CALIFORNIA
DEPARTMENT OF JUSTICE

Immigration Detention in California

A Comprehensive Review with a Focus on Mental Health

2025

Immigration Detention Facility Review Team

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Executive Summary

Pursuant to California Assembly Bill 103 (AB 103) (2017), since 2017 the California Department of Justice (Cal DOJ) has reviewed and reported on detention facilities in which noncitizens are housed or detained by Immigration and Customs Enforcement (ICE) to increase transparency about the conditions in these facilities. Prior to this 2025 report, Cal DOJ issued three reports: two regarding general facility conditions, and one focused on each facility's response to the COVID-19 pandemic. This report provides an overview of our findings regarding mental health and the availability and quality of mental health services in these facilities. Topics covered include the prevalence of mental health conditions in the detained population, the ways conditions of confinement in these facilities impact mental health, and the ways being diagnosed with or showing symptoms of mental health conditions can impact the experience of detention.

The landscape of immigration detention facilities has significantly changed since 2017. Currently all facilities in California are privately operated. As the country recovered from the COVID-19 pandemic, restrictions loosened, detainee populations increased, and operations at the facilities mostly returned to pre-pandemic practices. While national immigration detention numbers significantly decreased due to COVID-19 and related court orders, the number of individuals held at immigration detention facilities nationwide has increased in the last few years from 21,939 held on a single day in federal fiscal year (FFY) 2021 to 37,684 in FFY 2024, as reported by ICE.[1] Cal DOJ noticed a similar trend in California with the number of individuals held in California facilities increasing from 1,751 on a single day during Cal DOJ's 2021 reviews to 2,303 detainees during its 2023 reviews.[2] That number has climbed to 3,104 individuals as of April 16, 2025.[3] Notably, only 25.7% of those held in custody in California were reported as having a criminal history.[4] Increases in population levels at detention facilities will have implications for the facilities' ability to provide for the health care and other detainee needs highlighted in this report.

For its fourth report, Cal DOJ inspected all six active facilities in California:[5]

1. Adelanto ICE Processing Center (Adelanto) operated by The Geo Group, Inc. (GEO Group) in Adelanto;
2. Desert View Annex (Desert View Annex) operated by GEO Group and housing additional detainees in Adelanto;
3. Golden State Annex (Golden State) operated by GEO Group in McFarland;
4. Imperial Regional Detention Facility (Imperial) operated by Management & Training Corporation (MTC) in Calexico;
5. Mesa Verde ICE Processing Facility (Mesa Verde) operated by GEO Group in Bakersfield; and
6. Otay Mesa Detention Center (Otay Mesa) operated by CoreCivic in Otay Mesa.

Cal DOJ's prior reports identified inadequate mental health care services at detention facilities in California. This finding is consistent with research and other reviews of facilities nationwide and is

1 U.S. Immigration and Customs Enforcement, Annual Report, Fiscal Year 2024 (Dec. 2024) p. 22 <https://www.ice.gov/doclib/eoy/iceAnnualReportFY2024.pdf> (as of Apr. 10, 2025).
2 Detainee population is as measured by the sum of the daily population count at each facility at the time of Cal DOJ's visit to that facility.
3 U.S. Immigration and Customs Enforcement, Detention Management, Fiscal Year 2025 Detention Statistics <FY25_detentionStats04162025.xlsx> (as of Apr. 22, 2025).
4 *Ibid*.
5 As reported in our 2021 report, there is a seventh facility under contract but not in use by ICE, Central Valley Annex in McFarland, which is also operated by GEO Group. Cal DOJ did not inspect this facility because it did not hold immigration detainees during the reviews covered by this report. (Cal. Dept. of Justice, Office of the Attorney General, *Immigration Detention in California* (Jan. 2021) pp. 4-6 <https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/immigration-detention-2021.pdf> (as of Apr. 18, 2025).)

of concern given the well-established negative impacts of detention on mental health.[6] Detainees experience high rates of depression, anxiety, and post-traumatic stress disorder, increased likelihood of self-harm behavior, and negative changes in self-perception. All these conditions can worsen with increased lengths of time spent in facilities.[7] Cal DOJ's findings and national research also consistently show that in recent years the amount of time detainees spend in solitary confinement has increased, even for detainees who are suicidal or who are diagnosed with another mental health condition for which isolation is not recommended. Segregation—the term ICE and the detention facilities use to describe restrictive housing or solitary confinement—is associated with negative mental health outcomes and exacerbation of existing mental health conditions.[8]

Due to the prevalence and severity of poor mental health outcomes, this report provides an in-depth review of mental health care services in immigration detention facilities and detention conditions that impact immigration detainees' mental health. This report is intended to provide an overview of a detainee's experience accessing – or attempting to gain access to – health care from arrival to a facility until departure, health care staffing, quality of health care, suicide prevention and response, barriers to health care, and conditions of confinement that can impact mental health such as security classification, discipline, restrictive housing practices, use of force, sexual abuse protocols, programming and recreation, and access to counsel and legal support.

While mental health and related medical services varied across the six facilities, Cal DOJ found that the issues identified in its 2019 and 2021 reports persisted, and new areas of concern emerged.[9] Key findings in this report include:

- ***Medical and Mental Health Care Records***. Recordkeeping and maintenance of health care files at all six facilities were deficient, which is especially concerning given the critical nature of the records and the high degree of confidentiality these records require. Cal DOJ reviewed files at Adelanto and Desert View Annex in which healthcare providers entered conflicting diagnoses and prescriptions that did not correspond to the documented diagnosis. Similarly, at Golden State Annex, medical providers documented inconsistent psychiatric diagnoses, which at times were conflicting. At Golden State and Mesa Verde, progress notes in medical charts were found to be copied and pasted from previous visits rather than reflecting the treatment and observations of mental health staff present during the visits documented. At Imperial and other facilities, the criteria for placing a detainee on the serious mental illness watch list were unclear. At Otay Mesa, both mental health and medical records were not properly updated or maintained to ensure that providers were offering appropriate referrals or providing treatment to address ongoing health concerns. Without appropriate and comprehensive records, providers were often unable to create and implement adequate treatment plans, which Cal DOJ observed at nearly every facility.

- ***Suicide Prevention and Intervention***. Cal DOJ observed a deficiency in suicide prevention and intervention strategies in every facility. At Imperial, Golden State Annex, and Mesa Verde, standard suicide risk assessments were not consistently administered, despite a robust questionnaire available to staff who were tasked with this duty. Nearly every facility also failed to engage in safety planning to ensure continued monitoring and follow-up with detainees and

6 Bosworth, *The Impact of Immigration Detention on Mental Health: A Literature Review* (2016) Social Science Research Network <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2732892> (as of Apr. 16, 2025); Filges et al., *The Impact of Detention on the Health of Asylum Seekers: An updated systematic review: A systematic review* (July 2024) Campbell Systematic Reviews <https://doi.org/10.1002/cl2.1420> (as of Apr. 16, 2025).

7 *Ibid.*

8 *"Endless Nightmare": Torture and Inhuman Treatment in Solitary Confinement in U.S. Immigration Detention* (Feb. 2024) Physicians for Human Rights <https://phr.org/our-work/resources/endless-nightmare-solitary-confinement-in-us-immigration-detention> (as of Apr. 11, 2025).

9 Cal DOJ also reviewed medical services at detention facilities in preparation for a third report published in 2022 but focused this review specifically on the facilities' response to the COVID-19 pandemic.

to reinforce their coping skills after release from suicide watch, despite the heightened risks of self-harm during the period following placement on suicide watch. Most facilities also appeared to make decisions about releasing detainees from suicide watch by consensus among a mixed group of health care and other staff members, when this should be a clinical decision made by a licensed mental health provider.

