidnapping, sexual violence, and death. Adults and teens struggle to escape from governments that threaten them with imprisonment and torture due to their faith or politics. Women flee violent partners in places where police will not protect them. Women and girls seek refuge from forced marriage, sexual abuse, and female genital mutilation (FGM). Yet arrival in the US often brings new traumas, including forced detention that is often re-traumatizing and can last for months or even years.

Humanitarian Outreach for Migrant Emotional Health (H.O.M.E.) is a mental health nonprofit whose licensed professionals assess and evaluate the emotional needs of persons engaged in the U.S. immigration process. In this capacity, beginning in October 2021, at the request of attorneys from nonprofit legal agencies, H.O.M.E. clinicians conducted interviews with nine persons detained at the Torrance County Detention Facility (TCDF) in Estancia, New Mexico and a tenth person who was previously detained there. Four of these interviews took place in November, 2022. H.O.M.E. experts have also reviewed the records kept by TCDF healthcare providers for seven of the 15 men still in detention at TCDF.

This document summarizes our findings and analyzes them in the light of relevant scholarly literature. Particular attention is given to (1) the tragic increased likelihood of preventable suicide deaths among persons detained in Immigration and Customs Enforcement (ICE) facilities, (2) the grievous shortfalls in TCDF suicide prevention protocols compared to evidence-based best practices, (3) detainees’ fear of solitary confinement in response to their acknowledging suicidal thoughts to TCDF healthcare staff, and (4) serious and disturbing inadequacies in the detainee mental healthcare records of TCDF providers.

Increased likelihood of preventable suicide deaths at TCDF and other ICE facilities

As survivors of life threatening events and trauma, asylum seekers are more likely to suffer from Posttraumatic Stress Disorder (PTSD) and/or depression. And while most patients with these diagnoses do not attempt suicide, associated symptoms such as hopelessness and self-blame increase this worrisome possibility. Even among non-detained migrants, separation from family, fears about those left behind, and loss of social network all create risks for suicidal behavior (Forte et al, 2018).
The increased likelihood of suicide among migrants is also tied to ICE detention. A team of researchers (Erfani, et al., 2021) from Harvard University, Stanford University, and Boston Children’s Hospital reviewed public records and found that in 2020 suicide deaths among detained migrants increased eleven times over the previous ten-year average. These researchers identified the following contributing factors: increasing lapses in mental health care in ICE detention, increased length of detention, delayed psychiatric appointments, falsified observation logs for suicide patients, and the use of solitary confinement for depressed patients.

Because these risks are well known, the heightened potential for suicide deaths in ICE detention centers is not at all surprising. And when this risk is recognized and acknowledged, preventive action can (and should) be taken (e.g., Haroz, et al., 2020).

**TCDF fails to employ effective, evidence-based suicide prevention strategies**

One example of a successful suicide prevention strategy is the World Health Organization Brief Intervention and Contact program (WHO BIC), which has been validated over several years and across many global populations. The goals of the program are to increase the survivor’s engagement with treatment, build their self-efficacy, and increase their social support (WHO, 2001). *But what our clinicians found in their interviews of TCDF detainees was exactly the opposite:*

- First, instead of promoting treatment engagement, TCDF’s practices leave detained persons terrified of engaging with ICE health professionals because they fear they will be treated punitively and placed in solitary confinement. One patient told our evaluator he was worried about disclosing his suicidal thoughts even to her, an external clinician, because of the risk that ICE staff might find out.

- Second, instead of building self-efficacy, a basic psychological need, asylum seekers at TCDF are locked away from any possibility of participating in normal home and community life. Every minute of their day and every aspect of their personal functioning is controlled by TCDF officers, making self-efficacy impossible.

- Third, instead of strengthening social support, another basic human need, TCDF detention destroys it by imprisoning vulnerable individuals in an environment where they have no contact with their loved ones or with a stable supportive community. Some detainees succeed in establishing friendships with other migrants, only to lose them through deportation or even suicide. Moreover, when a detainee confides suicidal thoughts to a staff member, TCDF responds by locking that person in solitary confinement.

In a meta-analysis of several empirical studies, Jobes and colleagues (2015) identified four common characteristics of evidence-based approaches to suicide prevention:
1. **Successful interventions help the patient recognize factors that trigger their suicide risk.** In contrast, trauma survivors detained in TCDF report that they deny their suicidality out of fear of being placed in solitary confinement.

2. **Successful interventions are collaborative.** They are implemented in a spirit of empathy and understanding, and they validate the person’s emotional state. Reports from TCDF detainees, however, describe an adversarial environment in which they are shamed and dehumanized, not only for mental health symptoms, but for exhibiting basic human needs and emotions.

3. **Successful suicide interventions inspire, and in turn draw from, the patient’s own motivations to live.** But TCDF detainees we interviewed reported increased fear, despondency, and hopelessness during their time in detention.

4. **Finally, successful interventions emphasize hope and a life worth living.** The reality for detained trauma survivors is that they know their odds of attaining immigration protection are low. Many perceive their immigration quest as a life-or-death struggle, yet each time a peer is deported or an authority figure fails to listen, their hope is diminished. Some see death by suicide as preferable to the torture and other life-threatening experiences from which they fled and to which they could be returned.

