NATIONAL IMMIGRANT JUSTICE CENTER

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**Testimony of**
**Mary Meg McCarthy, Executive Director**
**National Immigrant Justice Center**
**Before the**
**Hearing of the U.S. House of Representatives Judiciary Committee**
**Subcommittee on Immigration, Citizenship, Refugees,**
**Border Security & International Law**
**Hearing on Problems with Immigration Detainee Medical Care**
**June 4, 2008**

## I. Introduction

Thank you, Madame Chairwoman and members of the Subcommittee. My name is Mary Meg McCarthy. I have served as Executive Director of the National Immigrant Justice Center, a program of Heartland Alliance for Human Needs & Human Rights, for 10 years. Prior to joining the organization, I represented asylum seekers as a *pro bono* attorney. I am grateful for the opportunity to testify in support of the Detainee Basic Medical Care Act of 2008.

Madame Chairwoman and members of the Subcommittee, medical care for people who are detained in this country is in critical condition. It is but one symptom of a dysfunctional immigration system.

This afternoon, I would like to provide a brief overview of the broken health care system for immigrant detainees, detail examples of the battles fought by the National Immigrant Justice Center to obtain health care and urgent treatment for immigrants in detention, and make recommendations for reform. The Detainee Basic Medical Care Act will greatly improve the quality and delivery of care to detained asylum seekers and other men and women in administrative detention. In addition to this critical function, it will remove the veil of secrecy that shrouds the deeply flawed immigration detention system.

The National Immigrant Justice Center, or NIJC, is a legal aid organization based in Chicago. In addition to direct service, NIJC litigates in the federal courts and advocates

for systemic reform with policy makers. NIJC and its *pro bono* partners provide legal representation to approximately 8,000 individuals annually, including low-income immigrants, refugees, victims of human trafficking, unaccompanied minors, and asylum seekers. During the past 25 years, NIJC has developed the largest network of *pro bono* attorneys in the United States, totaling more than 1,000 attorneys from leading law firms.

Throughout most of the nation, the U.S. Immigration and Customs Enforcement, or ICE, contracts with local county jails to detain non-citizens held in administrative custody. Many of these facilities are located in remote rural areas, far from immigration lawyers and social service providers. Strict secrecy regarding the disclosure of information regarding administrative detainees keeps them further isolated.

NIJC regularly visits the Illinois and Wisconsin county jails under contract with ICE to offer legal rights orientations, conduct individual intake, and accept cases for representation of non-citizens held in ICE custody. Immigration detention is administrative, not criminal, in nature. Unlike individuals held in criminal detention, immigrants in administrative custody have no right to court-appointed counsel. Despite the best efforts of NIJC and other legal aid organizations, only about ten percent of detainees obtain sufficient legal counsel.[1] Thus, legal rights presentations are often the only opportunity for detained immigrants and asylum seekers to gain an understanding of their legal rights and the available avenues for complaint and redress.

The government has broad authority to decide who is detained and for what duration, with little oversight and virtually no checks-and-balances. As a result, the system is arbitrary and lacks transparency. NIJC's direct representation of detained clients and its regular presence in the jails gives it a unique, insider's perspective on ICE's persistent failure to provide basic health care, respond to urgent needs, conduct vigorous oversight, and take corrective action. Despite this insight, much of the data obtained by NIJC related to detention conditions is garnered through requests under the Freedom of Information Act and federal litigation.

The medical staff and guards at ICE contract facilities have proven to be more open to communication with advocates and service providers than the federal agencies. In 2003-04, NIJC conducted a program under which it educated jail staff on the medical and mental health needs of the immigrant detainee population, and trained them to better understand the unique and often tragic experiences of asylum seekers, torture survivors, and victims of domestic violence in immigration detention. This project, which was implemented in Illinois, Michigan, and Wisconsin, was well received by medical staff and guards at the jails, who welcomed information on areas of medicine in which they

[1] According to the *Washington Post's* recent series on health care in immigration detention, only one in ten detained immigrants have legal representation. Dana Priest and Amy Goldstein, "As Tighter Immigration Policies Strain Federal Agencies, The Detainees in Their Care Often Pay a Heavy Cost," *Washington Post*, May 11, 2008. In fiscal year 2006, only 48% of *all* non-citizens were represented by counsel in immigration court proceedings. United States Department of Justice, Executive Office for Immigration Review, FY 2006 Statistical Year Book, G1 (2007).

were unfamiliar, such as tropical medicine and infectious diseases. The project also addressed practical issues, such as conducting medical exams through interpreters. Throughout this project, NIJC staff tried to work with the Division of Immigration Health Services (DIHS) to share our findings and seek its involvement, but to no avail. DIHS all but ignored our attempts to collaborate and improve conditions for these men and women.

