

NATIONAL IMMIGRANT JUSTICE CENTER

A HEARTLAND ALLIANCE PROGRAM

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RE: Request for investigation into inadequate mental health services, treatment, and accommodations, including improper use of solitary confinement, in ICE detention

Dear CRCL Officer Culliton-González:

The National Immigrant Justice Center (NIJC) files this complaint on behalf of three individuals formerly detained by Immigration and Customs Enforcement (ICE) and on behalf of the thousands of individuals facing mental health illness and challenges while in ICE custody. We urge CRCL to investigate system-wide abuses and deficiencies in the treatment and care of individuals with mental health challenges in ICE custody.

The endemic nature of these deficiencies are evidenced in this complaint by: the declaration of three individuals recently released from three different ICE detention facilities – Angela Osorio, Edwin Silva, and Jefferson Estime; the declarations of three medical professionals with extensive experience working within the immigration detention system – Dr. William Weber, Dr. Altaf Saadi, and Dr. James Recht, who have all conducted medical and psychological evaluations for individuals in immigration detention; and the extensive body of literature documenting abuse and mistreatment of mentally ill and disabled individuals in ICE detention, described below.

Throughout this cover letter, we identify four patterns of neglect or abuse apparent throughout Ms. Osorio, Mr. Silva and Mr. Estime’s experiences and in existing literature: 1) delayed care or unanswered requests for care; 2) neglectful and improper mental health treatment; 3) egregious psychological and medical understaffing system-wide; and 4) the continued, flagrant use of solitary confinement. This cover letter also identifies the ways in which ICE’s conduct violates its own civil detention standards.

The harmful consequences of immigration detention on a person’s mental health have been extensively documented over the last decade.¹ For asylum seekers fleeing violence or persecution who have already suffered prior trauma, the stress uniquely associated with being in detention further intensifies and exacerbates the impact of that trauma.² The effects are similarly pernicious for individuals in ICE detention with pre-existing mental health disabilities such as bipolar affective disorder, post-traumatic stress disorder (PTSD), and anxiety disorders, among others. Despite mounting evidence of the damaging impact of immigration detention on individuals’ mental health—particularly those with existing mental illness—ICE continues detaining immigrants at alarming rates.

Worse still, ICE has failed to respond or take corrective action despite being on repeated notice of the inadequate, and at times life-threatening, failures of mental health care services within its detention system. A 2019 memorandum from the Office of Civil Rights and Civil Liberties (CRCL) to the then Deputy Director of ICE delineated over fifteen complaints alleging that ICE Health Service Corps (IHSC) was systematically providing inadequate medical and mental health care and oversight to people in immigration detention facilities throughout the U.S.³ The memo describes ICE’s lack of psychiatric monitoring as a cause of the mental health deterioration of many detained individuals.⁴ Three years later, and despite numerous subsequent reports of similar harms, ICE does not appear to have remediated any of the problems identified in the memo.

Based on the totality of the evidence presented here, we urge you to initiate an investigation into ICE’s provision of mental health care to people in its custody, including the improper use of solitary confinement.

I. Requests for Mental Health Care Are Delayed or Unanswered

Significant delays in providing mental health services and treatment—or in some instances the outright denial of such care—are pervasive across ICE detention facilities. Delay or denial leaves individuals in anguish and aggravates symptoms for those with pre-existing or emerging mental health disabilities.

¹ M. von Werthern et al. 2018. “The Impact of Immigration Detention on Mental Health: A Systematic Review,” *BMC Psychiatry* 18, (1): 382. <https://doi.org/10.1186/s12888-018-1945-y>. Additionally, many of the same systematic issues alleged here are described in the *Fraihat v. ICE* litigation where plaintiffs allege endemic failure by the government to provide detained immigrants with appropriate medical and mental health care and ICE’s punitive use of segregation. Civil Rights Education and Enforcement Center. “*Fraihat v. ICE and DHS*.” <https://creeclaw.org/case/fraihat-v-immigration-and-customs-enforcement/>.

² Altaf Saadi et al. 2020. “Understanding US Immigration Detention: Reaffirming Rights and Addressing Social-Structural Determinants of Health,” *Health and Human Rights* 22, (1): 187–97. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7348446/>.

³ Cameron P. Quinn and Marc Pachon. Memorandum to Ronald Vitiello and Michael P. Davis. March 20, 2019, “ICE Health Service Corps (IHSC) Medical/Mental Health Care and Oversight Complaint,” Office for Civil Rights and Civil Liberties. <https://s3.documentcloud.org/documents/6575024/ICE-Whistleblower-Report.pdf>.

⁴ *Id.*

When Ms. Osorio was detained at the Chase County Detention Center in Kansas, she waited for two months before seeing a mental health provider despite enduring significant symptoms of clinical depression because the facility didn't have on-site mental health services. When she finally did see a provider, the call was conducted over Zoom. She requested a follow-up appointment, but the request went unanswered.⁵

Similarly, Mr. Silva describes that it usually took up to a month to get mental health appointments in ICE custody at the Dodge County Jail in Wisconsin. Prior to his detention, Mr. Silva had been diagnosed with bipolar disorder, and when he informed the Dodge County staff and requested medication, the staff told him they would need to first confirm his diagnosis with the doctor who treated Mr. Silva prior to his detention. But neither the jail nor ICE ever did this follow up. As a result, Mr. Silva spent the duration of his detention—more than four months—unmedicated.⁶ In Mr. Estime's case, the Clay County Jail in Indiana failed entirely to provide him with the medication he needed for his diagnosed depression and bipolar disorder, for the full duration of his detention there.⁷

Ms. Osorio, Mr. Silva, and Mr. Estime's experiences are indicative of significant delays and failures to respond to requests for treatment in ICE detention facilities nationwide. For example, a 2017 report by Human Rights Watch documented significant delays in mental health treatment in the Eloy Detention Center in Arizona.⁸ In one case, a detained woman resorted to self-cutting and self-harm when she was denied access to the facility's psychiatrist despite having reported to the facility a mental health crisis.⁹ Even after she harmed herself, it was four days until she was finally able to see a psychiatrist.¹⁰

Similarly, a 2019 Human Rights First report documented a pattern of delayed responses and denials to requests for psychiatric care across three New Jersey facilities. According to the report, ICE failed to conduct basic mental health screenings during its intake process and ignored requests for psychiatric care made by individuals in their initial interviews with the agency.¹¹ In one case, a facility denied medication to a U.S. veteran diagnosed with PTSD, triggering flashbacks and other painful symptoms he subsequently experienced in response to loud noises in the facility.¹²

Another investigative report by Disability Rights California revealed the same pattern of delay in one of the largest facilities in the U.S.—the Adelanto Detention Facility in California. The report cites several cases in which ICE failed to provide necessary psychiatric medications for several days at a time. One

⁵ See appendix A at ¶ 10, Declaration of Angela Osorio.

⁶ See appendix B at ¶ 4, Declaration of Edwin Silva.

⁷ See appendix C at ¶ 6, Declaration of Jefferson Estime.

⁸ "Systemic Indifference: Dangerous & Substandard Medical Care in Immigration Detention." 2017. Human Rights Watch. <https://www.hrw.org/report/2017/05/08/systemic-indifference/dangerous-substandard-medical-care-us-immigration-detention>.

⁹ *Id.* at 58.

¹⁰ *Id.*

¹¹ "Ailing Justice—New Jersey: Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention." 2018. Human Rights First. <https://www.humanrightsfirst.org/sites/default/files/Ailing-Justice-NJ.pdf>.

¹² *Id.* at 9.

individual with a history of serious mental illness did not receive his psychiatric medication for ten days because it was “pending ICE approval.”¹³

In 2020, NIJC, the American Civil Liberties Union and Human Rights Watch reported on appalling conditions and due process problems at ICE facilities with new contracts signed during the Trump administration.¹⁴ This report, based on interviews with 150 people, concluded that, “facilities appeared unequipped to provide adequate mental health services while a suicide crisis emerges in immigration detention centers.” In one Louisiana facility there were no mental health professionals on staff, resulting in mental health requests either going ignored or being addressed through insufficient remote telephonic services.¹⁵

These examples of documented deficiencies in detention facilities nationwide match the patterns and practices described by Ms. Osorio, Mr. Silva, and Mr. Estime, and are identified by the affiant medical doctors as endemic to ICE’s detention system. Dr. Saadi and Dr. Recht have observed people in ICE custody become so accustomed to delays in receiving preventive and emergency medical care that many simply stop asking for help. The doctors recall one detained woman who stated, “When we have pain, we don’t tell anyone. It isn’t worth it. They won’t help us, and if we complain, they treat us worse.”¹⁶ It is evident that the immigration detention system regularly falls below the standard of care for individuals with mental health disabilities or disorders when it comes to delivering timely appointments.

II. When ICE Does Provide Mental Health Care, That Care is Poor, Deficient and Neglectful

When ICE does respond to requests for mental health care, the care provided is often deficient and/or neglectful, resulting in egregious consequences, particularly for those with pre-existing mental health disabilities. The medical experts who have provided affidavits in support of this complaint, along with corroborating reports documenting cases nationwide, describe improper practices by medical providers at ICE facilities including: prescribing the wrong medications or none at all; failing to respond to crisis moments or breakdowns; and abusive bedside manner and treatment of individuals suffering from mental health challenges.

Mr. Estime, who came into detention with a pre-existing diagnosis of bipolar disorder and depression, said the following regarding his time in the Clay County Jail and his experience with suicidal ideation:

“I felt like I was never properly treated at Clay, even though I was physically assaulted [by a sergeant], and I suffer from bipolar disorder and depression. The facility knew I had mental health

¹³ Aaron J. Fischer, Pilar Gonzalez, Richard Diaz. 2019. “There Is No Safety Here: The Dangers for People with Mental Illness and Other Disabilities in Immigration Detention at GEO Group’s Adelanto ICE Processing Center.” Disability Rights California. https://www.disabilityrightsca.org/system/files/file-attachments/DRC_REPORT_ADELANTO-IMMIG_DETENTI_ON_MARCH2019.pdf

¹⁴ “Justice-Free Zones U.S. Immigration Detention Under the Trump Administration.” 2020. National Immigrant Justice Center Human Rights Watch, American Civil Liberties Union. https://immigrantjustice.org/sites/default/files/content-type/research-item/documents/2020-04/Justice-Free%20Zones_Immigrant_Detention_Report_ACLU-HRW-NIJC_April-2020.pdf.

¹⁵ *Id.* at 46.

¹⁶ See appendix D at ¶ 14, Expert Affidavit of Dr. Altaf Saadi and Dr. James Recht.

issues because my lawyer sent them some documents to prove it, but that didn't matter to them. There were no mental health services at the facility.”¹⁷

Furthermore, Mr. Silva met with a psychologist once during his four-months at Dodge but he said that they only talked to him for half an hour, and he would have preferred to be prescribed the medication he needed for his disorders. He repeatedly told the medical staff about his bipolar disorder, but they failed to provide him with any medication. He often felt like medical staff didn't care about him and thought he was exaggerating or faking his symptoms. The doctor would tell him he “was okay” and that “his situation was only temporary and that it would pass.”¹⁸

Drs. Saadi and Recht describe a culture of cost cutting that results in widespread negligence throughout ICE's facilities, where medical staff “sometimes simply performed internet searches of their symptoms, and provided [detained individuals] with ‘advice’ such as ‘drink more water.’”¹⁹ In fact, Drs. Saadi and Recht note that water and ibuprofen are the most commonly prescribed remedies for a wide range of health symptoms and disorders for those detained by ICE. In her declaration, Dr. Saadi describes the story of a man detained in a California detention facility who, prior to his detention, thrived in his employment and life while taking medications for his schizophrenia diagnosis.²⁰ Once in ICE custody, he experienced a two-week delay in receiving any medication at all and subsequently was prescribed an ineffective drug for his disorder.²¹ As a direct result, he endured hallucinations and four suicide attempts. According to Dr. Saadi, “ICE prescribed alternate medication because it was less expensive. Medical decisions are often made with profit in mind.”²²

The doctors' descriptions are corroborated by numerous reports and complaints across detention facilities nationwide. For example, one of the complainants described in the 2019 CRCL memorandum to ICE highlighting mental health care deficiencies experienced auditory hallucinations and suicidal ideations during his time detained in the Eloy Federal Contract Facility in Arizona; he was, however, prescribed an antidepressant rather than an anti-psychotic medication, likely worsening his psychosis.²³ Another individual in the same facility became so unstable that he lacerated his penis and required hospitalization and surgery. In his case too, IHSC notified the facility psychiatrist several times about the individual's deteriorating psychosis-like symptoms, but the psychiatrist did not treat him.²⁴ These cases demonstrate that ICE and their subcontractors are not meeting the mental health needs of those in their detention centers, with extremely serious consequences.

III. Understaffing Contributes to Deficient Mental Health Services

In September 2020, the House of Representatives Oversight and Reform Committee reported on its year-long investigation across nearly two dozen detention ICE facilities, and concluded that ICE's

¹⁷ See appendix C at ¶ 4, Declaration of Jefferson Estime.

¹⁸ See appendix B at ¶ 5, Declaration of Edwin Silva.

¹⁹ See appendix D at ¶ 13, Expert Affidavit of Dr. Altaf Saadi and Dr. James Recht.

²⁰ *Id.* at ¶ 15

²¹ *Id.*

²² *Id.*

²³ *Supra* n. 3.

²⁴ *Id.* at 2-3.