- ***Use of Force Practices***. Cal DOJ identified disproportionate use of force against individuals with mental health diagnoses. At Desert View Annex, Otay Mesa, and Imperial, use of force incidents disproportionately impact detainees with mental health conditions. At Mesa Verde and Golden State Annex, staff overutilize discipline and use of force generally. Although Mesa Verde reported to Cal DOJ that it had no use of force incidents, the Department of Homeland Security (DHS), Office of Inspector General found that Mesa Verde did not appropriately record and report a significant use of force incident that occurred when detainees who participated in hunger strikes were transferred to out-of-state facilities.[10] Across several facilities, staff did not adequately review health records and consider mental health conditions prior to engaging in calculated use of force incidents.

- ***Mental Health Review Before Discipline or Segregation***. Facilities generally were not conducting the mental health reviews required by ICE's detention standards before imposing disciplinary measures or placing detainees in segregation or restrictive housing. These reviews were not occurring at Adelanto, Desert View Annex, Golden State, and Imperial. They appeared to occur at Mesa Verde, but only *after* a detainee was already placed in segregation. Additionally, Mesa Verde's psychiatrist reported never finding that placement in restricted housing was inappropriate for a detainee for mental health reasons, which is inconsistent with the expected rate of serious mental illness in detained populations. At Otay Mesa, Cal DOJ's expert reviewed multiple records in which facility staff had approved restrictive housing placements for detainees experiencing significant mental health concerns, including a case in which a detainee had engaged in self-harm and been placed on suicide watch during a nine-month placement in segregation. And at Imperial and Mesa Verde, detainees who were identified in facility mental health logs experienced longer lengths of stay in segregation than detainees who were not present in such logs. Some detainees at both facilities spent periods of several months to over a year in conditions of isolation, which is harmful for any detainee but presents particular risk to those with underlying mental health conditions.

- ***Quality of Mental Health Care*.** No facilities consistently offered adequate psychotherapy services for the mental health conditions most commonly observed in detainee populations in California. At Imperial and Otay Mesa, ongoing staffing vacancies meant that there was no psychologist or equivalent staff to offer psychotherapy services. Other facilities did offer such services, but sessions were most often short and irregular. All facilities offered psychiatry, but psychiatry alone is not sufficient to support a mental health program, particularly when serving a population with high rates of depression and post-traumatic stress disorder. Cal DOJ found that across all facilities, psychiatrists prescribed psychotropic medications but did not consistently order metabolic laboratory tests or Abnormal Involuntary Movement Scale (AIMS) tests at baseline or over the course of treatment. These tests are necessary both to monitor treatment effectiveness and to track the development of side effects, some of which can be life- or health-threatening and/or not reversible without early intervention. Cross collaboration between the medical and mental health providers through multidisciplinary treatment planning, which is necessary to ensure coordinated and effective treatment, did not consistently occur at any of the facilities.

10 Office of Inspector General, Dept. of Homeland Security, *Limited-Scope Unannounced Inspection of Mesa Verde ICE Processing Center in Bakersfield, CA* (Nov. 2023) pp. 3-4 <https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-03-Nov23.pdf> (as of Apr. 14, 2025).

- ***Staffing.*** Staffing vacancies and hiring challenges impacted Imperial and Otay Mesa most significantly but were common at many of the facilities. At Otay Mesa and Imperial, there were vacancies in key mental health staff positions including psychologist and licensed social work positions, which made providing psychotherapy impracticable. Additionally, the psychiatry care at several detention facilities was provided by the same psychiatrist, which is not sufficient for the statewide demand for services. Imperial did not have its Medical Director position filled, which resulted in delays in addressing clinical errors by lower-level health staff. Imperial's remote location poses an ongoing challenge to its ability to hire health care staff, while the facility appears to have addressed this problem for detention staff by offering higher salaries. Medical staff at Imperial and Otay Mesa reported that the lengthy background check process imposed by ICE had resulted in the loss of candidates for key healthcare positions.

- ***Pat Downs.*** Mesa Verde's pat down search policy, in which detainees were subjected to pat down searches anytime they left their housing unit, undermined access to necessities including services and activities supporting mental and physical health. Detainees described the searches as invasive and inappropriate and reported the searches had a chilling effect on their decisions about whether to obtain medical and mental health services and meals. Indeed, the policy resulted in allegations of sexual assault and numerous complaints from detainees. Despite the numerous complaints, the facility denied that any allegation was founded.

- ***Security Classifications***. Detention files at Adelanto, Desert View Annex, and Mesa Verde did not always contain proper justification for all the elements comprising classification scores, which meant more detainees were placed in higher security levels than they would have been if scores required more robust evidence. Reclassifications were often overdue at Otay Mesa. At Golden State Annex, Adelanto, and Desert View Annex, detainees with special vulnerabilities (e.g. prior victims of assault and LGBTQ+ detainees) were placed at higher security levels, despite higher risks of harm. Many facilities designated detainees as belonging to Security Threat Groups (STGs), such as gangs, based on insufficient evidence , and did not appear to meet PBNDS requirements to use objective support to validate STG affiliation as current and active.[11] For example, Cal DOJ observed facilities counting past, inactive STG affiliation equivalently to active affiliation. Wrongful determinations of STG membership result in more restrictive conditions of confinement, and can also negatively impact eligibility for release as an alternative to detention or the outcomes of subsequent bond hearings and removal proceedings, all of which can adversely impact mental health.[12] These errors, if ongoing, carry especially severe consequences in light of the current federal administration's use of such designations to support transferring detainees to custody outside of the United States.

- ***Due Process and Mental Health.*** Detention facilities did not consistently satisfy their obligations to ensure that mental health conditions did not prevent detainees from participating in their immigration legal proceedings. For example, Cal DOJ received reports from attorneys that detainees appeared for court without having received prescribed medication or other needed treatment, such that they could not meaningfully participate in their hearings. The settlement agreement in *Franco-Gonzalez v. Holder* provides that detainees diagnosed with certain mental health disorders be appointed an attorney, among other processes, and that facilities post information notifying detainees of the settlement.[13] The required information was often not visible at the facilities. Many detainees were unaware of the opportunity to determine their eligibility for *Franco-Gonzalez* benefits, particularly at Imperial and Otay Mesa, which may have been due to this lack of posted information.

11 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part I, p. 60 <https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf> (as of Apr. 21, 2025).

12 See, e.g. Filges et al., *The Impact of Detention on the Health of Asylum Seekers: An updated systematic review: A systematic review* (July 2024) Vol. 20, No. 3, Campbell Systematic Reviews (July 2024) <https://doi.org/10.1002/cl2.1420> (as of Apr. 16, 2025).

13 *Franco-Gonzalez v. Holder* (C.D.Cal., Sept. 25, 2015, 2:10-cv-02211-DMG-DTB) ECF No. 859.

Overall, Cal DOJ's findings make clear that these facilities need significant improvements to adequately address the mental health needs of those held within their walls. Unfortunately, as of the publication of this report the Trump Administration has made moves to eliminate internal federal government oversight of conditions at immigration detention facilities. On March 21, 2025, federal employees received news of the closure of DHS' Office for Civil Rights and Civil Liberties (CRCL) and the Office of the Citizenship and Immigration Services Ombudsman, and of sizeable staff reductions in the Office of the Immigration Detention Ombudsman (OIDO).[14] Both CRCL and OIDO have reviewed facilities, responded to complaints of civil rights violations and problematic facility conditions, published reports informing the public of their findings, and overseen corrective actions by the facilities designed to improve conditions of confinement and safeguard detainee rights. The Trump Administration's decision to reduce or eliminate such oversight is concerning and makes Cal DOJ's facility reviews, which will continue in 2025, even more crucial.

14 Gilmer, *Trump Aides Shutter Homeland Security Civil Rights Office*, Bloomberg Government (Mar. 21, 2025) <https://news.bgov.com/bloomberg-government-news/civil-rights-advocates-brace-for-cuts-in-homeland-security-unit> (as of Apr. 1, 2025); Sganga et al., *DHS gutting offices that offer civil rights and immigration liaison services*, CBS News (Mar. 21, 2025) <https://www.cbsnews.com/news/trump-administration-gutting-dhs-civil-rights-branch> (as of Apr. 1, 2025).