## II. Overview of the Broken Health Care System for ICE Detainees

The use of administrative detention for non-citizens has skyrocketed during the past 12 years. In 1996, the U.S. government had a daily immigration detention capacity of 8,279 beds. By 2006, that number had increased to 27,500, with funds appropriated for future expansion.[2] In fiscal year 2007, more than 322,000 non-citizens were held in immigration detention facilities, [3] with a daily average of approximately 33,000 detainees. According to ICE officials, approximately 350 facilities that hold immigrant detainees operate under Intergovernmental Service Agreements (IGSAs). An additional eight service processing centers (SPCs) are owned and operated by ICE, and seven contract detention facilities (CDFs) are operated by private contractors such as Corrections Corporation of America or the GEO Group.[4] Most of the IGSA facilities are county jails that were not designed to hold a civil detainee population for what can be months or years.

The May 2008 reports by "60 Minutes," *The New York Times,* and *The Washington Post* revealed the shockingly sub-standard conditions under which many asylum seekers and other non-citizens are held in federal custody. Eighty-three immigrants have died in custody in the past five years.[5] Countless others have suffered immeasurably while they or their loved one begged ICE to provide care. The press has done an admirable job of educating the public and policy makers on the sorry state of this system. Sadly, these reports were not news to many advocates. In NIJC's extensive experience, immigration detainees frequently have to fight to obtain basic medical care and treatment for life-threatening conditions. Many never receive care, especially those with limited English language fluency and no legal representation.

ICE detention facilities are governed by the ICE Detention Standards, which were negotiated between the Immigration and Naturalization Service (INS) and the American Bar Association, to apply to facilities that hold non-citizens in ICE custody for 72 hours or more. ICE adopted these standards when it succeeded the INS, but it has steadfastly refused to codify the standards in statute or regulation, leaving the standards legally

[2] Jorge Bustamante, Report of the United Nations Special Rapporteur on the Human Rights of Migrants, Mission to the United States of America, A/HRC/7/12/Add.2, 5 March 2008, at 11.
[3] Testimony of Gary Mead, before the House Subcommittee on Immigration, Hearing on "Problems with ICE Interrogation, Detention, and Removal Procedures," February 13, 2008.
[4] For a list of CDFs and SPCs, *see* "Semiannual Report on Compliance with ICE National Detention Standards January – June 2007," U.S. Immigration and Customs Enforcement Office of Detention & Removal (released May 2008).
[5] Dana Priest and Amy Goldstein, "System of Neglect," *Washington Post*, May 11, 2008.

unenforceable. This is a fundamental point. Immigrant detainees and their advocates have little recourse when the government refuses to enforce its own rules.

While ICE touts its expenditure of funds on immigrant health care,[6] as described below, only a few DIHS nurses decide whether or not to authorize the thousands of requests for treatment that are submitted by on-site medical care staff in these jails.

## III. Domestic and International Human Rights Law Requires Adequate Health Care

The United States is a nation that values liberty and respects the rule of law. We do not deprive individuals of liberty without due process of law, regardless of their nationality or alienage. Our due process protections include the right to humane treatment while in custody. Of course, people in immigration detention are in administrative, not criminal custody. Many have no criminal record whatsoever, having arrived on our shores seeking asylum or protection from torture. Others have committed only minor civil infractions and have no serious or violent history. As a result, our immigration detention facilities are filled to a significant degree with immigrants who pose no threat to our communities and who should be released on parole, into secure alternative programs, or under orders of supervision.