“grossly negligent” response to medical and mental health needs is in part due to facility understaffing of medical professionals.²⁵ This conclusion reflects the experiences of Ms. Osorio and Mr. Estime. During Ms. Osorio’s detention at the Chase County Detention Center, there was only one nurse who, according to Ms. Osorio, “always seemed irritated and overwhelmed. Sometimes she passed out medication in the morning and she always ignored you.”²⁶ In Mr. Estime’s case, the complete lack of mental health services on-site at the Clay County Jail meant that he didn’t receive *any* medication for his pre-existing disorders while detained there. “I’d ask for medication so many times so that they could help me sleep at night,” he recalls, “but it was impossible to get them because there was no psychologist, no psychiatrist, no one. I felt desperate at Clay. I don’t know how long I would have lasted locked up in there.”²⁷

An Office of Inspector General (OIG) report from last year enumerated the many factors that hamper ICE’s ability to maintain adequate medical and mental health staff at detention facilities, including the distance of offsite medical facilities and the reluctance of some providers to treat people in detention due to stigmas in local communities from such work.²⁸ This understaffing results in dire consequences for individuals in detention, including death. The death report for Jean Carlos Jimenez-Joseph, a 27-year-old Panamanian migrant who died by suicide in ICE custody in the Stewart Detention Center in Georgia, stated that “due to mental health professional vacancies, [facility] staff postponed Mr. Jimenez-Joseph’s next psychiatric evaluation by several weeks instead of addressing his repeated complaints such as hearing voices and suicidal ideation.”²⁹

ICE’s band-aid response to staff shortages has been to increase the use of telehealth for mental health counseling, with staff from one facility assisting others by video or phone. This strategy, however, creates a host of other problems for people in detention. Ms. Osorio, for example, had to wait up to two months to see an outside mental health provider over Zoom. She said many people in detention needed mental health care but were discouraged to seek help because the process took too long or they were too scared to ask for help.³⁰ She said, “when I finally saw a therapist, the meeting was conducted over Zoom, which felt impersonal.”³¹

In other cases, the integrity of mental health services are compromised when done by video because it is difficult if not impossible to ensure quality interpretation. In the 2020 joint report mentioned above, one man detained at the Richwood Correctional Center described his telehealth experience: “I was having a

²⁵ U.S. House of Representatives Committee on Oversight and Reform and Subcommittee on Civil Rights and Civil Liberties. 2020. “The Trump Administration’s Mistreatment of Detained Immigrants: Deaths and Deficient Medical Care by For-Profit Detention Contractors.” <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2020-09-24.%20Staff%20Report%20on%20ICE%20Contractors.pdf>.

²⁶ See appendix A at ¶ 10, Declaration of Angela Osorio.

²⁷ See appendix C at ¶ 6, Declaration of Jefferson Estime.

²⁸ Department of Homeland Security Office of Inspector General. 2021 “Many Factors Hinder ICE’s Ability to Maintain Adequate Medical Staffing at Detention Facilities.” OIG-22-03. <https://www.oig.dhs.gov/sites/default/files/assets/2021-11/OIG-22-03-Oct21.pdf>.

²⁹ Jennifer M. Fenton. Memorandum to Matthew Albence. July 1, 2018, “Investigative Findings— Death of ICE Detainee Jean Carlos JIMENEZ-Joseph,” The Office of Professional Responsibility. <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/Jean%20Carlos%20Jimenez-Joseph%20Death%20Report%20May%202017%20%28Stewart%29.pdf>

³⁰ See appendix A at ¶ 14, Declaration of Angela Osorio.

³¹ *Id.* at 10.

lot of emotional issues and stress here. So, I asked for a psychologist. I saw one on the video tablet at the clinic. There was a staff person who ‘translated,’ but she really cannot speak Spanish. Then they sent me sleeping pills, but I didn’t want them.”³² According to Dr. Weber, “the failure of facilities to provide interpretation services can be a detriment to immigrant mental health in multiple ways. For instance, if an immigrant is unable to express their feelings with medical or psychological staff, they might feel increasingly isolated. Furthermore, staff might not realize if a patient’s mental condition is worsening or if the patient were developing dangerous symptoms such as suicidal thoughts.”³³

IV. ICE’s Continued Use of Solitary Confinement Puts Lives at Risk, Especially Those With Mental Health Issues

In 2012, NIJC reported that ICE’s use of solitary confinement in immigration detention facilities is often “arbitrarily applied, significantly overused, harmful to detainee’s health, and inadequately monitored.”³⁴ NIJC found immigrants in isolation cells were suffering hallucinations, fits of anger, and suicidal impulses.³⁵ The effects of being isolated continued beyond detention and after release, including depression and memory loss.³⁶ Ten years after NIJC published these findings, solitary confinement remains a systemic practice in ICE detention facilities across the U.S., including for those with mental health challenges, often with irreversible consequences.

The United Nations considers the prolonged use of solitary confinement tantamount to torture and says it should be banned in most cases.³⁷ The United Nations Special Rapporteur on Torture considers placement of people with psychosocial disabilities in solitary confinement to be “cruel, inhumane or degrading treatment.”³⁸ Yet, according to Drs. Recht and Saadi, ICE uses solitary confinement regularly across detention facilities both as punishment and also as a short-term and long-term approach to managing mental health and illness in detention facilities.³⁹ One 2018 study of ICE solitary confinement lasting longer than 14 days, conducted by the Journal of Population Research, revealed that over 57% of solitary confinement cases involved an individual with a diagnosed mental illness, though they make up about 15% of the ICE detention population.⁴⁰ Another investigation conducted by the International Consortium

³² *Supra* n. 14 at 37.

³³ See appendix E at ¶ 10, Expert Affidavit of Dr. William Weber.

³⁴ “Invisible in Isolation: The Use of Segregation and Solitary Confinement in Immigration Detention.” 2012. National Immigrant Justice Center and Physicians for Human Rights.

https://immigrantjustice.org/sites/immigrantjustice.org/files/Invisible%20in%20Isolation-The%20Use%20of%20Segregation%20and%20Solitary%20Confinement%20in%20Immigration%20Detention.September%202012_7.pdf.

³⁵ *Id.*

³⁶ *Id.* at 12.

³⁷ “Solitary Confinement Should Be Banned in Most Cases, UN Expert Says, UN News,” 2011. UN News. October 18, 2011.

<https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says>.

³⁸ “United States: Prolonged Solitary Confinement Amounts to Psychological Torture, says UN Expert,” 2020. OHCHR. February 28, 2020.

<https://www.ohchr.org/en/press-releases/2020/02/united-states-prolonged-solitary-confinement-amounts-psychological-torture?msclkid=211b4870bf1411ecbc0fc9c52b20d8d0>.

³⁹ See appendix D at ¶ 19, Expert Affidavit of Dr. Altaf Saadi and Dr. James Recht.

⁴⁰ *Id.*

of Investigative Journalists found that of 8,400 placements in solitary confinement in ICE custody, nearly a third were cases of people in detention with a mental illness.⁴¹

This inappropriate use of solitary confinement to manage mental health care needs contradicts international rulings, decades of studies, and anecdotes showing that any time spent in segregation can be detrimental to a person's mental health, especially for individuals with pre-existing mental health illnesses.⁴² In particular, solitary confinement can increase the likelihood of suicide attempts and death. This is confirmed by testimony from Dr. Saadi and Dr. Recht who documented numerous cases of people put on suicide watch after time in segregation.⁴³

Mr. Silva was placed in some form of isolation five times during the four months he was detained. He recounts ICE officers punishing him with solitary for “any little thing,” including a placement in solitary for twenty-four hours for not wearing a shirt during a detainee count. During solitary confinement his mental health symptoms worsened. “I came to feel in a way that I’d never felt before,” he recalls. “I thought about having to return to Nicaragua, where I would be in danger... I felt depressed. I cried whenever I was in solitary. I couldn’t sleep. We didn’t have the right to do anything... I felt like I didn’t want to live.”⁴⁴

Mr. Silva’s experiences are emblematic of ICE’s abuse of solitary confinement. In May 2019, whistleblower and former DHS policy adviser Ellen Gallagher shared publicly details regarding the agency’s overuse of solitary confinement.⁴⁵ She observed ICE to be repeatedly violating policies that require a search for less restrictive measures before people are placed in prolonged solitary confinement.⁴⁶ Solitary confinement is routinely used as the first and only option, rather than as a last resort.⁴⁷

Gallagher’s review of weekly reports also showed ICE’s widespread use of segregation, particularly of those with serious mental illnesses and often for minor incidents. Examples included: a person with mental illness “found guilty of possession of an unauthorized item”—a green pepper “hidden” in his sock—and sentenced to 15 days in disciplinary segregation; another person with mental illness placed in disciplinary segregation pending investigation because he “admitted blowing kisses to [the] GEO officer posted in [the] dormitory;” and a person with a history of mental illness, including a suicide attempt, who

⁴¹ Antonio Cucho. 2019. “How US Immigration Authorities Use Solitary Confinement-ICIJ.” International Consortium of Investigative Journalists. May 20, 2019. <https://www.icij.org/investigations/solitary-voices/how-us-immigration-authorities-use-solitary-confinement/>.

⁴² Kayla James and Elena Vanko. 2021. “The Impacts of Solitary Confinement.” Vera.org. April 2021. <https://www.vera.org/downloads/publications/the-impacts-of-solitary-confinement.pdf>.

⁴³ See appendix D at ¶ 19, Expert Affidavit of Dr. Altaf Saadi and Dr. James Recht.

⁴⁴ See appendix B at ¶ 9, Declaration of Edwin Silva.

⁴⁵ Maryam Saleh and Spencer Woodman. 2019. “A Homeland Security Whistleblower Goes Public About ICE Abuse of Solitary Confinement.” The Intercept. May 21, 2019. <https://theintercept.com/2019/05/21/ice-solitary-confinement-whistleblower/>.

⁴⁶ Spencer Woodman et al. 2019. “Solitary Voices: Thousands of Immigrants Suffer in Solitary Confinement in ICE Detention.” The Intercept. May 21, 2019. <https://theintercept.com/2019/05/21/ice-solitary-confinement-immigration-detention/>.

⁴⁷ “Internal Watchdog Finds ICE Violations of Solitary Confinement Policy,” 2021. American Civil Liberties Union. October 21, 2021. <https://www.aclu.org/news/immigrants-rights/internal-watchdog-finds-ice-violations-of-solitary-confinement-policy>.

was sentenced to two nearly consecutive stints in disciplinary segregation for “engaging in sexual acts” (which was actually a consensual kiss with another detained immigrant).⁴⁸

In his declaration, Dr. Weber describes his work with mentally ill individuals who were taken off their psychiatric medication and subsequently placed into segregation.⁴⁹ He recounts working with a client who “was initially placed in solitary confinement and while there, his mental state decompensated to the point where he developed delusions and required off-site inpatient hospitalization. Despite being cleared for removal from solitary confinement, he was kept there while staff waited for orders from ICE on a plan for his release and location.⁵⁰ Dr. Weber’s expert opinion is that subjecting individuals with severe mental health conditions to segregation should be prohibited and if the patient is unstable, he/she should be transitioned to higher psychiatric care at a specialized psychiatric facility.⁵¹

Fear of solitary confinement leads individuals with mental disabilities to avoid disclosing critical mental health symptoms and issues, particularly related to suicide. Ms. Osorio, who had never before engaged in self-harm, began cutting herself while in detention. She intentionally hid this behavior out of fear of being sent to solitary confinement. Similarly, as described in the investigative report by Disability Rights California, when a woman at the Adelanto Detention Center engaged in self-cutting and required five days of hospitalization, mental health staff there wrote: “[Cristina] has been hesitant to tell myself and other providers about her cutting and how severe her [suicidal ideation] is because she doesn’t want to be placed in a suicide smock and made to sit alone in a cell.”⁵² Another person detained at Adelanto stated, “I cannot ask for help because they will put me on suicide watch by myself and I get more depressed. It does not help. I don’t trust them. So I suffer in silence.”⁵³

V. ICE’s Failure to Provide Adequate Care to Individuals with Mental Health Disabilities and Its Continued Use of Solitary Confinement Violates Its Own Standards

The patterns of inadequacy and neglect described in this complaint violate ICE’s detention standards in numerous ways. According to ICE’s most recently published data, the three facilities referenced by Ms. Osorio, Mr. Silva and Mr. Estime are inspected pursuant to the 2019 National Detention Standards (NDS) for Non-Dedicated Facilities (Chase County Jail and Dodge County Jail) and the 2008 Performance-Based National Detention Standards (PBNDS) (Clay County Jail).⁵⁴ This section outlines some of the violations of standards evidenced by this complaint (this is a non-exhaustive list).

⁴⁸ *Supra* n. 45.

⁴⁹ *See* appendix E at ¶ 7, Expert Affidavit of Dr. William Weber.

⁵⁰ *Id.*

⁵¹ *Id.* at ¶ 8

⁵² *Supra* n. 13.

⁵³ *Id.* at 25.

⁵⁴ “Detention Management.” n.d. Ice.gov. <https://www.ice.gov/detain/detention-management>.

A. ICE’s treatment of Ms. Osorio and Mr. Silva violated standards pursuant to the 2019 National Detention Standards for Non-Dedicated Facilities

Standard 4.3 on Medical Care requires that all people in detention shall have access to appropriate medical, dental, and mental health care.⁵⁵

- Section II(A)(2) requires necessary and appropriate mental health care services.⁵⁶ ICE violated this standard by failing to provide timely mental health appointments to Ms. Osorio when she was detained at Chase. Ms. Osorio had to wait two months to see a therapist despite her rapidly deteriorating mental health. Similarly, ICE failed to investigate Mr. Silva’s diagnosis of bipolar disorder and did not provide the necessary medication he needed during the approximately four months of his detention.
- Section II(D) requires that individuals in detention receive a mental health screening upon arrival and be asked for information regarding history of mental illness.⁵⁷ ICE violated this standard when it failed to provide a mental health screening to Ms. Osorio upon her arrival to Chase and upon Mr. Silva’s to Dodge, despite his recent diagnoses of serious mental illness.

Standard 4.5 on Significant Self-Harm and Suicide Prevention and Intervention requires that a facility have a written suicide prevention and intervention program that includes protocols to address suicidal detainees and people in detention at risk of self harm.⁵⁸

- Section II(C) requires a mental health screening within 12 hours of admission, yet ICE failed to provide mental health screenings to Mr. Silva and Ms. Osorio upon their arrivals to Chase and Dodge, respectively.
- Section II(H) states that deprivations and restrictions on suicidal detainees must be minimal because suicidal detainees may be discouraged from expressing their intentions if the consequences of reporting those intentions are punitive.⁵⁹ ICE frequently violates this standard by using punitive measures such as solitary confinement against people in detention who are having suicidal ideation. This, in turn, creates a chilling effect; Ms. Osorio expressed her fear of being punished through solitary confinement as the reason for not disclosing her suicide attempt to detention staff.