Glossary of Terms

AB 103	California Assembly Bill 103 (2017)
ADA	Americans with Disabilities Act
AP	Advanced Practitioner
Cal DOJ	California Department of Justice
CCTV	Closed-Circuit Television
CDCR	California Department of Corrections and Rehabilitation
CQI	Continuous Quality Improvement
CRCL	Office for Civil Rights and Civil Liberties, U.S. Department of Homeland Security
COVID-19	Coronavirus disease, an infectious disease caused by the SARS-CoV-2 virus.
DHS	U.S. Department of Homeland Security
DON	Director of Nursing
OIG	Department of Homeland Security's Office of the Inspector General
EMR	Electronic Medical Record
ERO	ICE Enforcement and Removal Operations
FDA	Food and Drug Administration
FFY	Federal Fiscal Year
FTE	Full-time Equivalent
HSA	Health Services Administrator
ICE	U.S. Immigration and Customs Enforcement
IGSA	Intergovernmental Service Agreement
IHSC	ICE Health Services Corps
INA	Immigration and Nationality Act
LCSW	Licensed Clinical Social Worker
LOP	Legal Orientation Program
LOS	Length of (detention) Stay
LVN	Licensed Vocational Nurse
MDD	Major Depressive Disorder
MRI	Magnetic Resonance Imaging
NCCHC	National Commission on Correctional Health Care
NDS	National Detention Standards (2000 and 2019)

ODO	ICE Office of Detention Oversight
OIDO	Office of Immigration Detention Ombudsman
PBNDS	Performance-Based National Detention Standards (2008 and 2011)
PREA	Prison Rape Elimination Act
PRR	ICE's ERO COVID-19 Pandemic Response Requirements
PTSD	Post-traumatic Stress Disorder
RHU	Restrictive Housing Unit
RN	Registered Nurse
SMI	Serious Mental Illness
SMU	Special Medical Unit
SSRI	Selective Serotonin Reuptake Inhibitor
USMS	U.S. Marshals Service

Introduction

U.S. Immigration and Customs Enforcement (ICE) detains immigrants in public and private facilities throughout the United States, including private detention facilities in California, for purposes of civil immigration proceedings. In 2017, the California State Legislature enacted AB 103, codified at Government Code section 12532, in response to growing concerns about the health and safety of people that the federal government detains pending civil immigration proceedings, including concerns regarding housing people in disciplinary or administrative segregation, the quality and accessibility of health care, suicides, and access to counsel. AB 103 requires that the Attorney General's Office review and report on the conditions of confinement, the standard of care, and due process rights at locked immigration detention facilities through July 1, 2027.[15] AB 103 is designed to bring increased transparency about the conditions in the facilities where immigrants are detained.

In this fourth report, the Attorney General, through the California Department of Justice (Cal DOJ), provides members of the public and policymakers with information about the living conditions of people in civil immigration detention in California with a focus on the impact conditions of confinement have on the mental health of detained individuals, these individuals' access to mental health care, the quality of the mental health care provided, the ways that mental health symptoms can have impacts on other aspects of detention experience, and the impact of the conditions of confinement on due process rights.

For this report, Cal DOJ staff supported by a team of experts reviewed each of the six locked immigration detention facilities in operation in the state, all of which are privately operated. As part of the review of each facility, the Cal DOJ team toured each facility, interviewed detained individuals and staff, and reviewed and analyzed logs, policies, detainee records, and other documentation.

At the time of Cal DOJ's site visits to these six facilities, there were 2,303 detained individuals from 90 countries including Mexico, Uzbekistan, El Salvador, Russia, Honduras, Guatemala, Colombia, Georgia, Peru, and Senegal. Many of these individuals are California residents and many others are relatives of California residents. The transparency afforded through this report is critical for understanding the welfare of every person in California, including people who are detained.

15 AB 103 also directs the Attorney General's office to review circumstances surrounding the apprehension and transfer of detainees under section 12532 subdivision (b)(1)(c). However, following litigation brought by the federal government to challenge AB 103, the Ninth Circuit held that the United States was likely to succeed on its claim that this provision violated the law. (*United States v. California* (9th Cir. 2019) 921 F.3d 865, 870, cert. den. (June 15, 2020) 141 S.Ct. 124 (Mem.).)

Contracts, Facility Closures, and Potential New Facilities

When Cal DOJ published its AB 103 report in 2022, ICE had contracts for eight immigration detention facilities in California. Six facilities are currently operating in California and were reviewed for this report. The seventh facility, Central Valley Modified Community Correctional Facility in McFarland ("Central Valley Annex"), did not hold ICE detainees in 2023 when Cal DOJ conducted its reviews. The eighth facility, Yuba County Jail in Marysville, ended its contract with ICE and stopped housing immigration detainees as of February 2023.[16] CoreCivic, GEO Group, and MTC have contracts with ICE to make approximately over 7,000 beds available to detain immigrants in California.

I. AB 32

Federal courts enjoined California's recent legislative efforts to prohibit private immigration detention facilities from operating in the state. On October 11, 2019, the California State Legislature passed Assembly Bill 32 (AB 32) (2019) prohibiting private immigration detention facilities from operating unless pursuant to a contract already existing prior to January 1, 2020, not including any extensions to that contract.[17] GEO Group and the federal government challenged AB 32 as unconstitutional.[18] On September 26, 2022, the Ninth Circuit held that AB 32 violated the Supremacy Clause of the U.S. Constitution as to ICE-contracted facilities, and remanded the case to the federal district court for further proceedings in light of this finding.[19] On May 23, 2023, the district court entered an order declaring AB 32 unconstitutional and invalid as applied to persons operating private immigration detention facilities pursuant to a contract with ICE, the U.S. Marshals Service, or other federal agency acting pursuant to the detention authority of the Immigration and Nationality Act, 18 U.S.C. § 4013(a)(3), and enjoined California from enforcing AB 32 against such persons.[20]

II. Potential New Facilities

No new immigration detention facilities have opened in California since Cal DOJ's 2022 report. However, in August 2024, DHS issued a Request for Information for facilities that could be used for detention in the San Francisco Enforcement and Removal Operations (ERO) Field Office's jurisdiction, which includes the Central Valley and Northern California.[21] In March 2025, ICE issued a sole source justification and approval notice to allow CoreCivic to use a facility it owns in California City for immigration detention purposes, and GEO Group submitted a proposal to use McFarland Detention Center to expand its available detention space in Kern County.[22]

16 Hendricks, '*Waste of Federal Funds': ICE Ends Contract With Northern California Jail After Years of Outrage Over Conditions*, KQED (Dec. 9, 2022) <https://www.kqed.org/news/11934879/waste-of-federal-funds-ice-ends-contract-with-norcal-jail-after-years-of-outrage-over-conditions> (as of Apr. 15, 2025).

17 Penal Code §§ 9500, 9505

18 *The GEO Group, Inc. v. Newsom* (S.D.Cal. Dec. 30, 2019, No. 19-cv-2491-JLS-WVG) 2019 WL 7373612; *United States of America v. Newsom* (S.D.Cal. Jan. 24, 2020, No. 20-cv-154-MMA-AHG) ECF No. 1.

19 *The GEO Group, Inc. v. Newsom* (9th Cir. 2022) 50 F.4th 745, 763.

20 *The GEO Group, Inc. v. Newsom* (S.D.Cal. May 23, 2023, No. 19-cv-02491-RSH-LR) ECF No. 87.

21 U.S. Dept. of Homeland Security, ICE West Coast Multi-State RFI (Aug. 14, 2024) <https://sam.gov/opp/b062f46b8208474f807af0a75e0d320f/view> (as of Apr. 15, 2025).