A host of constitutional principles and international laws govern the treatment of individuals in custody. All individuals in this country — regardless of their legal status — are protected by the Eighth Amendment (made applicable to the states by the Fourteenth Amendment), which prohibits cruel and unusual punishment. International human rights law also requires that all individuals in custody be treated humanely, regardless of citizenship status. For example, Article 10 of the International Covenant on Civil and Political Rights (ICCPR) states that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."[7] Torture and cruel, inhuman, and degrading treatment are outlawed by the Universal Declaration of Human Rights (UDHR)[8] and the Convention Against Torture (CAT).[9] The ICCPR and CAT were both ratified by the United States; the UDHR is accepted as universal law. In addition, United Nations guidelines call for non-discrimination while in custody, prompt medical care and attention, access to hygiene and sanitary conditions, and health care that meets national and community standards.[10]

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[6] ICE has stated that it spent nearly $100 million in fiscal year 2007 on medical care for detainees. ICE Statement for the Washington Post, May 7, 2008, *available at* www.ice.gov/pi/detainee_health_wash_post_statement.htm.

[7] International Covenant on Civil and Political Rights art. 10, December 19, 1966, 99 U.N.T.S. 171.

[8] Universal Declaration of Human Rights art. 5, December 10, 1948, U.N.G.A. res. 217 A(III).

[9] Convention against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment arts. 2 and 16, December 10, 1984, 1465 U.N.T.S. 85.

[10] *See*, e.g., United Nations Standard Minimum Rules for the Treatment of Prisoners, May 13, 1977, Economic and Social Council res. 2076 (LXII); Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (No. 49) at 298, U.N. Doc. A/43/49 (1988).

The United Nations High Commissioner's Guidelines on Applicable Criteria and Standards Relating to the Detention of Asylum Seekers call the detention of asylum seekers "inherently undesirable."[11] The Guidelines recognize that there may be circumstances in which detention of asylum seekers becomes necessary. [12] However, in those situations the Guidelines are unambiguous: "Conditions of detention for asylum seekers should be humane with respect shown for the inherent dignity of the person." The Guidelines state that "the permissible exceptions to the rule that detention should normally be avoided must be prescribed by law."[13]

Due process also affords detained non-citizens the right to counsel, which has proven to be a near prerequisite to obtaining basic health care in immigration detention. However, rights are meaningless if they cannot be effectuated by the individuals they are meant to protect. Because non-citizens in custody are not provided counsel (although they are entitled to it), the right to adequate health care is a battle that many are left to fight on their own from remote and isolated detention facilities, a battle not often won.

## IV. DIHS Policies Violate Applicable Laws and ICE's Own Detention Standards

The ICE Detention Standard on Medical Care, while far from perfect, requires that, "All detainees shall have access to medical services that promote detainee health and general well-being."[14] But because the standard is not enforceable, it remains, in effect, "aspirational." Unfortunately, the policy that seems to exercise greater influence over provision of medical care to ICE detainees is implemented by the Division of Immigration Health Services (DIHS) in Washington, D.C.

As a matter of policy, DIHS errs on the side of refusing treatment to people who need care. The results are dangerous for detainees and frustrating to many jailers. In fact, the Deputy Warden of York County Prison in York, Pennsylvania, where federal immigration officials have held detainees for years, famously wrote to the local ICE office that DIHS had "set up an elaborate system that is primarily interested in delaying and/or denying medical care to detainees."[15]

In fact, the DIHS mission statement is contradictory to provisions of the ICE Detention Standard on Medical Care, which provides for at least basic medical care for the duration

[11] "UNHCR Revised Guidelines on Applicable Criteria and Standards Relating to the Detention of Asylum Seekers," United Nations High Commissioner for Refugees (February 1999), Geneva, *available at* http://www.unhcr.org.au/pdfs/detentionguidelines.pdf. Although UNHCR's guidelines are not binding, they represent how UNHCR, the agency charged with supervising the application of the Refugee Convention, believes asylum seekers should be treated.
[12] *Id*.
[13] *Id*.
[14] *See* ICE Detention Standard on Medical Care, section I, *available at* http://www.ice.gov/doclib/partners/dro/opsmanual/medical.pdf.
[15] Letter from Roger Thomas, Deputy Warden, York County Prison, to Joe Sallemi, D.A.D.D., ICE, regarding DIHS, dated November 28, 2005, at p. 3.

of detention. DIHS provides health services only for emergency care, defined as a "condition that is threatening to life, limb, hearing or sight." In short, the DIHS mission, as revealed in a document obtained by *The Washington Post,* is to keep the detainee "medically ready" for deportation.[16] This view was reiterated by Mr. Gary Mead, Acting Director of ICE Detention and Removal Operations, who questioned whether care was necessary as long as the detainee was "medically capable" of being removed.[17]

Another significant barrier to obtaining health care is the fact that requests for treatment that are made by medical personnel on-site in the jails must be submitted to off-site DIHS Managed Care Coordinators (MCCs). These are three nurses, not doctors, who are based in Washington, D.C. These three MCC nurses currently receive and review the medical requests submitted by on-site staff in the jails, effectively serving all 33,000 individuals currently in ICE custody across the nation.[18] According to *The Washington Post*, in one recent month, the MCCs received 3,000 requests for care.[19] Working five days per week, at this rate, each of the three MCC nurses would have to review and respond to approximately 50 requests per day.