Standard 2.9 on Special Management Units (SMUs) provides standards for the use of Administrative Segregation and Disciplinary Segregation⁶⁰

- Section II(M) requires people in detention to be evaluated by a healthcare professional prior to placement in an SMU; instructs that ICE refrain from placing detainees with a serious mental illness⁶¹ in an SMU on the basis of such mental illness; requires that ICE make every effort to

⁵⁵ U.S. Immigration and Customs Enforcement. Rev. 2019. “National Detention Standards for Non-Dedicated Facilities.” <https://www.ice.gov/doclib/detention-standards/2019/nds2019.pdf>.

⁵⁶ *Id.* at 112.

⁵⁷ *Id.*

⁵⁸ *Id.* at 130.

⁵⁹ *Id.* at 133.

⁶⁰ *Supra* n. 55 at 53.

⁶¹ Standard 4.3 of the 2019 NDS defines ‘serious mental illness’ as a condition that a qualified medical provider has determined to meet the criteria for a “serious disorder or condition” which includes significant symptoms for bipolar disorder, and one or more of the following active psychiatric symptoms and/or behaviors: severe disorganization,

place detainees with a serious mental illness in a setting outside of the facility where appropriate treatment can be provided; and requires continual monitoring and evaluation by a mental health care provider, with particular restrictions for any person determined to be facing deteriorating mental health because of the use of segregation.⁶² ICE repeatedly violated this standard by subjecting Mr. Silva to multiple periods in SMU while detained at Dodge. On one occasion, he was sent to a segregation cell for not wearing a shirt during a detainee count. On another, he was placed in a segregation cell because he didn't go to the dining hall for breakfast with the other individuals in detention, even though he wasn't hungry and didn't know it was mandatory. The detention staff at Dodge made no effort to place Mr. Silva in an alternative setting. A qualified mental health provider never conducted a face-to-face clinical contact to monitor Mr. Silva's mental health even though his segregation placement further deteriorated his mental health.

B. ICE violated multiple standards pursuant to the 2008 Performance Based National Detention Standards in its treatment of Mr. Estime during his time at the Clay County Jail

Part 4 Section 22 on Medical Care requires that people in detention have access to emergent, urgent, medical, and mental health care in a timely and efficient manner.⁶³

- Section II (10) requires people in detention to have access to specified 24-hour emergency medical, dental, and mental health services.⁶⁴ Mr. Estime was physically assaulted by a sergeant upon arrival at Clay and yet did not receive emergency medical services for his injuries.
- Section II (19) says that each person newly admitted, including transfers, should receive a documented medical, dental, and mental health screening upon intake and, within 14 days of arrival, a comprehensive health appraisal by qualified personnel in a private setting.⁶⁵ Here, ICE failed to provide Mr. Estime with a mental health screening, despite his pre-existing mental health illnesses.
- Section V(K) requires each facility to have an in-house or contractual mental health program where based on intake screening, medical documentation or subsequent observations by detention staff, the administrative health authority shall immediately refer any person with mental health needs to a mental health provider for an evaluation. It also requires the provider to develop an overall treatment plan that may include transfer to a mental health facility if the person's mental illness needs exceed the treatment capability of the facility.⁶⁶ Mr. Estime's attorney provided documentation of his mental health diagnoses to Clay, yet they refused to let him see an off-site mental health provider or provide medication for his mental illnesses, unless he first received therapy. Mr. Estime refused therapy knowing that his mental illnesses would not be ameliorated through talk therapy alone, without medication. As a result, he was detained for almost two months without receiving mental health treatment or medication.

active hallucinations or delusions, mania, catatonia, severe depressive symptoms, suicidal ideation and/or behavior, marked anxiety or impulsivity.

⁶² *Supra* n. 55 at 62.

⁶³ U.S. Immigration and Customs Enforcement. 2008. "ICE/DRO Detention Standard– Medical Care." https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf

⁶⁴ *Id.* at 2.

⁶⁵ *Id.*

⁶⁶ *Supra* n. 63 at 13.

Part 4 Section 24 on Suicide Prevention and Intervention is meant to protect the health and well-being of people in ICE custody through a comprehensive Suicide Prevention and Intervention Program that minimizes risk.⁶⁷

- Section V(A) requires that all facility staff who interact with and/or are responsible for people in Custody are trained on recognizing verbal and behavioral cues that indicate potential suicide, demographic, cultural, and precipitating factors of suicidal behavior, and responding appropriately to suicidal and depressed detainees.⁶⁸ Section V(B) requires staff to utilize this training to engage in ongoing monitoring of people in detention to identify any person at risk of suicide. ICE violated these standards when it failed to recognize Mr. Estime’s suicidal ideation, especially given Mr. Estime’s history of sexual trauma and serious mental health illnesses.

Request for Investigation

The three declarants in this complaint received deficient mental health care and Mr. Silva was subjected to improper use of solitary confinement while detained at different ICE immigration detention facilities. Their cases are far from anomalous and illustrate a troubling pattern of failures by ICE to provide adequate mental health care to vulnerable people in detention who suffer from mental health disabilities, as evidenced by the expert declarations provided by Dr. Saadi, Dr. Recht, and Dr. Weber and the voluminous body of literature described throughout this letter. While ICE recently issued a new Directive on the identification, diagnosis, treatment, and monitoring of individuals with serious mental disorders, this memo does little to address the egregious deficiencies identified throughout this complaint, largely because the Directive merely reiterates ICE’s existing civil detention standards with regards to conditions and on-site care.⁶⁹

In light of the declarants’ experiences and expert testimonies, we request that CRCL investigate the provision of mental health care and improper use of solitary confinement in every immigration detention facility in the system. We ask that for each of these investigations, CRCL look specifically into the following indicators of care:

- Responsiveness to mental health appointment requests to ensure that people in detention with mental health challenges receive timely evaluation and treatment;
- Quality of mental health care driven by individual clinical needs and consistent with prevailing standards of care, including appropriate medication management;
- Sufficiency and competence of available trained mental health clinical staff available; and,
- Improper use of solitary confinement and similarly restrictive segregation housing, most urgently for people with mental health needs and disabilities.

Sincerely,

Nubia Fimbres, NIJC Policy Associate, nfimbres@heartlandalliance.org

Nayna Gupta, NIJC Associate Director of Policy, ngupta@heartlandalliance.org

⁶⁷ U.S. Immigration and Customs Enforcement. 2008. “ICE/DRO Detention Standard– Suicide Prevention and Intervention.”

https://www.ice.gov/doclib/dro/detention-standards/pdf/suicide_prevention_and_intervention.pdf.

⁶⁸ *Id.* at 2.

⁶⁹ U.S. Immigration and Customs Enforcement. “ICE Directive 11063.2: Identification, Communication, Recordkeeping, and Safe Release Planning for Detained Individuals with Serious Mental Disorders or Conditions and/or Who are Determined to be Incompetent by an Immigration Judge.” April 5, 2022.

<https://www.ice.gov/doclib/news/releases/2022/11063-2.pdf>.

Appendix

Appendix A: Declaration of Angela Osorio

Appendix B: Declaration of Edwin Silva

Appendix C: Declaration of Jefferson Estime

Appendix D: Expert Affidavit of Dr. Altaf Saadi and Dr. James Recht & Curriculum Vitae

Appendix E: Expert Affidavit of Dr. William Weber & Curriculum Vitae

Appendix A

I, Angela Maria Osorio-Pena¹, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. My name is Angela Osorio. I was born in Colombia and came to the United States in 2000 when I was a teenager. I have lived in the United States for more than twenty years. I have three wonderful US citizen children. My sons are wonderful young men and I am very close to them.
2. In March 2017, I was convicted of bringing counterfeit obligations into the U.S. I was sentenced to one day in prison and two years probation. I cooperated with law enforcement in a federal investigation and gave them all the information I knew. Because of my cooperation with federal authorities, my family and I have received threats and I am afraid I will be killed if I return to Colombia. My asylum case is currently pending before the Board of Immigration Appeals.
3. In April 2021, three years after I received my conviction and served a day in prison, ICE arrested me at work. ICE detained me at McHenry County Adult Correctional Facility in Woodstock, IL. In October, I was transferred to Chase County Detention Center in Cottonwood Falls, KS and finally released in January 2022, after about ten months of detention.
4. Before detention, I did not have any mental health issues. However, detention affected me a lot in so many different ways, including my mental health. It affected me to be away from my family and not knowing what was going to happen to me. I hated thinking that if my family needed something, I couldn't do anything about it because I was in detention, helpless. It was the first time I was away from my kids. I had only been away from my twelve-year-old son for one night before.
5. Detention changed not only my routine but also my entire life. The conditions of detention and the way staff treated us was way too much for me to handle. I used to cry all day, sleep a lot, and have sweaty hands and chest pains. I felt like I was living a nightmare. I was fighting with a voice inside my head saying things were hopeless. One of the girls suggested that I take medication. Many people in custody took medications because everybody was going through something hard, and being detained made it that much harder. At first, I didn't want to take medication because I thought it was just stress but it got to the point where I felt so depressed that I had to request a mental health appointment in August.
6. After waiting two to three weeks, I finally got an appointment. There was only one mental health practitioner at McHenry, and she met with me for only two minutes. When I told her how I was feeling, I was crying. I told her all my symptoms, and she just said, "Okay, you start medicine tomorrow." The doctor never looked me in the eyes; she only typed. She didn't even pretend to listen. She didn't let me express how I felt or explain that she was diagnosing me with depression. The doctor didn't tell me what the medication would do to me or if there would be any side effects. I tried to ask about the side effects later but never got a response. When I went back to see her to request a higher dosage, she treated me the same. She acted as if she didn't even care. Sometimes the doctor talked to me in front of everyone; it was not private. I couldn't express my feelings. The medication helped a little in that I could sleep a little more and my hands weren't as sweaty but it didn't get all better. The thoughts were still there. The voice inside my head was still there saying, "you see, no one cares."

¹ A-Number: 

7. I lost my mom when I was 16-years-old and not a single day goes by that I don't miss her. I never left my kids because I know what it's like to grow up without a mom. But when I was in detention, I felt like it would be easier for my kids if I weren't alive anymore. I felt like my being in detention was too much stress for them. Those are the kinds of thoughts I was wrestling within my head. I had a lot of time to myself to think, and that is where my mind went. We spent 17 hours a day locked down. You get tired of reading, and the mind starts going to darker places.
8. Because of these thoughts, I tried to commit suicide at the end of August by cutting my wrists. The other girls in detention helped me by putting pads on my wrists. I didn't tell the guards because I knew they would put me in solitary confinement, and I didn't want that. Out in the general population, I could at least be with others and talk to my family over the phone. I was terrified of being in solitary confinement. I would hear bad things about being in solitary, like being completely alone 24/7 without anything to distract you. I was already in a bad place, mentally, and I knew that if they confined me without any contact, it would be a million times worse. Others would say that they would take me downstairs if I kept hurting myself. So I decided it was better to hide my suicide attempt and mental health issues to avoid solitary confinement.
9. When I was transferred from McHenry to Chase in October, my medication came with me, but the stress and depression worsened. In McHenry, I was only with others, like me, that were in detention due to their immigration status. At Chase, I was with a mixed population. The culture of the general population scared me. I saw more bullying and other scary things, including drug use and sex. It was terrible, and I felt unsafe. I felt very stressed after my transfer to the point where I suffered from high blood pressure, which I never had before. I also had a bad rash on my legs. I had to get a cortisone shot when I got out of detention. After I arrived at Chase, I had mental and physical health problems.
10. Chase didn't have any mental health services on-site. I had to wait for two months to start seeing a therapist even though my mental health symptoms were getting worse. When I finally saw a therapist, the meeting was conducted over Zoom, which felt impersonal. Chase only had one nurse, and she always seemed irritated and overwhelmed. Sometimes she passed out medication in the morning and she always ignored you. You had to send an email to see the nurse, but they had problems with the system, and requests would often get deleted. It wasn't until later that someone would notice if the email was sent or not. It was all a mess.
11. I felt mistreated and disrespected by the Corrections Officers (COs). Sometimes COs would pass out the medicine. One time, I was waiting in line to get my medication, and the other girls who took medication were sleeping. The CO asked, "where are the junkies? Why aren't they here for their meds?" They often made remarks that dehumanized others. I was taking medicine because I needed to, not because I wanted to. We all were. We weren't junkies.
12. You couldn't mention any health problems to the COs because they'd get annoyed and would ignore you. You had to see the nurse. I had a terrible migraine at one point that I was throwing up, but the COs didn't do anything. My cellmate was worried for me and told the COs to do something. Their solution was to offer me Pepto-Bismol even though I said it wasn't my stomach; I was nauseous because of my migraine. Things like this would make me realize that the detention staff simply didn't care about you or your well-being.

13. The COs at Chase were no different from the ones in McHenry. I never felt more mistreated than when I was detained at Chase. I would tell the COs, "I just got my period. Can I get some sanitary pads?" and they would get annoyed. They would answer back, "again?" and give me two pads, which were not enough to last for my entire period. We asked for books, but they didn't have any. They'd tell me, "ask your family." Once, I complained that the food wasn't fully cooked, but the CO's just told me to "throw it away and don't eat it." They weren't going to do anything about it because they didn't care.
14. At Chase, many people were suffering from depression and other mental health issues but weren't taking medication. These people tried to get help, but Chase didn't have a mental health provider. We had to fill out a form to request an appointment with an outside provider. It would take a month to get an appointment, and we would only see the provider over Zoom. Many people needed mental health care, but they either gave up because it took too long to see a doctor or were too scared to ask for help.
15. At McHenry, the only thing that sometimes would make detention a little more bearable was looking out the windows. I'd sit on my bunk bed and look out the windows, seeing birds, trees, and the sky. When I got to Chase, I didn't have that small comfort anymore because the facility didn't have any windows. I couldn't see the sun, the clouds. I didn't know if it was daytime or nighttime. We couldn't even go outside. These conditions hurt my mental health. I didn't like that medication was the only remedy for mental health issues in detention because it was not enough. We needed to go outside, know what was going on in our immigration cases, talk to others, eat decent food, and get treated with respect. Things like that would have a big difference to my mental health. It would have been better to have someone listen to me so that I could express what I was going through. Some therapy would have helped a lot.
16. Even though I'm no longer in detention, my depression hasn't gone away. There isn't a single day that I don't cry and don't think about detention. Every single day, I remember some memory of when I was detained at McHenry or Chase. I live in constant fear that I'm going to wake up in that awful place again any day. When I'm working, I find it very hard to focus. I try, but I just can't. I never felt like this before detention. It's like I was a different person. Sometimes, I'm just sitting at work, crying out of nowhere.
17. Since being released, I've continued to take medication for my depression, but sometimes I still feel like I did in detention. It's hard to explain, but sometimes I feel like I never really left because my mental health isn't like before. My doctor raised my medication dosage, and my mental health has improved, but sometimes I still hear that voice in my head. The same voice telling me that life is not worth living and I will end up in detention again, or worse, deported. It sometimes tells me that I should have committed suicide when I had the chance.
18. I want to raise my voice around the issue of immigration detention. I don't want anybody to go through what I went through when ICE detained me. The treatment is inhumane. Immigrants are human beings. ICE just leaves you in detention as if you have committed some terrible crime, and they don't even come to check on you. They don't provide information when we need it the most. We want to know when we have our next court date and what is going on in our case. There should be more information and better communication. If they're not going to provide

information, we should at least have access to a computer to look up things ourselves. I felt useless when I was there.