22 ICE, *Class urgent and compelling justification for multiple detention facilities supporting ICE* (Mar. 7, 2025) <https://sam.gov/opp/e9aa4c41a123404fbfa22773026cdc99/view#description> (as of Apr. 14, 2025); American Civil Liberties Union, *ACLU FOIA Litigation Reveals Information About Plans to Expand ICE Detention Facilities Nationwide* (Apr. 11, 2025) <https://www.aclu.org/press-releases/aclu-foia-litigation-reveals-information-about-plans-to-expand-ice-detention-facilities-nationwide> (as of Apr. 14, 2025).

This Report: Mental Health

Key Mental Health Issues Immigrants and Detained Individuals Face

In its prior reports, Cal DOJ identified significant concerns and deficiencies in the way that detention facilities address immigration detainees' mental health needs. This report looks closer at applicable standards and how immigration facilities in California are addressing detainees' mental health needs.

Immigration detainees require adequate mental health services to address both pre-existing mental health conditions and those that result from detention itself. Psychology literature consistently demonstrates that individuals held in immigration detention experience negative mental health impacts, which worsen with increased lengths of detention and which persist long after release.[23] Depression, anxiety, and post-traumatic stress disorder (PTSD) are the mental health conditions most frequently experienced by detainees, along with increased self-harm behavior.[24] In one study of asylum seekers, people who had been detained reported extremely high rates of these conditions, with 86% experiencing depression, 77% anxiety, and 50% PTSD.[25] Immigration itself disturbs the continuity of one's life course, which can have mental health impacts even when not accompanied by negative experiences such as detention.[26] Understanding this background is important to applying mental health care standards to the services available in detention facilities.

Solitary confinement deserves special focus due to its strong association with negative mental health outcomes, which can include PTSD, increased risk of self-harm and suicide, psychotic symptoms, lasting brain damage, and exacerbation of existing mental health conditions.[27] ICE itself issued a directive that solitary confinement should only be used for detainees with mental health diagnoses "as a last resort and when no other viable housing options exist."[28] Nonetheless, Cal DOJ has previously found ongoing practices of detention facilities placing detainees, some of whom had mental health conditions, in solitary confinement for extended periods.[29] This finding is consistent with a September 2023 DHS Office for Civil Rights and Civil Liberties' report finding facility practices of holding detainees in solitary confinement when on suicide watch or otherwise diagnosed with serious mental illness.[30]

Applicable Standards Related to Mental Health

Immigration detention facilities are supposed to operate in accordance with applicable standards, including standards for the provision of health care services. Such standards include constitutional

23 Bosworth, *The Impact of Immigration Detention on Mental Health: A Literature Review* (2016) Social Science Research Network, p. 4 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2732892> (as of Apr. 15, 2025).

24 *Id.* at p. 4; Filges et al., *The Impact of Detention on the Health of Asylum Seekers: An updated systematic review: A systematic review* (July 2024) Vol. 20, No. 3, Campbell Systematic Reviews <https://doi.org/10.1002/cl2.1420> (as of Apr. 16, 2025); Forrest and Steel, *The impact of immigration detention on the mental health of refugees and asylum seekers* (2023) Vol. 36, No. 3, J. of Traumatic Stress 642 <https://doi.org/10.1002/jts.22944> (as of Apr. 16, 2025).

25 Filges et al., *The Impact of Detention on the Health of Asylum Seekers: An updated systematic review: A systematic review* (July 2024) Vol. 20, No. 3, Campbell Systematic Reviews (July 2024) <https://doi.org/10.1002/cl2.1420> (as of Apr. 16, 2025).

26 Ainslie et al., *Contemporary Psychoanalytic Views on the Experience of Immigration* (2013) Vol. 30, No. 4 of Psychoanalytic Psychology 663; Grinberg and Grinberg, *Psychoanalytic Perspectives on Migration* in Psychoanalysis and Culture (Bell, edit. 1999).

27 Physicians for Human Rights, "Endless Nightmare": Torture and Inhuman Treatment in Solitary Confinement in U.S. Immigration Detention (Feb. 2024) <https://phr.org/our-work/resources/endless-nightmare-solitary-confinement-in-us-immigration-detention> (as of Apr. 17, 2025).

28 ICE, 11065.1: Review of the use of segregation for ICE detainees (Sept. 4, 2013) p. 6 <https://www.dhs.gov/sites/default/files/publications/segregation_directive.pdf> (as of Apr. 17, 2025).

29 *Immigration Detention in California* (Jan. 2021), *supra*, pp. 26-28; Cal. Dept. of Justice, Office of the Attorney General, *Immigration Detention in California* (Feb. 2019) pp. 23, 77, 88 <https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/immigration-detention-2019.pdf> (as of Apr. 23, 2025).

30 Dept. of Homeland Security, Office of Civil Rights and Civil Liberties and the Office of General Counsel to ICE, *Retention Memo: Segregation of Individuals with a Mental Health Disability and/or Serious Mental Illness* (Sept. 1, 2023).

requirements, federal and state law requirements, federal detention standards, and applicable professional standards.[31] Indeed, the contracts for these facilities include language requiring them to follow applicable federal and state laws. In reviewing the facilities' mental health care and conditions of confinement, Cal DOJ considered all relevant applicable standards.

The Supreme Court of the United States has held that when the government takes a person into custody, it must provide for that person's "basic human needs—e.g. food, clothing, shelter, medical care, and reasonable safety" and, separately, that medical professionals in custodial settings may be held liable for decisions that constitute a "substantial departure from accepted professional judgment, practice, or standards."[32] The Ninth Circuit has found that civil detainees are entitled to more considerate treatment than individuals held in connection with criminal charges.[33] Fourteenth Amendment substantive due process rights include the right to adequate mental health care for detainees with mental illness, and such care must consist of "mental health treatment that gives [the individual] a realistic opportunity to be cured or improve the mental condition for which they were confined."[34]

All immigration detention facilities presently operating in California are also bound by ICE's Performance-Based National Detention Standards (PBNDS), issued in 2011 with revisions in 2016.[35] ICE has contractual authority to enforce its detention standards and has faced criticism for its failure to do so.[36]

The PBNDS address both general health and mental health care. Under the PBNDS each facility must provide "medically necessary and appropriate medical, dental and mental health care and pharmaceutical services."[37] These services include "comprehensive, routine and preventive health care, as medically indicated, emergency care, specialty health care, timely responses to medical complaints, and hospitalization as needed within the local community."[38] The PBNDS further lay out that mental health programs must include crisis intervention, referrals for evaluations, diagnosis and treatment by a competent mental health professional, and suicide prevention.[39] The PBNDS section 4.3.V.A. also requires detention center medical facilities to maintain accreditation with and compliance with the standards of the National Commission on Correctional Health Care (NCCHC). The NCCHC standards incorporated by the PBNDS explicitly require that a facility's responsible physician develop treatment protocols consistent with national clinical practice guidelines.[40] The PBNDS themselves require but do not define "necessary and appropriate" care, which therefore also relies on the ethics and practice standards of these professions.

31 See ICE, Performance-Based National Detention Standards 2011 (rev. Dec. 2016) <https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf> (as of Apr. 21, 2025) [hereafter ICE, PBNDS 2011]; National Commission on Correctional Health Care, Basic Mental Health Services (2025) <https://www.ncchc.org/spotlight-on-the-standards/basic-mental-health-services> (as of Apr. 17, 2025).

32 *DeShaney v. Winnebago County Dept. of Social Services.* (1989) 489 U.S. 189, 199-200; *Youngberg v. Romeo* (1982) 457 U.S. 307, 323.

33 *Jones v. Blanas* (9th Cir. 2004) 393 F.3d 918, 931-935; but see *Matherly v. Andrews* (4th Cir. 2017) 859 F.3d 264, 276 [declining to follow *Jones*].