**Fear of solitary confinement among H.O.M.E. interviewees**

Without exception, when a detained migrant disclosed suicidal thoughts to a H.O.M.E. evaluator, they also noted their unwillingness to discuss these thoughts with TCDF staff, including internal healthcare professionals. Their consistent reason for hiding this critically important symptom was fear of the inevitable detention center response: solitary confinement and its associated humiliations:

One TCDF detainee told a H.O.M.E. clinician that he experienced solitary confinement as demoralizing, and his symptoms increased as a result. He feared being placed there again and therefore did not want TCDF staff to know about his suicidal thoughts.

Another patient reported he had stopped speaking with the TCDF psychiatrist out of fear of being placed in solitary confinement. Peers who had been confined there described a cell with a concrete bed and a diet limited to raw celery, carrots, and garlic cloves. Despite extreme cold, they were forced to remove all clothing except an open medical gown, and they were given no blanket. This patient’s fear of solitary confinement inhibits him from disclosing suicidal thoughts or showing negative emotions. He stated, “I avoid letting anyone see me cry. That way, they don’t suspect I’m not okay.”

A third patient confirmed the above description of conditions in solitary confinement through his own direct experience. He detailed his unsuccessful attempts to find relief from the cold, and he reported health concerns due to the inadequate diet he received in solitary confinement. He does not disclose any information to TCDF staff and stated, “No one in here tries to understand.”
A fourth patient, despite severe PTSD symptoms that began after trauma in his country of origin, reported that he avoids appointments with the TCDF psychologist or psychiatrist out of fear he will be locked in solitary confinement.

These migrants have good reason to be fearful about solitary confinement. The risk of suicide rises significantly when detained persons are subject to this debilitating form of incarceration. Extensive research on this practice shows a significant association between solitary confinement and mental health deterioration, including increased depression, PTSD, psychosis, and mortality (Luigi, et al., 2020). After only a few days in solitary confinement, detained persons may exhibit sleep disorders, panic attacks, appetite disturbance, hallucinations, and increased suicidal ideation (Patler, et al., 2018). Psychological harm from solitary confinement worsens with its extended or repeated use, and the impacts can persist well past release from detention. Yet despite these widely known effects, TCDF and other ICE facilities continue to impose solitary confinement on trauma survivors who acknowledge thoughts of suicide.

**Serious and disturbing inadequacies in the detainee mental healthcare records of TCDF providers**

Experts from H.O.M.E. reviewed internal TCDF mental healthcare records of seven detainees and found numerous troubling inadequacies. Several are described below.

**Sparse and meager healthcare records**

The most striking feature of these records was their sparsity. Mental health reports normally include:

- Detailed descriptions of the patient’s symptoms and analysis of how these symptoms do or do not indicate a mental health diagnosis.

- Wellness goals, developed in collaboration with the patient, that detail desired treatment outcomes.

- A treatment plan that describes how the goals will be achieved.

- Psychotherapy notes for every contact between patient and caregiver. It is standard for such notes to include descriptions of session content, changes in the patient’s functioning or mood, application of the treatment plan, and progress toward goals (or the lack thereof).

H.O.M.E.’s careful review of the TCDF mental health records determined that they consistently lacked these key features. Even patients placed under suicide-watch precautions had no psychotherapy notes. One detainee’s reported symptoms included auditory hallucinations (“hearing voices”) — a clear indication of the need for thorough psychiatric evaluation. Yet no such follow-up was noted. In another case, a detainee with nightmares and flashbacks was diagnosed with PTSD but the provider failed to record the nature of the precipitating trauma event — the first requirement for such a diagnosis (APA, 2022). Furthermore, the provider’s
records did not indicate any treatment plan or therapeutic counseling to address this patient’s PTSD.

**Non-therapeutic framing of patient needs**

Effective mental healthcare professionals are empathetic. They respect their patients’ expressed emotions, they acknowledge their pain, and they recognize the daunting realities of their patients’ lives. But TCDF providers described their patients’ experiences in euphemistic terms that minimized the extent of their suffering, and they assigned blame to patients for traumatic circumstances over which they had no control. For example:

- A patient’s physical pain was described as “impaired comfort.”
- A patient who reported extreme fear of being deported was described as displaying “ineffective coping.”
- A patient who reported intense fear of forced removal to his country of origin was told to “think positively” and “be grateful for what he has.”

These approaches deny the patient’s experience, diminish his humanity, discourage him from acknowledging his trauma, and fail to account for the reality that he may be forced to return to a place where he was tortured or faced other life-threatening circumstances.

**Conclusion**

The clinical interviews that H.O.M.E. mental health professionals conducted with TCDF detainees and our review of TCDF healthcare records revealed serious, sometimes life-threatening, lapses in care. Furthermore, they revealed that TCDF practices stand in stark contradiction to evidence-based recommendations by mental health experts while contributing to the emotional suffering and deteriorating mental health of detainees in their custody.

Best practices for mental health care in general and for suicide prevention in particular begin with placing patients in a safe and caring community. For example, recovery from PTSD requires that a patient develop a sense of safety and security. When the patient remains in an adverse or threatening environment, this crucial step toward healing is not possible.

It is therefore clear that the most appropriate approach to the care of TCDF detainees experiencing mental health-related symptoms is release to a safe and stable environment, participation in normal home and community life, and the opportunity to seek appropriate care.
References