19. People don't realize that detention affects friends and family, not just the people detained. Later I learned that my son would wake up in the middle of the night crying, saying that God wasn't real because I wasn't there with him. Everyone should try to put themselves in our shoes and imagine what it's like to live in fear and get treated like you're not human. It's not fair what we go through as immigrants. The treatment in detention needs to change. I would prefer to never talk about immigration detention again and forget about the whole experience, but people need to know what it is like when ICE picks you up and locks you up. I know some people won't tell their stories because they are scared, and I feel I need to talk for them. I need to share my experience so that things can change for the people still inside.
20. I authorize the National Immigrant Justice Center (NIJC) to submit this Civil Rights and Civil Liberties Complaint on my behalf, and I further authorize CRCL to conduct any follow-up communication with NIJC attorneys and staff.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief.

Executed on the 11 day of April in the year of 2022.

Signature: 

Date: 4/11/22

Appendix B

I, Edwin Jose Silva Garcia¹, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

1. My name is Edwin Jose Silva Garcia. I was born in Nicaragua on May 10, 1995. I came to the United States in 2012 when I was 17 years old.
2. When I lived in Indiana in 2021, I suffered a mental health crisis that resulted in my hospitalization. At the hospital, I was diagnosed with bipolar disorder and anxiety and I was given medication. I was discharged but returned to the hospital a second time because my symptoms did not improve.
3. I left Indiana and moved to Wisconsin soon after my hospitalization. After I moved, I didn't take my medication because I didn't think I needed it. But in August, I got upset with an acquaintance, and I broke a window. I was in a bad place with my mental health. The police came and arrested me. I spent one day in jail and did not have any charges pressed against me in the end. But instead of being released after that day, ICE arrested and placed me into immigration detention at Dodge County Detention Center from August 19, 2021, to December 23, 2021.
4. I had a very difficult time in detention. I couldn't sleep at night because I was afraid of getting deported to Nicaragua and being hurt by people there. I felt guilty about how I had acted and how it led to detention. I couldn't believe my entire life was changing. None of my friends or family could visit me at Dodge because they lived too far away. Thinking about all this put me into a depression. I told the medical staff about my bipolar disorder, but they didn't give me medication. The doctors said they needed to investigate my diagnosis with the hospital in Indiana, but they never did during the four months I was detained. I asked for my medication several times because I wasn't feeling well inside. I felt depressed. The medication would have helped a lot. It took a long time to get medical and mental health appointments, usually up to a month.
5. I met with a psychologist once, but it didn't help to talk to her. I felt like talking to her wasn't going to fix the problems that made me depressed, like being in detention in the first place and not having medication. When I told the medical staff that I needed help, they would say that my situation was only temporary and that it would pass. I knew that wasn't true. My immigration case would continue even after detention. Maybe that's why it didn't help to talk to them. Sometimes I felt like the doctor thought I was exaggerating or faking my symptoms because the doctor would say I was okay. She didn't give my bipolar disorder and anxiety a lot of importance. I never received my medication when I was in detention.
6. The guards were indifferent to the people in detention. They just didn't care. I remember getting sick from Covid-19 and being in so much pain from a headache to the point where I almost cried. I begged the guards for help but had to wait over five hours to get medical attention because the guards wouldn't do anything about it.
7. During the four months of my detention, I was placed in some type of solitary confinement five times, ranging from four hours to two weeks. I think I was solitary for a total of one month. The guards would punish me for any little thing. For example, when I first arrived, I didn't know that all the detainees had to wake up at 7:00 am to have breakfast at the dining hall. One time I didn't

¹ A-Number: 

go to the dining hall because I wasn't hungry, and I stayed in my cell, so the guards punished me with solitary confinement. The detainee counts were also very strict. If you weren't standing, fully clothed, by the time the guards came by to count, they would punish you with solitary. One time, they locked me in a solitary cell for an entire day because I didn't have my shirt on when I stood up during the count. I felt like the guards were more strict about the rules with us Hispanics. It just felt like the guards punished us more often with solitary confinement.

8. One guard, in particular, mistreated me a lot. He would yell at me as if I were a dog. When I stood up for myself and told him that he didn't have a right to speak to me like that, he almost hit me. The guard got so upset that another guard had to intervene to calm him down because he was about to pick a fight with me. Another time, the same guard took my order through the commissary, but he never gave me my order when everyone else got theirs. The guard said he didn't have my order, even though I remember him taking it. I raised my voice because I was so upset, and I got punished with solitary confinement. It felt like the guard provoked me on purpose so that I would end up in solitary. I think he had it out for me for that first incident where he wanted to fight me, and other officers had to stop him.
9. Being in solitary confinement worsened my mental health symptoms. I came to feel in a way that I'd never felt before. I would sit in solitary thinking about what would happen to me if I returned to Nicaragua—thinking of how my life would be in danger. I thought a lot about my grandfather, who was murdered in Nicaragua, and how that could happen to me. Everything came to my mind. I felt so depressed. I cried whenever I was in solitary. I couldn't sleep at night. We didn't have the right to do anything. I never seriously thought about taking my life, but I did feel like I didn't want to live anymore.
10. I want guards to be held accountable for their actions. It's not fair that I ended up in solitary confinement so many times for little reason. They need more supervision to know they can't be bad and indifferent toward people in detention. It would also have been better if it didn't take such a long time to see a doctor. If I tried setting up an appointment to see one today, I wouldn't get an appointment until a month later or longer. It's all very delayed.
11. My life has changed a lot after detention. Everything is just so much harder now. I didn't have any money when I came out of detention. I went to Florida to stay with my family for a while, but I can't live off them forever. I feel like a burden to my family, and this all makes me feel depressed like I did in detention. I'm not in detention anymore, but that doesn't mean my mental health has gotten better. I'm always thinking about how I may end up in jail again at any point. I'm always thinking about being deported to Nicaragua and how I could end up dead like my grandpa. These thoughts never really live in my head. I am working toward improving my mental health. I will soon start seeing a therapist to help me with my problems and I know I can be a better person but I also hope detention conditions get better too.
12. I authorize the National Immigrant Justice Center (NIJC) to submit this Civil Rights and Civil Liberties Complaint on my behalf, and I further authorize CRCL to conduct any follow-up communication with NIJC attorneys and staff.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief.

Executed on the 13 day of May in the year of 2022.

Signature:

A handwritten signature in black ink, appearing to read 'Edwin Jose Silva Garcia', written over a horizontal line.

Date: 5/13/2022

Certificate of Oral Translation

I, Nubia Fimbres, swear under penalty of perjury pursuant to 28 U.S.C. § 1746 that I am fluent in English and Spanish and that I have orally translated this document to the best of my ability.

I reviewed this document with Edwin Jose Silva Garcia, and have incorporated all corrections and changes. Accordingly, I declare under penalty of perjury that the document has been faithfully translated and executed to the best of my knowledge, memory, and belief.

Date: May 13, 2022

Signature: /s/Nubia Fimbres

Appendix C

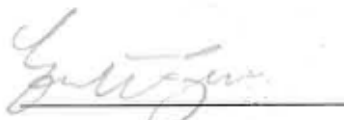
I, Jefferson Estime¹, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C § 1746 that the following is true and correct:

1. My name is Jefferson Estime, and I was born on September 6, 1992, and am 29 years old. I was transferred to ICE custody on September 3, 2021, first to Dodge County Detention Center in Wisconsin and then to Clay County Jail in Indiana on February 4, 2022. My time in immigration detention was horrible, especially at Clay. They don't treat you right, and they don't care about you. There are so many problems in detention that it's dangerous just to be there. People get sick and could die in detention.
2. There were issues at Dodge, but they weren't anything compared to Clay. I was beaten up by a sergeant as soon as I arrived. I remember coming that night, and the staff was getting ready to put us in our cells. The sergeant that night wanted to put me in a cell with someone from Dodge that I didn't want to be with, so I told her not to put me with him. I'd had problems with the man at Dodge and wanted to avoid any more issues with him. The sergeant then tried to force me into the cell with this person, so I said, "You will have to put me in the hole [segregation] or something because I am not going in the cell with him." The next thing I know, the sergeant slams me to the ground and cuffs me up. With my face against the ground, I kept asking, "why are you putting your hands on me? What did I do"? She just kept telling me to "shut the fuck up."
3. None of the other guards did anything to stop her because she was a sergeant. After that happened, they took me to the hole and left me there overnight. My head was hurting from being slammed, but nobody gave me any medication. Nobody offered me to see a doctor or anything like that. The sergeant hit me so hard that the right side of my face was bruised, and I continued getting headaches throughout detention. There was pain medication, but it wasn't free. You had to buy it through the commissary, and I didn't have enough money. I didn't report the problem because another officer told me it was better to let it go and that I would never have to see her again, which I didn't.
4. I feel like I was never properly treated at Clay, even though I was physically assaulted, and I suffer from bipolar disorder and depression. The facility knew I had mental health issues because my lawyer sent them some documents to prove it, but that didn't matter to them. There were no mental health services at the facility. At least at Dodge, they had some, but none of that was available at Clay.
5. My mental health got worse at Clay. I felt like I was going crazy sometimes and still do, even though I'm out. It would help when my girlfriend talked to me, and she would calm me down and tell me everything was going to be okay, but sometimes I couldn't take it. I'd say to her over the phone, "one day; I might just hang myself and kill myself." I would only get three to four hours of sleep because my mind was racing with so many things.

¹ A#: 

6. At Dodge, I didn't take medication for my mental health because I felt like I didn't need them, but I wanted my meds at Clay. I'd ask for medication so many times so that they could help me sleep at night, but it was impossible to get them because there was no psychologist, no psychiatrist, no one. I felt desperate at Clay. I don't know how long I would have lasted locked up in there.
7. Even if I had gotten treatment and medicine, the lack of mental health care wasn't the only problem at Clay. The conditions were so bad. Nothing worked. The showers didn't work. People had to use bedsheets to cover themselves. The toilets didn't flush, and they would overflow. It was nasty. Staff would give us dirty clothes that belonged to other people in detention. I had to wash my sheets in the sink because they didn't do laundry. The food was so bad that I didn't eat it most of the time. I had to buy it from the commissary instead. When we tried complaining about the conditions, the guards wouldn't do anything. They'd just call us names saying, "oh, you a criminal." That's why I'm saying they don't care about you because they would say so themselves. All this made me feel worse and feel like I didn't want to live.
8. I'm relieved to be out of detention. But at the same time, not much has changed. When I'm alone, I still think about taking my life. That's why I'm trying to see someone for therapy and get my medication. Detention just made everything worse. But it can't be fixed. The only thing I needed was to get out. People can't live like that. Detentions, especially in a place like Clay, it's no place to live. People can go crazy.
9. I authorize the National Immigrant Justice Center (NIJC) to submit this Civil Rights and Civil Liberties complaint on my behalf, and I further authorize CRCL to conduct any follow-up communication with NIJC attorneys and staff.

Executed on the 2nd of May in the year 2022

X 
Jefferson Estimate

Date: 5/2/22

Appendix D

I, Dr. Altaf Saadi, and I, Dr. James Recht, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

- 1) I, Dr. Saadi, am a general neurologist and hospitalist neurologist at Massachusetts General Hospital (MGH) and assistant professor of neurology at Harvard Medical School. I am also associate director of the MGH Asylum Clinic. I completed my medical education at Harvard Medical School and my residency training in neurology at the Harvard Mass General Brigham MGH-BWH Residency program, also serving as Chief Resident.
- 2) My research training includes a post-doctoral health services research fellowship with the National Clinician Scholars Program at UCLA, where I also received a master's degree in Health Policy and Management at the UCLA Fielding School of Public Health. My current research focuses on neurologic and neuropsychiatric health disparities and social and structural determinants of health among racial/ethnic minorities, immigrants, and refugees.
- 3) I have been an asylum evaluator for the Physicians for Human Rights Asylum Network since 2017. In that capacity, I have conducted both medical and psychological evaluations for individuals in the community and in immigration detention centers. I have also assessed the medical conditions of confinement in immigration detention at facilities in California and Texas, including with Human Rights First and Disability Rights California. One of my clinical sites of practice includes the MGH Chelsea HealthCare Center which serves a large immigrant population, as well as serving as a refugee health assessment site. Put together, I have both clinical and research expertise with immigrant and refugee populations.
- 4) I, Dr. Recht, graduated with the degree of Doctor of Medicine from the University of Wisconsin School of Medicine in 1990. I completed my medical internship and psychiatric residency training in Boston, at Tufts Medical Center and St. Elizabeth's Medical Center. I was appointed to the clinical faculty at Harvard Medical School in 1996, and to the adjunct clinical faculty at Tufts University School of Medicine in 2014. I was promoted to Assistant Professor of Psychiatry in 2014.
- 5) I have extensive knowledge of, and experience with, immigrant and refugee populations. Beginning with my training in the Harvard Program for Refugee Trauma in the early 1990's, I have provided clinical care and evaluations for hundreds of trauma victims and their families. I have been a member of the Asylum Network of Physicians for Human Rights since 2007, and in that capacity, have performed over one hundred psychiatric evaluations for individuals applying for amnesty and/or asylum.