34 *Oregon Advocacy Center v. Mink* (9th Cir. 2003) 322 F.3d 1101, 1121; see also *Ammons v. Wash. Dept. of Social & Health Services* (9th Cir. 2011) 648 F.3d 1020, 1027.

35 U.S. Immigration and Customs Enforcement, Detention Management, Fiscal Year 2024 Detention Statistics (Dec. 2023); ICE, PBNDS 2011.

36 See, e.g., U.S. House of Representatives, Committee on Homeland Security, Majority Staff Report, ICE Detention Facilities: Failing to Meet Basic Standards of Care (Sept. 21, 2020) <https://www.splcenter.org/sites/default/files/ice_detetention_facilities_committee_report_draft4_0.pdf> (as of Apr. 17, 2025).

37 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § A, p. 260.

38 *Ibid*.

39 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § O, p. 269.

40 National Commission on Correctional Health Care, *Basic Mental Health Services* (2025) <https://www.ncchc.org/spotlight-on-the-standards/basic-mental-health-services> (as of Apr. 17, 2025).

Below is a summary of key elements of the PBNDS that apply to mental health care and provide a helpful context for this mental health focused review.

Standards Related to Access to and Continuity of Care

Detention facility standards also provide for detainees to be able to access needed care within a reasonable time and to be able to trust in the regularity of that care. The PBNDS require that each detainee be medically screened upon arrival,[41] that medical and mental health screenings including questions about acute or emergent medical conditions and suicide risk occur "as soon as possible, but no later than 12 hours after arrival,"[42] and that a comprehensive medical and mental health assessment occur within 14 days of arrival unless more immediate attention is required.[43] For ongoing care during detention, the PBNDS require a procedure that allows detainees unrestricted opportunities to freely request medical and mental health services.[44] This procedure requires clear written policies and regularly scheduled "sick call" times that are communicated to detainees.[45] A provider must evaluate detainees referred for mental health treatment within 72 hours, and each evaluation must consider any history of suicide attempts, illicit drug or alcohol use, or past mental health treatment.[46]

The PBNDS also include provisions for record keeping and discharge procedures that ensure continuity of care, and for reasonable accommodations for detainees with disabilities, including cognitive disabilities.[47]

Standards Related to Treatment Planning

Treatment planning is the process by which a provider, after evaluating a patient and arriving at a diagnosis, collaborates with the patient to develop treatment goals informed by the diagnostic assessment and to create a plan with actionable and measurable steps to achieve these goals. The PBNDS requires treatment plans as a result and component of a mental health evaluation, as an element of suicide prevention and intervention including after discharge from suicide watch, and as a tool to monitor progress and consider less restrictive alternatives when a detainee is subject to involuntary psychotropic medications.[48] The PBNDS also reference the use of "multidisciplinary teams" several times. They explain that these teams must be used to respond to sexual abuse,[49] to conduct internal review and quality assurance for medical and mental health care,[50] to address suicide prevention,[51] and to assess cases of disability and reasonable accommodation requests.[52] Such teams would include medical and mental health care personnel, detention staff who regularly interact with an individual whose care is a matter of discussion, and facility administration staff as needed.

41 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, § B, p. 53.
42 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, pp. 266-268; Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, § B, p. 333.
43 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § M, p. 268.
44 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § S, pp. 271-272.
45 *Id*. at pp. 271-272.
46 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § O, pp. 269-271.
47 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, §§ Z, BB, pp. 276, 278-279; Part 4.8 Disability Identification, Assessment, and Accommodation, Part II, pp. 344-345, Part V, §§ A, C, F, pp. 347-348, 349-352.
48 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § O, p. 270; Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, §§ D-F, pp. 334-336.
49 ICE, PBNDS 2011, Part 2.11 Sexual Abuse and Assault Prevention and Intervention, Part V, § J, p. 136; see also Part VIII, § B, p. 156.
50 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § EE, p. 280.
51 ICE, PBNDS 2011, Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, p. 332.
52 ICE, PBNDS 2011, Part 4.8 Disability Identification, Assessment, and Accommodation, Part II, p. 345; Part. V, § F, pp. 349-351.

Standards Related to Prevention of Suicide

Detainees have higher suicide risk than people in the general population. Additionally, the rate of suicide in immigration detention has increased in recent years, which researchers suggest may be related to concurrent increases in lengths of stay and persistent mental health care staffing shortages.[53] The suicide rate is even higher among detainees who are subject to periods of solitary confinement.[54] Accordingly, the PBNDS include a number of suicide prevention requirements including timely and thorough suicide risk assessments, identification of needs by self-referral or through daily observations by staff, and treatment planning.[55] Further, the PBNDS also spell out housing and monitoring standards for suicide watch that call for close supervision and welfare checks at least every eight hours and daily mental health treatment by qualified clinicians.[56] Lastly, they establish the need for review and critical incident debrief within 24 to 72 hours following a suicide or suicide attempt.[57]

Standards Related to Prevention of Sexual Abuse

Detention facilities are also subject to federal law and PBNDS aiming to reduce risk of victimization from sexual abuse, assault, or exploitation in detention. Such incidents can result in PTSD or other mental health conditions, and individuals with mental health disabilities are more vulnerable to victimization. The Prison Rape Elimination Act (PREA), which applies to detention facilities, was passed in 2003 to reduce sexual abuse in prisons and create a "zero-tolerance standard" for rape in prison.[58] The PREA requires correctional facilities to screen individuals for risk of being sexually abused by others or perpetrating sexual abuse within 72 hours of arriving to the facility and, where need is indicated, offer a prompt follow-up meeting with a medical or mental health professional.[59] Individuals who are victims of sexual abuse in custody must receive access to emergency medical treatment, crisis intervention services, medical and mental health evaluations and ongoing treatment as necessary, and the facility must also make mental health evaluation and treatment available to the alleged perpetrator.[60] The PBNDS also requires facilities to act affirmatively to prevent sexual abuse and assault; to provide prompt and effective intervention, and treatment for victims; and control, discipline, and prosecute perpetrators.[61]

Standards Related to Conditions of Confinement that Impact Mental Health

The PBNDS include many provisions governing the conditions of confinement for detained individuals. Provisions include the system of assigning security classification levels to detainees, the housing assignments that correspond to these classifications, the disciplinary system, and the use of solitary confinement or force against detainees.[62] These conditions overall have significant impact on detainee mental health and quality of life, but this summary focuses on selected provisions of the PBNDS that address mental health issues specifically.

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53 Erfani et al., *Suicide rates of migrants in United States immigration detention (2010-2020)* (2021) AIMS Public Health 8(3) p. 416 <https://pmc.ncbi.nlm.nih.gov/articles/PMC8334629> (as of Apr. 18, 2025); Terp et al., *Deaths in Immigration and Customs Enforcement (ICE) Detention: FY2018-2020* (2021) AIMS Public Health 8(1) p. 89 <https://pmc.ncbi.nlm.nih.gov/articles/PMC7870381> (as of Apr. 18, 2025).

54 Physicians for Human Rights, *"Endless Nightmare": Torture and Inhuman Treatment in Solitary Confinement in U.S. Immigration Detention* <https://phr.org/our-work/resources/endless-nightmare-solitary-confinement-in-us-immigration-detention> (as of Apr. 18, 2025).

55 ICE, PBNDS 2011, Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, §C-D, pp. 333-334. <https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf>.

56 ICE, PBNDS 2011, Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, §F, pp. 334-336.

57 *Id.* §J-K, pp. 336-337.

58 34 U.S.C. § 30302; see also *U.S. v. Mujahid* (2015) 799 F. 3d 1228, 1233.

59 28 C.F.R. § 115.41.

60 28 C.F.R. §§ 115.82, 115.83.

61 ICE, PBNDS 2011, Part 2.11 Sexual Abuse and Assault Presentation and Intervention, Part I, p. 127.

62 See, e.g., ICE, PBNDS 2011, Part 2.12 Special Management Units, Part 2.15 Use of Force and Restraints, Part 2.2 Custody Classification System, Part 3.1 Disciplinary System.