In a press conference on May 21, 2008, Chairwoman Lofgren described changes to DIHS policy that raise additional concerns about the quality of medical care provided under this system. Apparently, until 2007 an MCC nurse had the authority to approve requested medical care, but not to deny it. Cases that an MCC recommended for denial had to be reviewed by the Medical Director. As Chairwoman Lofgren described, a policy change now allows denial of requested treatment to be issued by the MCCs without review by the Medical Director. As a result, off-site nurses may deny care that was requested by on-site jail medical personnel — potentially endangering lives, and doing so with little to no oversight by doctors.

Chairwoman Lofgren described another change to DIHS policy that we find alarming. DIHS previously allowed on-site physicians or medical personnel in the ICE facilities to effectively appeal a denial of treatment by asking that the request be reviewed by three DIHS physicians, not including the Medical Director who may have previously authorized denial of treatment. While not fully independent, this process at least allowed for review by additional physicians. Chairwoman Lofgren's comments in the May 21 press conference suggest that this process has been replaced with a grievance process that no longer permits independent or even quasi-independent review.

Vigorous oversight by Congress and independent investigators must be conducted to measure the impact of these policy shifts with regard to the fairness of detainee access to treatment and the well-being of detainees. The Detainee Basic Medical Care Act corrects some of these problems by mandating that treatment decisions are based solely on

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[16] Dana Priest and Amy Goldstein, "System of Neglect," *Washington Post*, May 11, 2008.
[17] Transcript of *The Diane Rehm Show*, "Medical Care of Detained Immigrants," WAMU Radio 88.5 FM, (a National Public Radio affiliate in Washington, D.C), May 13, 2008, *available at* www.wamu.org.
[18] We understand that previously a fourth nurse reviewed requests from hospitalized detainees across the nation, but that such requests are now spread among the three remaining staff. *See*, e.g., http://www.icehealth.org/ManagedCare/ManagedCare.shtm.
[19] Dana Priest and Amy Goldstein, "In Custody, In Pain," *Washington Post*, May 12, 2008.

professional clinical judgments and by mandating the continuity of care. These ensure that immigrant detainees are able to consistently obtain prescribed medicine that they were administered prior to entering ICE custody. Finally, the bill's establishment of an administrative appeals process for denials of medical or mental health care will help to correct the dangerous DIHS policy that is in place today.

## V. NIJC's Clients Have Been Routinely Denied Adequate Health Care

We all know that policies have consequences for real people. Policies that are carried out with a callous disregard for humane treatment, medical ethics, and international human rights standards lead to the horrific stories you have heard today and read in recent national press coverage.

I would like to describe briefly several specific cases that reflect the persistent problems I have seen over a dozen years.[20] The stories of these men and women illustrate the urgent need for systemic reform of the immigration detention health system to improve screening, comprehensive medical and mental health evaluations, access to medical records, and response to urgent treatment requests. Many of these problems can be addressed through enactment of the Detainee Basic Medical Care Act.

### A. Inadequate Screening

Inadequate screening can fail to catch obvious medical conditions, including advanced stages of pregnancy, kidney stones, suicidal tendencies, and infectious disease. Early in my tenure at the National Immigrant Justice Center, a woman held in a county jail under contract to the INS, ICE's predecessor agency, gave birth in a jail bathroom. The INS and jail staff did not know she was pregnant. Granted, this case occurred several years ago, but little has changed. The same detention standards that were adopted by the INS in 2000 are still in place and frequently violated.

NIJC represented an Afghan asylum seeker who was detained for more than eight months in a county jail in Wisconsin. He developed kidney stones and saw the jail nursing staff repeatedly. On rare occasions, he was provided with Tylenol or ibuprofen. It took the intervention of an attorney at NIJC to obtain medical tests to diagnose his serious condition. Then, this asylum seeker was transferred to another facility unexpectedly, before the test results were available.