- 6) I am also co-leader of the Cambridge Health Alliance Asylum Program, where I provide training and assist in program development, and I work as a staff member and clinical supervisor in the Boston Healthcare for the Homeless Program Asylum Clinic.
- 7) Based on our research and experience working with detained individuals, we have observed the traumatic impacts of detention on individuals with pre-existing mental health challenges. Many individuals entering detention have experienced cumulative trauma: in their home country, which precipitated migration; during their migration journey; and, in community conditions in the United States (e.g., poverty, racism, housing instability, and employee exploitation).¹ Many detained individuals suffer from mental health problems, including post-traumatic stress disorder (PTSD), depression, and anxiety.
- 8) Detention itself can be traumatizing or re-traumatizing for immigrants.² While pre-migratory trauma and psychiatric comorbidity may increase an individual's vulnerability to harms encountered in immigration prison, research indicates that the impact of conditions of confinement is experienced by all detained individuals, not solely asylum seekers.
- 9) I, Dr. Saadi, conducted a 2021 study on health outcomes among detained immigrants in California. It is among the first to provide evidence that poor general and mental health outcomes are associated with experiences of the conditions of confinement in detention centers rather than solely attributable to pre-migratory trauma.³ These conditions of confinement in immigration detention include sleep deprivation, social isolation from family via difficulty accessing family visitation, witnessing or experiencing abuse or harassment, and barriers to needed physical and mental health care.⁴ These experiences of conditions of confinement are not experienced in isolation but are rather cumulative or co-occurring conditions.
- 10) Physical conditions in detention centers are harsh and inhumane. Facilities have extreme overcrowding, unsanitary conditions, inadequate ventilation, lack of access to clean drinking water, and nutritionally inadequate food.⁵ Detained individuals lack access to activities and meaningful outdoor recreation. These poor physical conditions result in

¹ Saadi A, De Trinidad Young ME, Patler C, Estrada JL, Venters H. Understanding US Immigration Detention: Reaffirming Rights and Addressing Social-Structural Determinants of Health. *Health Hum Rights*. 2020 22(1):187-197.

² Human Rights First. *Ailing Justice: Texas Soaring Immigration Detention, Shrinking Due Process*. 2018.

³ Saadi A, Patler C, De Trinidad Young ME. Cumulative Risk of Immigration Prison Conditions on Health Outcomes Among Detained Immigrants in California. *J Racial Ethn Health Disparities*. 2021 Nov 29:1–15.

⁴ *Id.*

⁵ Patler C, Saadi A. Risk of Poor Outcomes with COVID-19 Among U.S. Detained Immigrants: A Cross-Sectional Study. *J Immigr Minor Health*. 2021, 23(4):863-866.

health problems and further compound difficulties with mental health. Untreated mental illness can also aggravate comorbidities like diabetes, and cardiovascular disease.⁶

11) Poor sleep conditions in particular bring out psychiatric illness such as depression and anxiety and exacerbate existing mental health issues.⁷ Detention centers frequently keep the lights on in cells 24/7. If lights do go out, guards often interrupt individuals' sleep at night with flashlights. Sleep deprivation also contributes to cognitive dysfunction, thereby potentially reducing individuals' ability to participate in their legal cases and defend themselves.⁸

12) Detention center medical systems have limited health care services, are frequently understaffed, and are focused on managing acute care needs rather than chronic medical problems, resulting in medical neglect, delayed diagnoses and care, and severe negative consequences, especially among trauma-exposed individuals.⁹ Many detained individuals who need supportive psychotherapy do not receive it.¹⁰

13) Detained individuals face long delays in receiving both standard preventive and emergency care from medical professionals at detention clinics. When individuals do receive care, their medical needs often go completely unmet. Water and ibuprofen are the most commonly prescribed remedies for a wide range of symptoms and disorders. Detained individuals at the El Paso Processing Center reported that when they sought help for medical problems, the medical staff sometimes simply performed internet searches of their symptoms, and provided them with "advice" such as "drink more water."¹¹

14) As a result, many simply do not request medical help anymore. One woman stated, "When we have pain, we don't tell anyone. It isn't worth it. They won't help us, and if we complain, they treat us worse."¹²

15) In one detention center in California, I, Dr. Saadi, met and reviewed the medical records of a man who had been thriving and holding steady employment for years while on

⁶ "Diabetes and Mental Health," Centers for Disease Control and Prevention, last updated May 2021,

<https://www.cdc.gov/diabetes/managing/mental-health.html>; Fagiolini A, Goracci A. The effects of undertreated chronic medical illnesses in patients with severe mental disorders. *J Clin Psychiatry*. 2009 70 Suppl 3:22-9.

⁷ D'Aurizio G, Caldarola A, Ninniri M, Avvantaggiato M, Curcio G. Sleep Quality and Psychological Status in a Group of Italian Prisoners. *Int J Environ Res Public Health*. 2020 Jun 13;17(12):4224. See also Freeman, D., Sheaves, B., Waite, F., Harvey, A.G. and Harrison, P.J. Sleep disturbance and psychiatric disorders. *The Lancet Psychiatry*. 2020 7(7), pp.628-637.

<https://www.sciencedirect.com/science/article/abs/pii/S221503662030136X>.

⁸ Alhola, P. and Polo-Kantola, P. Sleep deprivation: Impact on cognitive performance. *Neuropsychiatric Disease and Treatment*. 2020. <https://psycnet.apa.org/record/2008-02717-005>; see also Lim, J. and Dinges, D.F., A meta-analysis of the impact of short-term sleep deprivation on cognitive variables. *Psychological Bulletin*, 2010 136(3), p.375.

<https://psycnet.apa.org/doiLanding?doi=10.1037%2Fa0018883>.

⁹ *Supra* n. 1.

¹⁰ Human Rights First. *Ailing Justice: Texas Soaring Immigration Detention, Shrinking Due Process*. 2018.

¹¹ *Id.* at 19.

¹² *Id.*

schizophrenia medications. Then he was picked up and detained by ICE. In detention, ICE personnel abruptly stopped his medications. After a nearly two-week delay, an alternative medication was prescribed, but it was not as effective. ICE prescribed alternate medication because it was less expensive. This case is emblematic of a larger trend in immigration detention facilities where medical decisions are often made with profit in mind rather than what is evidence-based medical practice and the patient's best interest. As a result, this individual's mental health deteriorated, and he experienced worsening auditory hallucinations and suicidal thoughts. He attempted suicide four times while in detention.¹³

16) Detained individuals report verbal and physical abuse by guards, which can significantly worsen their mental health. For example, during one of his acute mental health crises, the man with schizophrenia I interviewed recalled banging his body against a wall as he wrestled with voices telling him to kill himself. He said a guard referred to his distress as a "tantrum" and told him to "get over it." Other detainees told me that staff used frequent racial epithets and also referred to them as "crazies," or "Loony Tunes," or "trash." As another detained individual put it: "They see us not like human but as animals here."¹⁴

17) Because some security personnel and private prison officials are responsible for developing and managing health services, there is often a punitive instead of therapeutic approach to mental health care.¹⁵ The fear of negative consequences, including punitive treatment and overmedication force many to try to cope on their own instead of seeking help.¹⁶ Indeed, many detention facilities use solitary confinement as punishment or to monitor individuals who experienced victimization or are mentally ill, despite its detrimental impact on physical and psychological well-being.¹⁷

18) Individuals are particularly afraid to disclose suicidal thoughts for fear of being put in solitary confinement. One individual at the Adelanto Detention Center sliced her wrists, requiring five days of hospitalization. Mental health staff wrote: "[Cristina] has been hesitant to tell myself and other providers about her cutting and how severe her [suicidal ideation] is because she doesn't want to be placed in a suicide smock and made to sit alone in a cell." Another detained individual at Adelanto stated, "I cannot ask for help because they will put me on suicide watch by myself and I get more depressed. It does not help. I don't trust them. So I suffer in silence."¹⁸

¹³Altaf Saadi, "Op-Ed: Immigrants are suffering in detention. They need adequate healthcare now," *L.A. Times* (February 25, 2021), <https://www.latimes.com/opinion/op-ed/la-oe-saadi-immigration-health-care-detention-facilities-2019025-story.html>.

¹⁴*Id.*

¹⁵*Supra* n.1.

¹⁶Ailing Justice: Texas Soaring Immigration Detention, Shrinking Due Process. Human Rights First. 2018.

¹⁷*Supra* n.1.

¹⁸Aaron J. Fischer, Pilar Gonzalez, Richard Diaz. *There Is No Safety Here: The Dangers for People with Mental Illness and Other Disabilities in Immigration Detention at GEO Group's Adelanto ICE Processing Center*. Disability Rights California (March

- 19) A 2018 study of ICE solitary confinement placements lasting longer than 14 days revealed that over 57% of solitary confinement cases involved an individual with a mental illness, though these individuals are estimated to make up only about 15% of the ICE detainee population. Solitary confinement is being used as both a short and long-term approach to managing mental illness within detention facilities. For instance, the study reported dozens of cases of mental illness diagnoses within solitary confinement, as well as dozens of separate cases where individuals were moved to suicide watch upon placement in solitary confinement.¹⁹ The study discussed that there may be aggravation or degradation of mental health during confinement, which has been demonstrated within a larger body of literature.²⁰
- 20) Overcrowding, unsanitary conditions, and inadequate ventilation lead to the spread of disease and contribute to poor health.²¹ Prior infectious disease outbreaks in detention have included mumps, measles, and influenza. The conditions of confinement in immigration detention facilities create a perfect storm for the spread of COVID-19 infections. The COVID-19 pandemic has exacerbated the mental health challenges of detained individuals. Individuals are unable to see their families or participate in facility activities, further isolating them and provoking or exacerbating anxiety, trauma, and psychological distress. COVID-19 has also led to increased reliance on solitary confinement for individuals with respiratory symptoms.
- 21) The immigration detention system appears ill-equipped to provide adequate medical care to detained individuals. Based on our observations, it may in fact be impossible to deliver good medical care in a structure that is designed to punish. A foundation for well-being is absent. Even if medical and mental health services improved, physical and mental well-being is contingent on humane living conditions, which cannot be fundamentally fixed in this punitive system. Additionally, in detention, there is a widespread and often false assumption that the medical concerns of detained individuals are not legitimate. Corrections officers and medical staff mistrust detained individuals and often believe that they are exaggerating symptoms. There is a lack of basic respect for those seeking treatment, which runs contrary to how a therapeutic relationship with an individual should be developed.

2019), https://www.disabilityrightsca.org/system/files/file-attachments/DRC_REPORT_ADELANTO-IMMIG_DETENTION_MARCH2019.pdf.

¹⁹ Patler, C., Sacha, J.O. & Branich, N. The black box within a black box: Solitary confinement practices in a subset of U.S. immigrant detention facilities. *J Pop Research*. 2018, 35, 435–465. <https://doi.org/10.1007/s12546-018-9209-8>.

²⁰ Reiter K, Ventura J, Lovell D, Augustine D, Barragan M, Blair T, Chesnut K, Dashtgard P, Gonzalez G, Pifer N, Strong J. Psychological Distress in Solitary Confinement: Symptoms, Severity, and Prevalence in the United States, 2017-2018, *Am J Public Health*. 2020 Jan,110(S1):S56-S62. <https://pubmed.ncbi.nlm.nih.gov/31967876/>; see also Luigi M, Dellazizzo L, Giguère CÉ, Goulet MH, Dumais A. Shedding Light on "the Hole": A Systematic Review and Meta-Analysis on Adverse Psychological Effects and Mortality Following Solitary Confinement in Correctional Settings. *Front Psychiatry*. 2020 Aug 19, 11:840.

²¹ Patler C, Saadi A. Risk of Poor Outcomes with COVID-19 Among U.S. Detained Immigrants: A Cross-Sectional Study. *J Immigr Minor Health*. 2021;23(4):863-866.

22) The individuals in detention who we have worked with suffer from dangerous neglect. Their experiences are not uncommon or exceptional. Their experiences are representative of conditions across immigration detention facilities. Without accountability for the neglect and abuse experienced by individuals in ICE custody, there will continue to be deaths and exacerbated, serious mental health problems for those in detention.²²

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief.

Executed on the 16 day of May in the year of 2022.

Signature:



Altaf Saadi, MD MSc

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief.

Executed on the 16 day of May in the year of 2022.

Signature:



James Recht, MD

²² *Supra* n. 1.