For detainees with mental disabilities or those experiencing mental illness, but who are otherwise competent, the PBNDS require that the disciplinary process must "consider whether the [d]etainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed," and must consult with a mental health professional "as to whether certain types of sanctions, (e.g., placement in disciplinary segregation, loss of visits, or loss of phone calls) may be inappropriate."[63] Similarly, facility personnel must consult medical staff before using force against detainees with medical or mental health needs, or others in "special circumstances."[64]

The PBNDS include provisions to protect against the negative mental health outcomes that are a risk for detainees placed in solitary confinement, requiring that:

- detainees cannot be automatically placed in solitary confinement due to their mental illness, and that "every effort" should be taken to place these detainees in a setting where "appropriate treatment can be provided," including non-solitary confinement alternatives;[65]
- "mental health staff conduct mental health consultations within 72 hours of the [d]etainee's placement in restrictive housing";[66]
- "a multi-disciplinary committee of facility staff, including facility leadership, medical and mental health professionals, and security staff, shall meet weekly to review the detainee's placement in restrictive housing;"[67] and
- "At least weekly, a mental health provider shall conduct face-to-face clinical contact with the detainee, to monitor the detainee's mental health status, identify signs of deterioration, and recommend additional treatment as appropriate."[68]

Recreation opportunities must also be available to those in segregation or detainees diagnosed with serious mental illness, as security concerns permit.[69]

Due Process and Legal Representation for Detained Persons with Mental Health Disabilities

Detainees have Fourteenth Amendment due process rights to conditions of confinement that do not interfere with their ability to retain counsel or represent themselves. In addition, detained noncitizens with serious mental illnesses or impairments in certain parts of the country are entitled to legal representation provided by the federal government pursuant to a settlement in *Franco-Gonzalez v. Holder*. In 2010, a group of detained noncitizens who had been diagnosed with mental illnesses filed a class action lawsuit against the Department of Homeland Security (DHS), seeking greater due process rights in immigration proceedings on account of their mental illnesses.[70] The court approved a class-wide settlement in 2015, with class members composed of all individuals who are in or will be in DHS custody for removal proceedings in California, Arizona, and Washington, who have been identified by medical personnel, DHS, or an Immigration Judge, as having a serious mental disorder that may render them incompetent to represent themselves in detention or removal proceedings and do not have counsel.[71]

63 ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part V, § A, p. 216.
64 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, § F, pp. 204-205.
65 ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, § P, pp. 182-183.
66 *Id*. at p. 183
67 *Id*.
68 *Id*.
69 ICE, PBNDS 2011, Part 5.4 Recreation, Part V, § E, pp. 372-373.
70 *Franco-Gonzalez v. Holder* (C.D.Cal 2010) 767 F.Supp.2d 1034, 1038.
71 *Franco-Gonzalez v. Napolitano* (C.D.Cal. Nov. 21, 2011) 2011 WL 11705815 at *16; *Franco-Gonzalez v. Holder* (C.D.Cal., Sept. 25, 2015, 2:10-cv-02211-DMG-DTB) ECF No. 859. The settlement applies to the class of plaintiffs from the

The settlement provides that in all cases involving a qualified mentally ill noncitizen facing removal proceedings, the individual is entitled to receive an appointed "qualified representative" in their immigration court proceedings, and a custody hearing for those detained beyond a reasonable period of time.[72] To facilitate identifying qualified class members, detention facilities must provide an initial mental health screening upon arrival, and another within 14 days, to determine whether the detainee shows "evidence of a serious mental disorder or condition."[73] If these screenings show such evidence, the detainee must receive a full-scale mental health assessment from a "qualified mental health provider" to determine if they qualify as a *Franco* class member, in which case ICE must be notified.[74]

The settlement additionally requires defendants to post English and Spanish notices of the settlement in every detention facility in California, Arizona, and Washington, in areas prominently visible to detainees.[75]

original lawsuit, who purported to represent detained individuals in the three listed states, and therefore does not apply in other states.

72 *Franco-Gonzalez v. Holder* (C.D.Cal. Apr. 23, 2013, 2:10-cv-02211-DMG (DTBx)) 2013 WL 3674492 at *3-4, *13.

73 *Franco-Gonzalez v. Holder* (C.D.Cal., Sept. 25, 2015, 2:10-cv-02211-DMG-DTB) ECF No. 859 at 2.

74 *Id*. at pp. 2-3.

75 *Id*. at p. 10.

Methodology

The findings presented in this report are the result of a multi-faceted methodology and extensive data analysis. Key components of Cal DOJ's reviews include researching publicly available information; obtaining and reviewing documents from Adelanto, Desert View Annex, Golden State, Mesa Verde, Imperial, and Otay Mesa; consulting with subject matter experts about mental health care, medical health care, and correctional standards; and conducting multi-day site visits to each facility to inspect, review files, and interview staff and immigration detainees. In addition to subject matter experts, Cal DOJ's review team consisted of attorneys, staff, and law clerks from the Civil Rights Enforcement Section, and research associates from the Cal DOJ Research Services Branch.

Review of Publicly Available Information and Stakeholder Input

In preparing the report, Cal DOJ consulted relevant publicly available government and nongovernmental entity reports, news articles, and legal filings related to the facilities. Cal DOJ also developed and circulated a survey for attorneys who represented detained clients housed at the reviewed ICE detention facilities between January 1, 2021, through March 3, 2023. Cal DOJ disseminated a similar survey for representatives of community-based organizations or legal orientation providers who have experience working with detainees in the facilities, but the survey did not yield responses. These surveys focused on the providers' perceptions of the mental health needs of the detainees, of the mental health services detainees received in the facilities, and of whether and how mental health issues impacted detainees' experience of detention. The results of this survey are integrated into the discussion of detainees' access to and experience with mental health services for each detention facility included in this report.

Consultation with Experts

Cal DOJ retained one mental health expert (Dr. Kahlil Johnson), one medical expert (Dr. Lisa Anderson), and one correctional expert (Dr. Dora Schriro) to assist in the reviews contained in this report. Since AB 103 does not impose substantive requirements on the facilities, the experts evaluated the six facilities in accordance with best practices and in consultation with the PBNDS 2011, rev. 2016 and industry standards, including standards promulgated by the National Commission on Correctional Health Care (NCCHC) and ICE's Pandemic Response Requirements (PRR). These experts provided invaluable feedback as Cal DOJ developed and implemented the review methodology, sharing key analyses in accordance with applicable standards and best practices that informed the report's findings.

Mental Health-Focused Comprehensive Facility Reviews

Cal DOJ's review process targeted two AB 103 focus areas: "conditions of confinement" and "the standard of care and due process provided" with a specific focus on mental health care. The review for each facility consisted of an assessment of: (i) requested documentation, including policies and procedures, staff and training records, facility logs, operations schedules, and other documents; (ii) facility tours; (iii) on-site records review; and (iv) interviews with facility personnel and detainees.[76] To evaluate conditions of confinement, Cal DOJ reviewed language access, grievances, discipline, and access to medical and mental health care, among other aspects of detainee experience. To evaluate standard of care and due process at each facility, Cal DOJ reviewed medical and mental health care files, detainee access to legal materials, the ability to retain and consult with attorneys, and the ability to access additional due process protections due for immigrants with certain mental health conditions.

76 Each facility maintains records differently, as reflected in different sections of this report.

Requested Documentation

The Cal DOJ team requested and received preliminary documentation from all six facilities prior to each site visit. This documentation included policies, practices, and protocols related to the medical and mental health care of detainees, including but not limited to, (i) access to medical and mental health services; (ii) access to medication; (iii) language access; (iv) the care of individuals with serious mental illness; (v) suicide prevention; (vi) the *Franco-Gonzalez v. Holder* injunction; (vii) staff training on trauma and trauma-informed care, cultural competence, among other relevant training; (viii) the housing and treatment of detainees in administrative and disciplinary segregation; and (ix) the treatment of detainees subjected to use of force. In addition, facilities provided medical and mental health logs and roster of detainees. On the first day of each site visit, each facility provided a detainee roster that generally reflected the sex, age, length of stay, country of origin, and security classification of detainees held at the facility. Cal DOJ summarized this data and prepared tables and charts included throughout this report.