NIJC also represented a West African asylum seeker who suffered immeasurable harm after being kidnapped by soldiers and held for six months as a sex slave and laborer. She finally escaped her captors and reached the United States, where she was detained in a Detroit area jail. Even though she was an asylum seeker, she was held with the criminal population. She was unable to obtain adequate medical screening or access to health care, despite the fact that she suffered from pelvic pain and bleeding as a result of the torture she endured in captivity. After extensive negotiations with NIJC, the government

[20] To protect client confidentiality, most of these cases are described without using the client's name. NIJC will provide this information to the Committee upon request and with client permission.

agreed to release her. NIJC arranged for her to obtain the medical and mental health counseling she desperately needed. She eventually won asylum.

In yet another case, a female client of NIJC exhibited signs of malaria that were not recognized by jail medical staff. The woman, an asylum seeker from Rwanda, recognized the symptoms and asked for medical care. She was provided with aspirin by the jail's medical staff. NIJC attorneys intervened and educated the jail physician, who had no experience or knowledge of tropical diseases. Malaria is easily treated, but can be fatal if misidentified or treated incorrectly. NIJC eventually convinced the government to release our client.

The Detainee Basic Medical Care Act requires that each immigrant in ICE custody receive a comprehensive medical and mental health screening upon arrival at a facility, and a comprehensive examination within 14 days of arrival. It also requires that appropriate personnel have access to medical records, an important step to ensuring proper diagnosis, prescriptions, and treatment.

### B. Inadequate Treatment and Deaths in Detention

In 2005, an Algerian asylum seeker, Hassiba Belbachir was detained at McHenry County Jail in Woodstock, Illinois.[21] According to the complaint filed in a civil rights and wrongful death suit brought by her estate, on March 13, 2005, Ms. Belbachir, who suffered from severe depression and panic attacks, told a nurse of her desire to take her own life. The next day, she saw a social worker and again expressed her suicidal feelings. The social worker recommended she see a psychiatrist. But rather than scheduling an emergency appointment, the nurse placed her on a list to see the psychiatrist at his routine weekly jail visit a full four days later. Ms. Belbachir committed suicide before she had an opportunity to see the psychiatrist. To make the situation even more tragic, on the day of her death, jail staff saw her lifeless body motionless on the floor of her cell in the medical pod, but did not intervene for 40 minutes, when they finally called for emergency service. By the time jail staff entered her cell, it was far too late. Her face was purple. The jail-issued knee socks knotted together and wrapped around her neck had asphyxiated her.[22]

Significantly, ICE authorities knew from annual inspections, before Ms. Belbachir's death, that McHenry County Jail had a history of failing to provide adequate mental health and suicide screenings to ICE detainees, maintained no adequate written suicide prevention policy, and failed to adequately train staff to prevent suicides. Even so, according to the Belbachir complaint, ICE authorities did not enforce the Detention Standards until after Ms. Belbachir's death.[23] Further, no one charged with overseeing

[21] The case of Hassiba Belbachir is discussed publicly because it is the subject of federal litigation. In addition, the attorneys for the Belbachir estate authorized the use of her name in this testimony
[22] Amended Complaint of the Estate of Hassiba Belbachir v. County of McHenry et al, Case 1:06-cv-01392, Filed Nov. 9, 2007 (N.D.Ill.)
[23] *Id*.

her custody and care was disciplined in any matter related to this gross failure of medical and mental health care and supervision.[24]

Such tragic and preventable cases call into question ICE's ability to monitor its facilities and conduct adequate, much less vigorous, oversight of its own operations. The Detainee Basic Medical Care Act requires ICE to report any death in detention to the Offices of the Inspector General of the Department of Homeland Security and Department of Justice within 48 hours. It also mandates reporting to Congressional oversight committees. These are critical measures long overdue. Only with greater transparency will we achieve accountability.