CURRICULUM VITAE

Date Prepared: April 14, 2022

Name: Altaf Saadi

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Education:

08/2004-05/2008	B.A.	Psychology, International Studies	Yale University
08/2009-05/2013	M.D. <i>cum laude</i>	Medicine	Harvard Medical School
07/2017-09/2018	M.Sc.	Health Policy and Management	University of California, Los Angeles

Postdoctoral Training:

06/2013-06/2014	Intern	Medicine	Massachusetts General Hospital
06/2014-06/2017	Resident	Neurology	Harvard Partners MGH-BWH
07/2017-07/2019	Postdoctoral Fellow	Health Services Research	University of California, Los Angeles National Clinician Scholars Program

Faculty Academic Appointments:

09/2019-01/2022	Instructor	Neurology	Harvard Medical School
02/2022-	Assistant Professor	Neurology	Harvard Medical School

Appointments at Hospitals/Affiliated Institutions:

10/2017-06/2018	Staff Neurologist	Neurology	Olive View-University of California Los Angeles Medical Center
01/2019-04/2019	Volunteer Neurologist	Neurology	Rancho Los Amigos National Rehabilitation Center
09/2019-	Assistant in Neurology	Neurology	Massachusetts General Hospital

Other Professional Positions:

07/2017-	Medical Expert and Volunteer Physician	Physicians for Human Rights Asylum Network
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Major Administrative Leadership Positions:

Local

02/2020-	Associate Director, MGH Asylum Clinic	Massachusetts General Hospital, Center for Global Health
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Committee Service:

National

01/2019-04/2020	Beyond Flexner Alliance	Member, Research Committee
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International

11/2017-	The Lancet	Member, Commission on Public Policies and Health in the Trump Era
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Professional Societies:

2014-	American Academy of Neurology 2016-2017	Member, Global Health Section Newsletter Editorial Board
2019-	2019-	Member, Refugees & Asylum Seekers Working Group
2020	2020	Abstract Reviewer for Health Care Disparities abstracts for annual meeting
2021-	2021-	Inclusion, Diversity, Equity, Anti-racism, and Social Justice (IDEAS) Subcommittee Abstracts Reviewer for Health Care Disparities abstracts for annual meeting

2014-	American Neurological Association 2018-2019 2019, 2020 2020-	Member, Junior Task Force Committee Abstract Reviewer for annual meetings Member, International Outreach Committee
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2018-	American Public Health Association 2019, 2020	Member, Abstract Selection Committee for Community Health Planning and Policy Development program
	2020	Moderator, Medical Care Committee Oral Session

Editorial Activities:

- **Ad hoc Reviewer**

The Lancet American Journal of Public Health Journal of Immigrant and Minority Health JAMA Network Open JAMA Internal Medicine JAMA Neurology	PLOS One Journal of Evaluation in Clinical Practice Injury Epidemiology Neurohospitalist Health Equity Journal of General Internal Medicine
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Honors and Prizes:

2008	Nakanishi Prize	Yale University	Leadership in enhancing race relations
2008	David Everett Chantler Award	Yale University	High moral character and purpose
2012	Dean's Community Service Award	Harvard Medical School	Community Service
2012	Ethics Fellow	Fellowship at Auschwitz for the Study of Medical Ethics	Ethics
2016	Palatucci Advocacy Leadership Forum	American Academy of Neurology	Leadership
2017	Enhanced Resident Leadership Program	American Academy of Neurology	Leadership

2021	Research Career Institute in Mental Health of Aging	National Institute of Mental Health	Research
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Report of Local Teaching and Training

Teaching of Students in Courses:

06/2014	Patient-Doctor II 2 nd year medical students	HMS 3-hr session for neurology examination teaching
09/2015- 10/2015	Human Systems: Nervous System and Behavior 2 nd year medical students	HMS 1.5-hr sessions per wk for 6 weeks
08/2015	Practice Mini-Clinical Evaluation Exercise (CEX) 3 rd year medical students	HMS 3-hr session
06/2016	Mind, Brain, Behavior and Development 2 nd year medical students	HMS 1-hr session for 2 weeks
03/2018- 05/2018	Doctoring I (Substitute Instructor) 1 st year medical students	David Geffen School of Medicine at UCLA 3-hr session for 3 weeks
12/2019	Health Advocacy II 2 nd year medical students	HMS, Cambridge Integrated Clerkship 3-hr session
07/2020	Mind Brain Behavior Course 1 st year medical students	HMS 1-hr guest lecture
07/2021	Mind Brain Behavior Course 1 st year medical students	HMS 1-hour lecture

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs):

08/2015	Neurology examination teaching PGY Internal Medicine Residents	BWH 1-hour session for two sessions
06/2016	Arterial lines and lumbar puncture skills workshop PGY2 Neurology Residents	BWH 40-minute session for five sessions
11/2019	Neurocysticercosis: A neglected “Great Imitator”	Harvard Partners MGH-BWH Neurology Residency noon didactic 1-hour session
12/2019	Unconscious Bias in Medicine	Harvard Partners MGH-BWH Neurology Residency discussion 1-hour session
08/2020	Health Equity and the Boston Context	Harvard Partners MGH-BWH Neurology Residency noon didactic 1-hour session
09/2020	Immigration and Mental Health	MGH Psychiatry Residency Psychosomatics Lecture 1-hour session
11/2020	Immigration, Healthcare, and Health: In Boston and Beyond	Harvard Partners MGH-BWH Neurology Residency noon didactic

1-hour session

Formal Teaching of Peers (e.g., CME and other continuing education courses):

No presentations below were sponsored by 3rd parties/outside entities

- 2021 Engaging Multifaceted Patients
MGB Health Equity, Quality & Patient Experience (QPE), Education & Training
- 2021 Patient Experience Forum: Immigrant Health 101: Meeting the Needs of Immigrant Patients
MGH/ MGPO Office of Patient Experience

Selected Local Invited Presentations:

No presentations below were sponsored by 3rd parties/outside entities

- 2017 Racial Disparities in Access and Use of Neurologic Care/ Keeping Current Seminar Series
Disparities Solution Center, MGH
- 2017 Public Health Advocacy in the Current Political Climate/ Grand Rounds
Fielding School of Public Health, UCLA
- 2018 Immigrant Health Advocacy/ Guest Lecture
Leadership and Advocacy Seminar Series, UCLA PRIME-LA Program
- 2019 Policy & Change: The Dangers for People with Mental Illness and Other Disabilities at the
Adelanto ICE Processing Center/ Panelist
Psychiatry Community and Global Psychiatry and Justice, Equity, Diversity and Inclusion,
UCLA
- 2019 Protecting the rights of our immigrant patients
Social Medicine Community Rounds, Cambridge Health Alliance
- 2020 Strategies for Ensuring Welcoming, Safe, and Equitable Health Care Environments for
Immigrant Populations
MGH Disparities Leadership Institute Workshop
- 2020 Immigration Detention, Mass Hysterectomies, and Pattern of Medical Neglect/ invited panel
presentation
Harvard Law School Immigration Project
- 2020 Creating Immigrant Friendly Health Systems: A Review of Best and Local Practices/ Speaker
MGH Center for Immigrant Health, Migration is Beautiful Campaign
- 2021 Latinx Immigrant Patient Experience / Panelist
Latino Medical Student Association (LMSA), Harvard Medical School
- 2021 Strategies for Ensuring Welcoming, Safe, and Equitable Health Care Environments for
Immigrant Populations
MGH Disparities Leadership Institute Workshop
- 2021 Policing and the Brain: How Neuroscience Can Contribute to Police Reform/ invited panel
presentation
Harvard Law School Petrie-Flom Center, MGH Center for Law, Brain, and Behavior
- 2021 Meeting the neurological needs of refugees and asylum-seekers/ invited presentation
MGH Department of Neurology, Stroke Research Meeting
- 2021 Trauma, Refugees, and Asylum Law / Guest Lecture
Trauma, Refugees and Asylum Law Seminar, Harvard Law School
- 2022 Translating Health Disparities Research into Practice/Policy
MGH Post-Baccalaureate Association Exploring Career Trajectories Speaker Series

Report of Selected Regional, National and International Invited Teaching and Presentations

No presentations below were sponsored by 3rd parties/outside entities

Regional

- 2011 Perspectives on Preventive Health Care and Barriers to Breast Cancer Screening Among Iraqi Women Refugees (selected oral abstract)
Society of General Internal Medicine: New England Regional Convention
- 2018 Health Care Disparities in Neurology: Where We are & Where We Need to Go/ Grand Rounds
Department of Neurology, University of Iowa
- 2018 Social Determinants of Neurological Disease: The Path to Health Equity/ Grand Rounds
Department of Neurology, University of California Irvine
- 2019 Immigrant Access to Healthcare/ invited workshop presentation
Insure the Uninsured Project (ITUP) Annual Conference, Sacramento CA
- 2019 Powerful Women in Health/ Guest Lecture Panelist
Dean's Powerful Women Speaker Series, Mount Saint Mary's University
- 2019 Immigrant health Under Trump: A Provider's Perspective/ invited webinar presentation
University of Southern California Center for Health Journalism
- 2019 Evidence Briefing: Policy & Practice Innovations to Protect & Improve Immigrant Health/
invited presentation
California Initiative for Health Equity and Action, California Latino Legislative Caucus,
Sacramento CA
- 2020 Immigrant Health Inequities, COVID-19 & Opportunities for Action/ Guest Expert Lecture
City of Boston's COVID-19 Health Inequities Task Force
- 2020 Immigrant Health Inequities, COVID-19 and Opportunities for Action / invited presentation
Boston Mayor's Office for Immigrant Advancement, COVID-19 Health Inequities Task Force
- 2020 Building Toward Racial Justice and Equity in Health / invited panel presentation
Massachusetts Attorney General's Office
- 2021 Immigrant Friendly Health Systems: Advancing the Concept of "Immigration-Informed Care"/
Grand Rounds
Boston Health Care for the Homeless
- 2021 Role of Advocacy in Neurology and Research: A Pathway for Changemaking/ Grand Rounds
Department of Neurology, Boston University Medical Center
- 2022 Neurologist as Advocate/ Guest Lecture
Spectrum of Physician Advocacy-1 Course, Boston University School of Medicine
- 2022 Neuropsychiatric Health of Refugees: Clinical and Policy Implications/ Ground Rounds
Department of Psychiatry, Boston University Medical Center

National

- 2017 Neurologic care access and utilization patterns in the United States (selected oral abstract)
Neuroepidemiology Platform Presentation, American Academy of Neurology Annual Meeting
Boston, MA
- 2017 From Zambia to the Navajo Nation: Incorporating the "Local" in Global Neurology/ invited
presentation
American Neurological Association Annual Meeting
San Diego, CA

- 2018 When the Target of Bias is the Provider: Navigating Discrimination in the Healthcare Workplace (selected oral abstract)
Beyond Flexner Alliance (Social Mission in Health Professions Education) 2018 Conference
Atlanta, GA
- 2018 Current policies and the health of immigrants/ invited panel presentation
Dean's Symposium on the Trump administration and the health of the public, Boston
University School of Public Health
Boston, MA
- 2018 Healthcare for Immigrants: Impact of Immigration Policy on Immigrant Health/ invited workshop presentation
Physicians for a National Health Program Annual Meeting
San Diego, CA
- 2018 Health Equity Now for Immigrants, Migrants and Refugees (selected oral abstract)
American Public Health Association Annual Meeting
San Diego, CA
- 2019 Engaging Scientists in the Science and Religion Dialogue/ invited panel presentation
American Association for the Advancement of Science (AAAS) Dialogue on Science, Ethics, and Religion (DoSER) program, University of Maryland-Baltimore
Baltimore, MD
- 2019 Perceived barriers and facilities to implementing "Sanctuary" "Safe spaces" policies for Immigrants in the Healthcare Context: A qualitative, multi-state study (selected oral abstract)
American Public Health Association Annual Meeting
Philadelphia, PA
- 2019 Increased acculturation enhances the negative impact of perceived discrimination on mental health (selected oral abstract)
American Public Health Association Annual Meeting
Philadelphia, PA
- 2020 Protecting Immigrants during the COVID-19 Pandemic/ invited panel presentation
Jewish Council for Public Affairs
New York, NY (Virtual)
- 2020 Symposium on Trauma-Informed Care for Immigrants/ invited presentation
University of California Davis Center for Reducing Health Disparities
Davis, CA (Virtual)
- 2020 Health Disparities and Parkinson's Disease: Understanding the Issue/ invited presentation
Davis Phinney Foundation for Parkinson's, Health Disparities Webinar Series
Louisville, CO (Virtual)
- 2020 Health Care Providers: How to Preserve Access to Care & Protect your Patients from Border Patrol and ICE Interference/ invited presentation
National Immigration Law Center, Physicians for Human Rights, and ACLU of Texas Border Rights Center Webinar Training
Houston, TX (Virtual)
- 2020 Twitter and Social Media: A Role for Neurology and Neuroscience Engagement/ Chair
American Neurological Association Annual Meeting
Los Angeles, CA (Virtual)
- 2020 Global Health at Home: Underserved Populations in the U.S./ invited presentation
American Neurological Association Annual Meeting
Los Angeles, CA (Virtual)

- 2020 Caring and Advocating for Immigrant Patients in the Current Political Climate/ Chair and Panelist
The Compassion in Action Healthcare Annual Conference
Boston, MA (Virtual)
- 2020 The Physician Role in Caring for Refugee Populations Locally and Globally/ invited panel presentation
Johns Hopkins School of Medicine, Refugee Health Partnership Student Group
Baltimore, MD (Virtual)
- 2021 Immigrant Friendly Health Systems: Advancing the Concept of “Immigration-Informed Care”/ invited presentation
Protecting Immigrant Families Campaign, Research Working Group
Virtual
- 2021 Health Disparities and Parkinson’s Disease: The Role of Trust/ invited panel discussion
Davis Phinney Foundation for Parkinson’s, Webinar Series
Louisville, CO (Virtual)
- 2021 Socioeconomic Consequences of Health Disparities (CME course) / invited presentation
Cleveland Clinic, Health Disparities 2021
Cleveland, OH (Virtual)
- 2021 Racial/Ethnic Health Disparities/ invited presentation
American Academy of Neurology Annual Meeting, Health Disparities Course (Virtual)
- 2021 Creating Immigrant-Friendly Health Systems
Urban Institute, Program on Immigrants and Immigration Brownbag Session
Washington, D.C. (Virtual)
- 2021 Neuropsychiatric Health of Refugees: Implications for Clinical Practice and Structural Policies/invited presentation
Refugee Health Symposium, UC San Diego Altman Clinical and Translational Research Institute, Center for Life Course and Vulnerable Population Research
San Diego, CA (Virtual)
- 2021 Role of Advocacy in Neurology and Research: A Pathway for Changemaking/ Grand Rounds
Department of Neurology, Northwestern University Feinberg School of Medicine (Virtual)
- 2021 “You only leave home when home won’t let you stay”: Displaced Populations and their Neuropsychiatric Health/ Grand Rounds
Department of Neurology, Hartford HealthCare and University of Connecticut (Virtual)
- 2021 Cumulative Risk of Immigration Detention Conditions on Health Outcomes Among Detained Immigrants in California (selected oral abstract)
American Public Health Association Annual Meeting (Virtual)
- 2021 Anti-Racism in Medicine: Anti-Racism in Immigration & Policy/ invited presentation
Society of General Internal Medicine Health Equity Commission “Anti-Racism in Medicine” Webinar Series (Virtual)
- 2021 Neurological Health Disparities and the COVID-19 Pandemic/ invited presentation
American Neurological Association Annual Meeting, Health Services Special Interest Group Session (Virtual)
- 2021 Healthcare in ICE Detention/ invited presentation
University of Southern California Equity Research Institute Symposium (Virtual)
- 2021 Equity for Displaced Populations: Policy and Practice Imperatives/ Grand Rounds
Department of Medicine, Baylor College of Medicine (Virtual)