Cal DOJ's staff and the retained experts also reviewed detainee records (detention files and mental and medical health records) onsite during each site visit based on their subject-matter expertise.

Detainee Interviews

Cal DOJ interviewed 154 detainees across the six detention facilities. Detainees participated either in standard interviews (125 detainees) consisting of questions pertaining primarily to detainees' access to and experience with mental health services at the facility, but also included questions related to due process, communication and interaction with facility staff, discipline, among other questions related to detainee's experiences within the facility. The remaining 29 detainees participated in interviews led by Cal DOJ's retained mental health, medical, and corrections experts based on their subject-matter expertise.[77]

Cal DOJ generally identified detainees for interviews based on the mental health logs provided by the facilities prior to each site visit and the facility rosters provided on the first day of the site-visits.[78] All interviewed detainees provided verbal consent to be interviewed by the team following an initial explanation regarding the purpose of the review and why they were being interviewed.

In general, interviews took place in an individual and private setting with either one or two Cal DOJ team members. Cal DOJ interviewed detainees in their preferred language, either by Cal DOJ staff who were proficient in the language or through a telephone interpretation service. The languages used during the interviews included Arabic, Bengali, English, French, Georgian, Hindi, Khmer, Lingala, Mandarin, Pashto, Russian, Somali, Soninke, Spanish, Tamil, Tigrinya, Uzbek, and Wolof.

Cal DOJ analyzed the data obtained from the standard interviews and the results were integrated into the discussion of each of the topics that are the focus of this report. The retained experts analyzed

77 The number of detainees at each facility who participated in standard interviews is as follows: Adelanto (6); Desert View (26); Mesa Verde (14); Golden State (21); Imperial (25); and Otay Mesa (33). The number of detainees at each facility who participated in expert interviews is as follows: Desert View (2); Mesa Verde (8); Golden State (6); Imperial (4); and Otay Mesa (9). Given the small number of detainees present at Adelanto (7 detainees) at the time of the site visit, Cal DOJ aimed to interview all detainees present at the facility. All but one detainee agreed to be interviewed. Cal DOJ did not conduct expert interviews at Adelanto.

78 The review team developed a standardized sampling strategy to select detainee interviewees for standard interviews following a mixed qualitative or non-probabilistic sampling approach involving purposeful sampling and quota sampling. Through the purposeful approach, approximately half of the interviewees in the sample for each facility were selected based on their appearance in the mental health logs provided by each facility. Through the quota sampling approach, approximately half of the interviewees were selected from the facility rosters provided on the first day of each site visit. The quota sampling approach sought to ensure that the interviewed detainees would be representative of each facility's population with respect to detainee nationality and sex, when applicable. Female detainees were only present at Adelanto (1) and Otay Mesa (169) at the time of the site visits.

the data obtained from the interviews they conducted, and Cal DOJ integrated those findings into the reviews of the facilities.

Staff Interviews

Cal DOJ and its experts interviewed facility leaders in the highest positions, such as wardens, health care services administrators, and mid-level and rank and file staff who either had expertise in particular functions—such as receiving and discharge, classification, and implementation of the Prison Rape Elimination Act—or who had a great deal of detainee contact like detention officers. Although most facility operators required that facility counsel be present for interviews, Cal DOJ advised staff that their participation was voluntary, that they would not be named in Cal DOJ's report, and that they would not be subject to retaliation for participating in the interviews.

Detained Populations

The Immigration and Nationality Act (INA) grants the U.S. Attorney General authority to arrest and detain noncitizens pending a decision on whether they may be ordered removed from the United States.[79] This authority applies to individuals who came to the United States without authorization, visitors whose visas have expired, and longtime lawful permanent residents whom the federal government asserts are subject to removal. ICE has discretion to release individuals facing removal charges upon payment of bond or other forms of supervised release, except for noncitizens that meet statutory requirements for mandatory detention, including past criminal convictions.[80] Mandatory detention applies to noncitizens—including lawful permanent residents—who have been convicted of a crime of moral turpitude or aggravated felony, as defined by federal law.[81] As a result of the 1996 Illegal Immigration Reform and Immigrant Responsibility Act, hundreds of criminal offenses subject noncitizens to mandatory detention, and can lead to those individuals spending months or even years in immigration detention.[82]

Detainee Demographics Snapshot

The following sections provide demographic snapshots for the active detainee population in each facility at the time of Cal DOJ's site visits. The data included generally reflects country of origin, age, sex, and length of stay information. In addition, information regarding the number of detainees present at each facility who appeared in one or more of the mental health logs produced by the facilities is also provided. **Table 1** provides the count of detainees by facility at the time of the Cal DOJ site visits, the date in which each detainee roster was generated, as well as the detainee arrival date range for all active detainees at the time of the site visits.

Table 1. Count of Detainees by Facility and Date Span of Data Provided by Facilities.

Detention Facility	Count of Detainees	Date Roster was Generated	Detainee Arrival Date Range
Adelanto	7	November 14, 2023	December 21, 2018 to August 11, 2020
Desert View	417	November 14, 2023	December 2, 2021 to November 13, 2023
Golden State	159	May 2, 2023	April 21, 2021 to May 1, 2023
Mesa Verde	41	May 1, 2023	April 8, 2020 to April 26, 2023
Imperial	492	June 13, 2023	May 3, 2019 to June 12, 2023
Otay Mesa	1,187	September 19, 2023	January 30, 2019 to September 17, 2023

79 8 U.S.C. § 1226 [detention on warrant issued by the Attorney General].
80 See 8 U.S.C. § 1226(c). The "mandatory detention" provision imposes no obligations on state and local law enforcement to hold non-citizens in custody, comply with requests by ICE for advance of their release, or transfer them to ICE following their release from custody.
81 *Ibid*.
82 See 8 U.S.C. § 1101(a)(43) [defining aggravated felonies].

Detainee Age and Sex

Table 2 shows the age composition of detainees at each facility at the time of the Cal DOJ site visits. Adelanto, Desert View Annex, and Golden State did not provide information regarding detainee age or date of birth. Female detainees were only present at Adelanto (1) and Otay Mesa (169) at the time of the site visits.

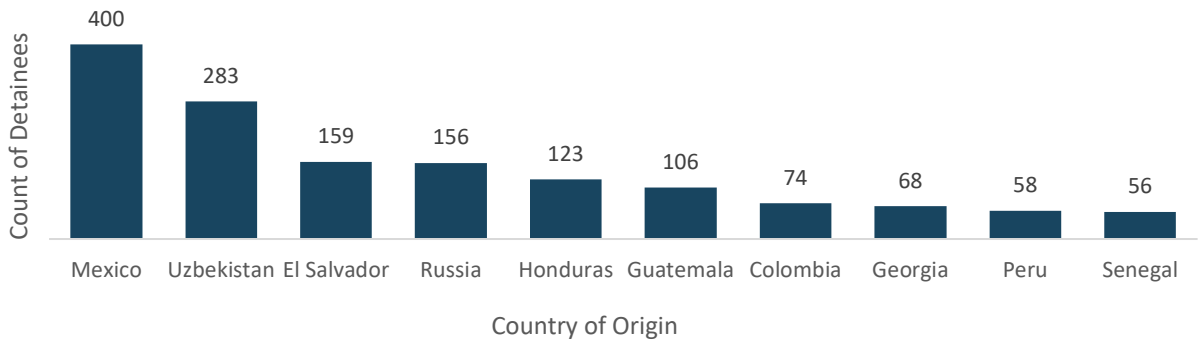
Table 2. Detainees' Age by Facility.[83]

Detention Facility	Average	Median	Min-Max	Standard Deviation
Adelanto	NA	NA	NA	NA
Desert View	NA	NA	NA	NA
Golden State	NA	NA	NA	NA
Mesa Verde	42.12	42	25-60	9.97
Imperial	33.60	32	18-72	9.68
Otay Mesa	34.73	34	18-67	10.02

Detainee Country of Origin

Detainees at the reviewed facilities represent over 90 countries. **Figure 1** illustrates the top 10 countries represented across facilities at the time of the Cal DOJ site visits.