### C. Failure to Transfer Medical Records When Detainees are Moved is a Persistent and Dangerous Problem

Over the lifespan of NIJC's project to educate health care practitioners in Midwestern facilities holding ICE detainees, NIJC spoke to dozens of jail staff and asked about their experience treating detainees. A common complaint from these nurses and other personnel included widespread failure to receive medical records when detainees were transferred from one ICE facility to another. In fact, in no case did a jail guard or medical professional tell NIJC that medical records were transferred to a new facility with an incoming detainee, despite the requirement in the ICE Detention Standards that records be transferred with each detainee.[25]

## VI. In Its Haste to Deport Non-Citizens, ICE Cuts Corners and Makes Rash Decisions that Have the Potential to Expose the Public to Health Risks

Last year, NIJC helped an African immigrant with infectious tuberculosis and AIDS seek much-needed medical treatment. This man was previously detained, but ICE released him on an order of supervision when it discovered he was HIV-positive. He was later diagnosed with AIDS. NIJC filed a motion for a stay of removal and expended extraordinary efforts to notify senior ICE officials that deportation would be inhumane in this case and could create a public health risk. The man was nonetheless put on a plane to Africa, an action that may have exposed other passengers to his infectious tuberculosis. NIJC strongly urges Congress to enact, and ICE to adopt, the provisions in the Detainee Basic Medical Care Act regarding continuity of care and development of discharge plans. As this case makes clear, such steps are not only critical for detainee health but also influence public safety.

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[24] *Id*.

[25] *See* ICE Detention Standard on Medical Care, section III.N., "Transfer and Release of Detainees," which states, "When a detainee is transferred to another detention facility, the detainee's medical records, or copies, will be transferred with the detainee." This standard was issued by the INS on September 20, 2000 and adopted by ICE along with the other Detention Standards when it succeeded the INS.

## VII. For Detainees Without Attorneys, Seeking Medical Attention Can be a Fruitless Quest

ICE, DIHS, and congressional oversight committees must recognize that due to a chronic lack of legal counsel, most detained immigrants never know of their right to health care, much less how to exercise that right. When they do request treatment or complain about a lack of adequate care, detainees face insurmountable procedural obstacles and an accountability vacuum. A lack of transparency regarding who is detained, where, and for what purposes keeps claims related to health care and detention conditions beyond the reach of legal service providers and out of public view. Most of the stories you heard today have pierced the veil only because a lawyer, a social service provider, a volunteer with a religious organization, or a family member fought to hold the government accountable for the treatment of a particular individual in its custody. Like the cases revealed by Freedom of Information Act requests and the recent reports from *The New York Times* and the *Washington Post* cited above, they are powerful anecdotes that suggest broader violations.

NIJC legal staff members routinely advocate for clients who need medical care and who cannot obtain it in ICE detention. Complaints about access to medical care are a constant theme in our conversations with detained immigrants. These grievances range from the denial of over-the-counter pain medication to a refusal to provide life-sustaining medication for chronic illnesses. In addition to general medical conditions, NIJC has fought on behalf of asylum seekers who have been denied treatment for injuries sustained from the torture and the persecution from which they have sought refuge in the United States. Without an attorney or an advocate, these individuals would never have received appropriate care. How many other detained individuals are being denied critical medical care? How can we balance the use of detention with the humane treatment of detainees?

Considering alternatives to detention would be a good start. It is inhumane to detain asylum seekers and other immigrants who have experienced trauma or other severe medical conditions. Alternatives to detention through non-governmental and private entities are proven to be secure and effective. Under these programs, an immigrant in removal proceedings is released to participate in an "enhanced supervision" program that requires regular check-ins with a caseworker, or in some cases, the use of an electronic ankle bracelet. Alternatives are less expensive than ICE detention, which averages approximately $95 dollars per day. Alternatives also provide a wider array of medical and mental health care options. The Detainee Basic Medical Care Act recognizes this humane and common sense approach by prioritizing the parole or bond of immigration detainees who have serious medical or mental health conditions.

## VIII. Conclusion

ICE and DIHS must provide screenings to all detainees in a timely manner and make decisions about treatment based on medical conditions, and <u>not</u> on the individual's immigration status. Providing adequate medical care is part of a broad range of detention conditions that the government must monitor and for which it must be accountable.

Accordingly, decisions about health care must be made by on-site attending medical professionals, and not by a team of bureaucrats in Washington, D.C. An appeals process must be established for the review of request denials from detainees by on-site medical professionals in detention facilities. The medical and mental health requirements, appeal process for denial of care, and increased oversight in the Detainee Basic Medical Care Act will facilitate care for all detained immigrants. In many cases, alternatives to detention may be both the most humanitarian and fiscally responsible actions.

Like any other area of government responsibility, where lives hang in the balance, maintaining humane detention conditions will depend upon oversight, transparency and accountability.

Thank you for the opportunity to testify today. I request that my full statement be made part of the record and would be pleased to answer your questions.