- 2022 The Neuropsychiatric Health of Refugees, Asylum Seekers and Forcibly Displaced People: Our Roles as Neurologists and Advocates/ Ground Rounds
Department of Neurology, The University of Chicago Medicine (Virtual)
- 2022 Supporting Immigrants, Refugees and Asylum-Seekers: A Role for Neurology, Research and Advocacy / Grand Rounds
Department of Neurology, University of California Los Angeles (Virtual)

International

- 2018 Medical-Forensic Examination for Asylum Seekers/ Webinar presentation
International Association of Forensic Nurses (Virtual)
- 2020 Anti-Immigrant Policy Climate and the need for “Sanctuary” or “Safe Spaces” in the Clinical Context/ Workshop
North American Refugee Health Conference (Virtual)

Report of Clinical Activities and Innovations

Current Licensure and Certification:

- 2020- Maine Medical License
2020- New Hampshire Medical License
2019- Massachusetts Medical License
2017-2019 California Medical License
2017 Certification, American Board of Psychiatry and Neurology

Selected Report of Scholarship

Peer-Reviewed Scholarship in print or other media:

Research Investigations

1. Jamal M, Yoon E, **Saadi A**, Sy T, Hashemzadeh M, Trends in the Utilization of Endoscopic Retrograde Cholangiopancreatography (ERCP) in the United States. *American Journal of Gastroenterology*. 2007 May; 102(5): 966-75. Epub 2007 Mar 23. PMID: 17319932.
2. Harburger, LL, Pechenino, A, **Saadi, A**, Frick, KM, Post-training Progesterone dose-dependently enhances object, but not spatial, memory consolidation. *Behavioural Brain Research*. 2008 Dec 12; 194(2): 174-80. PMID: 18687366.
3. Harburger, LL, **Saadi, A**, and Frick, KM, Dose-dependent effects of post-training estradiol plus progesterone treatment on object memory consolidation and hippocampus ERK activation in young ovariectomized mice. *Neuroscience*. 2009 April 21; 160(1): 6-12. PMID: 19223011.
4. **Saadi, A**, Bond, BE, Percac-Lima S. Perspectives on Preventive Health Care and Barriers to Breast Cancer Screening Among Iraqi Women Refugees. *Journal of Immigrant and Minority Health*. 2012 Aug; 14(4): 633-63. PMID: 21901446.
5. **Saadi A**, Bond, BE, Percac-Lima S. Bosnian, Somali, and Iraqi refugee women speak: A comparative study of refugee health beliefs on preventive health and breast cancer screening. *Women's Health Issues*. 2015 Sep-Oct; 25(5): 501-8. PMID: 26219676.
6. **Saadi A**, Patenaude B, Nirola D, Deki S, Tshering L, Clark S, Schaul L, Sorets T, Fink G, Mateen F, Quality of life in epilepsy in Bhutan. *Seizure*. 2016 July; 39: 44-8. PMID: 27257785.
7. **Saadi A**, Patenaude B, Mateen F, Quality of life in Epilepsy-31 inventory (QOLIE-31) Scores: A Global Comparison. *Epilepsy & Behavior*. 2016 Dec; 65: 13-17. PMID: 27838562.
8. **Saadi A**, Himmelstein DU, Woolhandler S, Mejia NI, Racial disparities in neurologic health care access and utilization in the United States. *Neurology*. 2017 Jun 13;88(24):2268-2275. Epub 2017 May 17. PMID: 28515272.

9. **Saadi A**, Okeng'o K, Biseko M, Shayo A, Mmbando T, Grundy S, Xu, A, Parker, R, Wibecan L, Iyer G, Onesmo P, Kapina B, Regenhardt R, Mateen FJ. Post-Stroke Social Networks, Depressive Symptoms, and Disability in Tanzania: A Prospective Study. *International Journal of Stroke*. 2018 Jan 01; 1747493018772788. PMID: 29676225.
10. Kim G**, Sanchez Molina U**, **Saadi A**. Inclusion of Immigration Status in Medical Records. *American Medical Association Journal of Ethics*. 2019 Jan; 21(1): E8-16. doi: 10.1001/amajethics.2019.8. **mentee
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3. **Saadi A**, McCray B, Ensrud E, Prasad S. Tongue infarction due to giant cell arteritis. *Practical Neurology*. 2016 Jan 5; 16(3): 231. PMID: 26733724.
4. Miskin DP, **Saadi A**, Chikoya L, Sloane JA, Koralnik IJ, Siddiqi OK. Challenges in the diagnosis and treatment of CNS demyelinating disorders in Zambia. *Multiple Sclerosis Journal Experimental, Translational and Clinical*. 2016. July 4; 2: 2055217316657117. eCollection 2016 Jan-Dec. PMID: 28607733.
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7. **Saadi A**, Ahmed S, Katz MH. Making a Case for Sanctuary Hospitals. *Journal of the American Medical Association*. 2017 Dec 5; 318(21):2079-2080. PMID: 29049516

8. Crotty GF, McKee K, **Saadi A**, Young AC, Solomon IH, Lyons JL. Clinical pathologic case report: A 70-year-old man with inflammatory cerebral amyloid angiopathy causing headache, cognitive impairment, and aphasia. *Journal of Clinical Neuroscience*. 2018 Mar; 49:71-75. Epub 2017 Dec 14. PMID: 29248380.
9. Ferenczi EA*, **Saadi A***, Bhattacharyya S, Berkowitz A. Glioblastoma arising within sites of encephalomalacia from vascular brain injury: two cases and a review of the literature. *Journal of Clinical Neuroscience*. 2018 Apr; 50: 110-115. PMID: 29422364 **Co-first Author*
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18. Franco-Vasquez A, Lemus S, Castillo K, Isaac M, **Saadi A**. Integration of Waiting Room 'Know Your Rights' Education into Medical Care of Immigrant Patients in a Federally Qualified Health Center: A Case Study. *Health Equity*. 2022 Jan 17; 6(1):13-20. doi: 10.1089/heq.2020.0145.
19. **Saadi A**, Medizabal A, Mejia N. Teleneurology and Health Disparities. *Seminars in Neurology*. In Press.

Curriculum Vitae

Date Prepared: January 2022

Name: James Recht, MD

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Community Practice
Boston Healthcare for the Homeless Program
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Phone: 617-876-0049

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Place of Birth: Milwaukee, Wisconsin

Education:

1986 B.A.; Marquette University (Psychology)

1990 M.D.; University of Wisconsin Medical School

Postdoctoral Training:

07/90-06/92 Internship and PGY-II Psychiatry
Tufts University/New England Medical Center
Boston, Massachusetts

07/93-06/94 PGY-III and PGY-IV in Psychiatry
St. Elizabeth's Medical Center
Boston, Massachusetts

Faculty Academic Appointments:

05/2013-current Assistant Professor of Psychiatry Part-Time, Harvard Medical School

Curriculum Vitae

Hospital/Affiliated Institution Appointments:

Current	Active Staff Boston Healthcare for the Homeless Program
	Teaching Associate Department of Psychiatry, Cambridge Health Alliance
	Co-Director Cambridge Health Alliance Asylum Program
05/2018-01/2021	Clinical Consultant, MGH Asylum Clinic, Massachusetts General Hospital

Professional Societies:

1990-current	Member, Massachusetts Medical Society
2008-current	Member, Physicians for a National Health Program
2009-current	Member, Physicians for Human Rights

Honors and Prizes:

1986	Phi Beta Kappa, Marquette University
1986	Magna cum Laude, Marquette University

Current Licensure and Certification:

1990-current	Massachusetts Medical License
1996-current	Board Certification, American Board of Neurology and Psychiatry
2001-current	DATA 2000 Authorization Buprenorphine Office-Based Treatment of Opioid Addiction

Appendix E

I, Dr. William Weber, make the following declaration based on my personal knowledge and declare under the penalty of perjury pursuant to 28 U.S.C. § 1746 that the following is true and correct:

- 1) I am a board-certified emergency physician on faculty at Harvard Medical School and the Beth Israel Deaconess Medical Center. I completed my medical education at Northwestern University and my residency in emergency medicine and fellowship in global emergency medicine at the University of Chicago.
- 2) I have a master's degree in public health and have served as a subcommittee chair on the American College of Emergency Physicians (ACEP) Public Health and Injury Prevention Committee since 2018. Our committee writes national practice and policy statements regarding systemic issues that influence public safety and emergency care.
- 3) I am the Medical Director of the Medical Justice Alliance (MJA), a nonprofit organization that seeks to help courts and administrative organizations better understand the medical condition of individuals in carceral settings by providing pro-bono expert witness testimony. In my work, I routinely review medical records pertaining to the medical care of patients in carceral facilities scattered throughout the U.S. and have written over 80 medical declarations discussing care as it pertains to the National Detention Standards, Centers for Disease Control and Prevention (CDC) recommendations for carceral facilities, and accepted standards of medical care. I have taught over 150 physicians from various specialties how to review medical records and evaluate the care received by patients. As a result of our work, multiple large prison systems have adopted strategies to comply with Centers for Disease Control and Prevention (CDC) guidelines. Over the past two years, we have reviewed cases of individuals in immigration detention in over ten detention facilities nationwide, including facilities in Arizona, California, Colorado, Michigan, Wisconsin, and others.
- 4) In my own daily practice, I often encounter individuals dealing with mental health crises, including those who are in immigration custody. I have conducted health evaluations for refugees seeking asylum, including discussing the physical and psychological difficulties faced in their countries of origin and during the immigration experience. In my volunteer work, I have worked with clients at numerous prisons, jails, and detention centers nationwide, including in Arizona, California, Illinois, and Wisconsin.
- 5) Based on my experiences working with detained individuals in facilities nationwide and supervising other physicians in my organization, I have observed the traumatic impacts of detention on individuals with previous psychiatric conditions and mental health challenges. In general, immigrant detention is already a traumatic time even without

previous psychiatric conditions. Many individuals who enter immigration detention already suffer from Post-traumatic Stress Disorder (PTSD) and/or depression as a result of experiences of traveling and being displaced or from facing persecution in their countries of origin. Detention exacerbates these underlying mental health conditions because such individuals do not have access to adequate treatment and medications and are deprived of many meaningful coping mechanisms such as family support or community networks due to their incarceration.

- 6) System-wide, mental health issues of individuals in detention are often ignored, misdiagnosed, or re-labeled as a disorder different from the one presented. For example, in California, a gentleman with known paranoid delusions had required psychiatric hospitalization due to abnormal behavior and thought patterns that rendered him incompetent to stand for trial. He was stabilized with medication and psychotherapy to the point that he regained competence to stand for trial. However, once he was placed in ICE custody, they discontinued his psychiatric medications and therapy despite numerous signs of worsening mental health status. As a result, the gentleman regressed and was found unfit to stand for trial again.¹

- 7) I have also worked with mentally ill individuals in detention who were taken off psychiatric medications and subsequently placed into solitary confinement or segregation. Segregation is a known risk factor for worsening a variety of mental health conditions.^{2,3} For instance, a client I worked with was initially placed in solitary confinement and while there his mental state decompensated to the point where he developed delusions and required offsite inpatient hospitalization. Despite being cleared for removal from solitary confinement, he was kept there while staff waited for orders from ICE on a plan for his release and location.⁴ This case is indicative of the damage that solitary confinement can cause patients who are already isolated from their loved ones, in a different culture, and who have often experienced past trauma.

- 8) Based on the significant scientific evidence of mental and physical effects of segregation, I believe that subjecting individuals with severe mental health conditions to segregation should be prohibited. If patients are so unstable as to not be safe in the general

¹ See *Domingo v. Barr*, CASE NO. 20-cv-06089-YGR, 2020 WL 5798238 (N.D. Cal. Sep. 29, 2020).

² Craig Haney, *Restricting the Use of Solitary Confinement*, Annual Review of Criminology, Vol. 1:285-310 (January 2018), <https://www.annualreviews.org/doi/abs/10.1146/annurev-criminol-032317-092326>.

³ Mike Corradini, Kristine Huskey, and Christy Fujio, *Buried Alive: Solitary Confinement in the U.S. Detention System*, Physicians for Human Rights (April 2013), <https://phr.org/wp-content/uploads/2013/04/Solitary-Confinement-April-2013-full.pdf>

⁴ Client is plaintiff in *Fraihat v. ICE*, 16 F.4th 613 (9th Cir. 2021).

population, there should be consideration of transition to a higher intensity of psychiatric care at a specialized psychiatric facility. In the criminal legal system, there are prisons that acknowledge this boundary for those with mental health challenges; but, in the immigration detention system, my observation is that segregation is often used without regard for mental health or disability.

- 9) Detention facilities regularly fail to provide adequate interpretation services for detained immigrants who do not speak fluent English. In nearly all of the cases I have reviewed, facilities fail to use interpreter services in a substantial proportion of visits, with many cases of using interpreters less than 30% of the time. The National Detention Standards require that facilities “identify detainees with limited English proficiency (LEP) (i.e., detainees who do not speak English as their primary language and who have limited ability to read, speak, write, or understand English) and provide LEP detainees with meaningful access to their programs and activities through language interpretation and translation services... through professional in-person or telephonic interpretation and translation services or bilingual personnel.”⁵
- 10) The failure of facilities to provide interpretation services can be a detriment to immigrant mental health in multiple ways. For instance, if an immigrant is unable to express their feelings with medical or psychological staff, they might feel more increasingly isolated. Furthermore, staff might not realize if a patient’s mental condition is worsening or if the patient were developing dangerous symptoms such as suicidal thoughts. The lack of consistent interpreter services risks damaging the mental health of detained immigrants and increases the potential of needing increased emergency resources if that person’s condition worsens.
- 11) Initial evaluations of those detained typically lack thoroughness and do not adequately address the root issues of mental health problems. Evaluations tend to ask generic yes/no questions without appropriate follow-up or discussion of a patient’s mental state. Questions such as “are you having thoughts of hurting yourself?” alone are insufficient to adequately assess and treat mental health problems. These shallow assessments result in providers failing to diagnose severe mental illness or refer individuals to external providers who could provide better mental health care.
- 12) Detention is traumatic and worsens mental illness—that is well-documented in academic studies and also evident through my experiences.⁶ For an individual struggling with a

⁵ National Detention Standards for Non-Dedicated Facilities, U.S. Immigration and Customs Enforcement (ICE) (revised 2019), <https://www.ice.gov/doclib/detention-standards/2019/nds2019.pdf>.

⁶ Caitlin Palter, Altaf Saadi, Maria-Elena De Trinidad Young, Konrad Franco, *Release from US immigration detention may improve physical and psychological stress and health: Results from a two-wave panel study in*

mental health disorder or disability, not having any control over their lives, not choosing what food they eat, and not having their own room can undermine their ability to cope with their mental health challenges. These impediments to mental health are exacerbated for individuals in solitary confinement or segregation where lights are typically left on 24 hours a day or individuals are frequently woken up throughout the night. These conditions are disruptive to sleep, which is critical for those suffering from mental health challenges and can prolong and increase damage.

13) The practice of transferring individuals across various detention facilities within the immigration system has an added negative impact on individuals with mental health challenges and disabilities. Transfers add yet another destabilizing factor to an individual's experience in detention—the stress of not knowing if and when a transfer will occur leaves individuals and their families in the dark. By relocating individuals to facilities far from family and support networks, transfers cut off the one source of support an individual in a mental health crisis may have during detention. Additionally, transfers fragment care, damaging therapeutic relationships and increasing the risk of gaps in care or failure to reinstate care.

14) The immigration detention system of care regularly falls far below the standard of care for treatment of individuals with mental disabilities and mental health disorders. Some facilities are worse than others, but the system is overall wholly inadequate. Providers are overwhelmed because of the high burden of mental illness amongst those in detention. Those in detention require extra care and attentive support, but often receive the opposite.

I declare under penalty of perjury pursuant to 28 U.S.C. § 1746 that the foregoing is true and correct to the best of my knowledge, memory, and belief. Executed on the 18th day of May in the year of 2022.

Signature:



William Weber, MD, MPH

William Weber MD, MPH

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Education

- 7/2020-3/2022 **The University of Chicago** - Chicago, Illinois
Fellowship in International Emergency Medical Education
- 6/2017-6/2020 **The University of Chicago Medical Center** - Chicago, Illinois
Residency in Emergency Medicine
- 8/2013-5/2017 **Northwestern University Feinberg School of Medicine** - Chicago, Illinois
Doctor of Medicine (M.D.), Magna Cum Laude
- 8/2013-5/2017 **Northwestern University Graduate School** - Evanston, Illinois
Master of Public Health (M.P.H.) with Honors
- 8/2009-6/2013 **Northwestern University** - Evanston, Illinois
Bachelor of Arts (B.A.), Magna Cum Laude

Clinical Experience

- 4/2022-Present **Beth Israel Deaconess Medical Center / Harvard University** – Boston, Massachusetts
Emergency Medicine Attending Physician
- 11/2020-3/2022 **The University of Chicago Comer Children's Hospital** – Chicago, Illinois
Pediatric Emergency Medicine Attending Physician
- 6/2020-3/2022 **The University of Chicago Medical Center** – Chicago, Illinois
Emergency Medicine Attending Physician

Licensure / Certification

- 2022 **Massachusetts – Medical License** – License number: 290881
- 2021 **American Board of Emergency Medicine** - Board Certified
- 2020 **Illinois – Medical License** - License number: 036.153143
- 2019 **Wisconsin – Medical License** - License number: 72342-20

Honors

- 2020 University of Chicago Research in Emergency Medicine Award
- 2019 Emergency Medicine Residents' Association Simulation Research Grant
- 2018 Medical Education, Research, Innovation, and Teaching Scholarship Recipient
- 2018 Emergency Medicine Residents' Association Advanced Airway Scholarship
- 2017 Graduated Magna Cum Laude in Scientia Experimentalis
- 2017 Delta Omega Honors Society for Graduate Studies in Public Health
- 2016 Gold Humanism Honor Society

Peer Reviewed Publications

Society Policies / Guidelines

Weber W, et al. *Clinical Management of Patients with COVID-19: Initial Approach to the Acutely Ill Patient*. World Health Organization (WHO) OpenWHO. 5/2021

Weber W. *License Renewal Fees for Graduating Residents*. Illinois State Medical Society Resolution 09.2020-6 (A-21) 3/2021

Weber W, Heins A, Liang S. *ED Vaccinations*. American College of Emergency Physicians (ACEP) Point-of-Care Tools. 11/2020

Weber W, et al. *COVID-19 Discharge Smart Phrase: Expected Recovery in the American College of Emergency Physicians COVID-19 Field Guide*. 5/2020

Barron R, Liang S, Josephson E, **Weber W**. *Best Practices in Testing Adults and Adolescents for Chlamydia and Gonorrhea in the Emergency Department: An Information Paper*. American College of Emergency Physicians. 7/2019

Weber W, et al. American College of Emergency Physicians Policy Statements (selections below):

Screening for Disease and Risk Factors in the Emergency Department (4/2021)

Prevention of Harm from Internet and Social Media Challenges (10/2020)

Medical Neutrality (6/2020)

Human Trafficking (2/2020)

Separation of Children from Family/Guardians (6/2019)

Academic Work

Weber W, Heins A, Jardine L, Stanford K, Duber H. *Principles of Screening for Disease and Health Risk Factors in the Emergency Department*. [manuscript submitted 2/2022]

Stellpflug S, **Weber W**, et al. *Approach Considerations for the Management of Strangulation in the Emergency Department*. Journal of the American College of Emergency Physicians Open. 4/2022

McFadden G, Thompson K, **Weber W**. *A Man with Difficulty Breathing*. Emergency Medicine Journal (EMJ). 11/2021

Weber W, Ahn J. *COVID-19 Conferences: Resident Perceptions of Online Synchronous Learning Environments*. The Western Journal of Emergency Medicine. 1/2021

Hsu A, **Weber W**, Heins A, Josephson E, Komberg R, Diaz R. *A Proposal for Selective Resuscitation of Adult Cardiac Arrest Patients in a Pandemic*. Journal of the American College of Emergency Physicians Open. 6/2020

Weber W, Moore J, Cheema N. *Traumatic Acetabular Protrusion*. The Western Journal of Emergency Medicine. 4/2018

Weber W. Rosh Review Questions. Rosh Review Emergency Medicine Question Bank. 2018-2020

Non-peer Reviewed Publications

Atencio A, **Weber W**. *Emergency Medicine: A Venezuelan Perspective*. SAEM Pulse Magazine. 5/2022

Meadows J, **Weber W**. *Strengthen Global Toxicology: An Antidote to Disparities in Global and Country-Level Toxicology Systems*. SAEM Pulse Magazine. 5/2022

Haroun K, **Weber W**, Khalifa G. *10 Years Later: The Effect of Egypt's Revolution on Emergency Response Systems*. SAEM Pulse Magazine. 11/2021

Concors E, Smith M, **Weber W**. *COVID-19 Outbreaks in Immigrant Detention Facilities*. SAEM Pulse Magazine. 3/2021

Weber W. *The Unintended Consequences of COVID-19 Lockdowns.* SAEM Pulse Magazine. 9/2020

Weber W. *A Primer for Managing Global Pandemics.* SAEM Pulse Magazine. 5/2020

Barron R, Liang S, **Weber W**, Josephson E. Chlamydia and Gonorrhea Testing Best Practices. ACEP Now. 1/2020

Weber W. *Misjudging Measles.* SAEM Pulse Magazine. 5/2019

Weber W. *Mark One or More Boxes.* Northwestern Medicine Magazine (reprinted). 1/2018

Weber W. *Boxes: My Ambivalence Toward Compartmentalizing.* Diversity and Inclusion Matters. 10/2017

Presentations

Weber W, Peña R. *A Brief Patient Experience Curriculum for Medical Learners to Foster Empathy.* Society for Academic Emergency Medicine (SAEM) Curricular Innovations, New Orleans, LA. 5/2022 [accepted]

Peña R, **Weber W.** *Physician as Patient: Building Empathy in Medical Learners Through Simulating the Patient Experience.* Society for Academic Emergency Medicine (SAEM) National Conference, New Orleans, LA. 5/2022

Weber W, Bedard R, Montagnes M, Neuber S. *The Doctor's White Coat vs. The Officer's Uniform: Who Calls the Shots?* Harvard Medical School and the Petrie-Flom Center at Harvard Law School. Boston, MA. 5/2022

Weber W, Mateos E, Matose T, White B. *A Physican's Duty to Treat: Rethinking Medical Ethics in Carceral Spaces.* Harvard Law School and Harvard FXB Center for Health and Human Rights. Boston, MA. 3/2022

Weber W, Kurin J. *Medical-Legal Advocacy for Patients in Carceral Facilities.* Mount Sinai Human Rights Program. Symposium on Health Justice. New York City, NY. 4/2021

Parmar P, **Weber W**, Murphey D, Niyogi A, Maldonado A, Kumar N. *Best practices in Writing Medical Declarations for Individuals in Detention.* Doctors for America. Immigrant Health Justice Workgroup. Washington, DC. 10/2020

Olson A, Moore P, Olson N, **Weber W**, Derstine A, Heuton M, Ahn J. *The "EM in 5" Curriculum: Learner and Presenter Perceptions.* Council of Residency Directors (CORD) Academic Assembly. Seattle, WA. 4/2019

Weber W. *Septal Necrosis with Oronasal Fistula secondary to Cocaine Insufflation.* Society for Academic Emergency Medicine (SAEM) National Conference, Indianapolis, IN. 5/2018

Davis J, Hall S, **Weber W**, Padela, A. *The Educational Preparedness of Emergency Medicine Trainees in Clinical Ethics.* Society for Academic Emergency Medicine (SAEM) National Conference, Indianapolis, IN. 5/2018

Weber W. *Once You Pop, the Fun Don't Stop: Best Practices after Incision and Drainage.* Illinois College of Emergency Physicians (ICEP) Spring Symposium, Chicago, IL. 5/2018

Weber W. *Playing Patient: Building Empathy through Patient Simulation.* Rocky Mountain Winter Conference on Emergency Medicine, Breckenridge, CO. 2/2018

Extracurricular Activities

Public Health / Social Emergency Medicine

2021-Present

National Medical Director

The Medical Justice Alliance, New York City, NY

Co-founded a non-profit organization that has trained over 150 physicians to provide pro bono expert witness testimony regarding medical care and has supported over 100 individual and class action cases involving individuals who are incarcerated or detained.

- 2018-Present **Public Health and Injury Prevention - Subcommittee Chair**
American College of Emergency Physicians. Irvin, TX
Authored guidelines for a national organization on topics such as strangulation injuries, sexually transmitted infections, and substance use disorders.
- 2018-Present **Patient Resource Advocate: Condoms, clothes, and chargers**
The University of Chicago Medical Center. Chicago, IL
Established a clothing closet for trauma and homeless patients in need of clothes. Started a targeted campaign for sexual wellness and procured over 10,000 condoms to give out to high-risk patients. Worked with volunteer services to provide phone chargers to patients who had no visitor access during the COVID-19 pandemic.
- 2018-Present **Abstract Review Committee**
Society for Academic Emergency Medicine (SAEM), Des Plaines, IL
Reviewed over 150 abstracts submitted to SAEM national conferences from 2018 to 2022.

Academic Emergency Medicine

- 2021-Present **Editorial Board Member**
Medical Malpractice Insights, Kirkland, WA
Helped provide direction and content for a monthly publication meant to improve patient safety through learning from cases involving poor patient outcomes.
- 2021-Present **Founder**
ChartDecoder.org, Chicago, IL
Developed a free web application that builds health literacy and empowers patients by translating technical medical terms in patient medical records into accessible language.
- 2018-2020 **Medical Education Research, Innovation, Teaching, and Scholarship Program**
Office of Graduate Medical Education, The University of Chicago, Chicago, IL
Surveyed residents to understand perceptions of online synchronous learning. Developed a curriculum for residents to simulate patient experiences as a way to build empathy.
- 2014-2017 **Curriculum Review Committee**
Feinberg School of Medicine, Chicago, IL
Compiled student feedback and worked with faculty to improve the medical curriculum.

Global Emergency Medicine

- 2020-Present **Immigrant Health Workgroup – Steering Committee**
Doctors for America - Section of Immigrant Health Justice
Developed a training curriculum for physicians to write medical review letters for immigration cases and trained over 80 physicians, residents, and medical students.

- 2020-Present **Global Emergency Medicine Academy - Executive Board IT Chair**
Society for Academic Emergency Medicine. Des Plaines, IL
Helped lead a committee to unify two national organizations comprising over 30 fellowship programs in global emergency medicine into a single entity.
- 2020-2022 **Medical Forensic Examiner for Asylees**
Marjorie Kovler Center of Heartland Alliance. Chicago, IL
Evaluated survivors of torture to document physical evidence of abuse in support of their asylum cases in immigration court.
- 2018-2020 **Educational Coordinator for Chicos Italian-American Emergency Medicine Externship**
The Department of Emergency Medicine. Northshore Health System, Evanston IL
Led high-fidelity mannequin simulation sessions for visiting Italian emergency medicine residents. Coordinated daily observation, simulation, and didactic experiences between five sites.

Certification

- 2021 American Board of Emergency Medicine - Board Certified
2019 Advanced Cardiac Life Support (ACLS)
2019 Pediatric Advanced Life Support (PALS)
2019 The Difficult Airway Course
2019 Practical Emergency Airway Management Course (Levitan)
2018 Medication-Assisted Treatment Waiver to Prescribe Buprenorphine for Opiate Dependence
2017 Advance Trauma Life Support (ATLS)
2017 Neonatal Resuscitation Program (NRP)

Memberships

- 2019-Present Delta Omega Honors Society
2017-Present Society for Academic Emergency Medicine
2016-Present American Academy of Emergency Medicine
2016-Present American College of Emergency Physicians
2016-Present Gold Humanism Honors Society
2013-Present Phi Beta Kappa Honors Fraternity

Personal

Exploring public transit systems / Backpacking / Hosting dinner and cocktail parties / Climbing