Figure 1: Ten Most-Represented Countries of Origin, All Facilities.



83 The standard deviation for a data set provides context for averages (mean). A low standard deviation indicates that the data points tend to be close to the mean of the set, while a high standard deviation indicates that the data points are spread out over a wider range of values. The median is the value that is exactly in the middle of a dataset when it is ordered. It is used to separate the lowest 50% from the highest 50% of values.

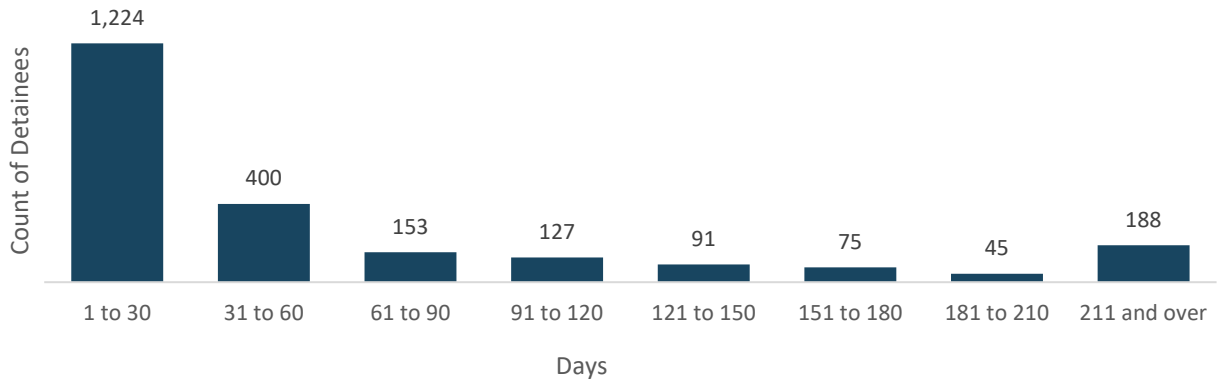
Detainee Length of Detention

Table 3 shows the average detainee length of detention in days by facility as well as other statistics. **Figure 2** provides a breakdown of detainees' length of stay in 30-day increments across facility.

Table 3. Detainees' Length of Detention by Facility (in Days).

Facility	Average	Median	Min-Max	Standard Deviation
Adelanto	1,492.00	1,595	1,190-1,789	208.39
Desert View	68.46	20	1-712	91.67
Golden State	183.04	98	1-741	192.57
Mesa Verde	254.76	173	5-1,118	264.03
Imperial	61.74	25	1-1,502	131.13
Otay Mesa	58.95	29	2- 1,693	98.01

Figure 2: Length of Detention in 30-day Increments, All Facilities.



Detainees who had Received Mental Health Services

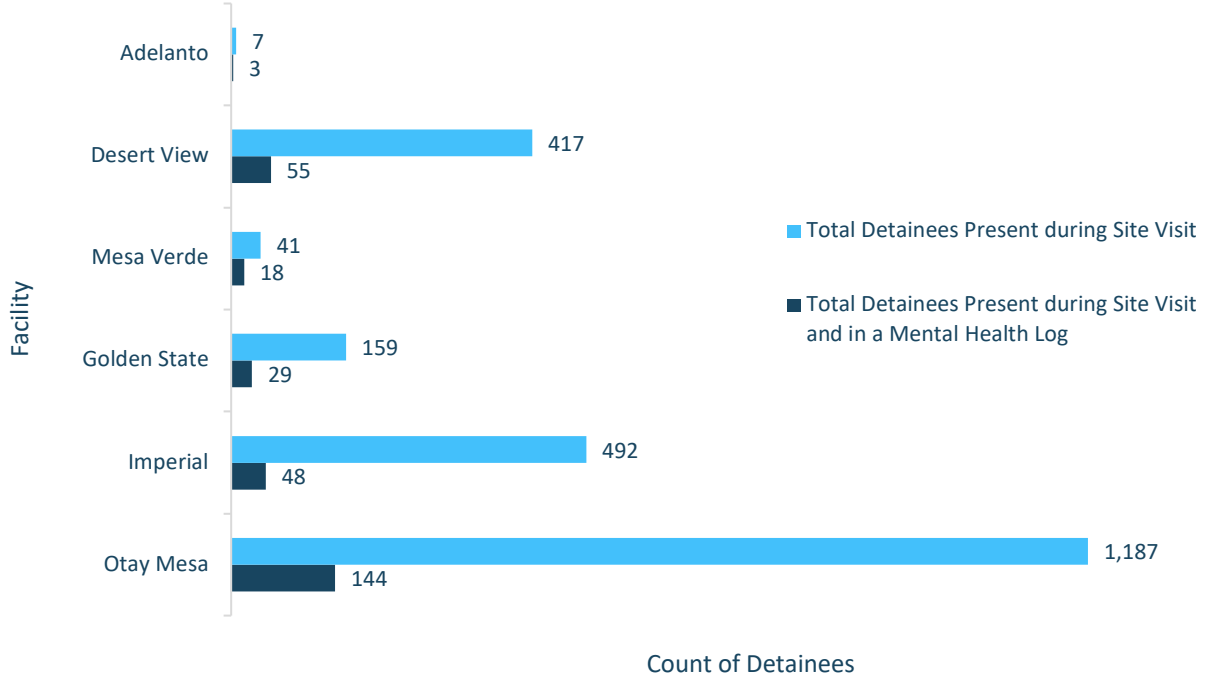
The Cal DOJ team requested that facilities provide documentation including (i) rosters of detainees who were receiving mental health care services and psychotropic medication; (ii) who had requested mental health care services at any point during their detention; (iii) who had been placed in medical housing or had been hospitalized due to a mental health reason; and (iv) who were present in any suicide-related log. All facilities provided documentation responsive to this request though the type of documentation and responsive time periods for these documents varied by facility.

Figure 3, below, shows the number of detainees held at the six detention facilities on the first day of each site visit along with the number of detainees present at the facility who appeared in one or more of the mental health logs produced by the facilities.[84] As illustrated in **Figure 3**, at the time of the site visits, 42.86% (three out of 7) of detainees present at Adelanto; 13.19% (55 out of 417) of detainees present at Desert View Annex; 18.24% (29 out of 159) of detainees present at Golden State; 43.90% (18

84 The majority of the logs produced by the facility were generated prior to the scheduled facility site visits. As such, the numbers provided for this analysis should be considered an approximation of the total detainees present in a mental health log during the site visits. Updated mental health logs on the first day of the site visit were only provided by Imperial and were used along with the pre-visit logs for the analysis presented here.

out of 41) of detainees present at Mesa Verde; 9.76% (48 out of 492) of detainees present at Imperial; and 12.13% (144 out of 1,187) of detainees present at Otay Mesa appeared in one or more of the mental health logs produced by the facilities.

Figure 3: Count of Detainees Present during Site Visit and Present in a Mental Health Log by Facility.



Facility Focus: Adelanto ICE Processing Center and Desert View Annex

Background and Summary of Key Findings

Adelanto

The Adelanto ICE Processing Center (Adelanto), located in Adelanto, California in San Bernardino County, is owned and operated by The GEO Group, Inc. (GEO Group). GEO Group purchased the facility, formerly a state prison, from the City of Adelanto in 2010 and contracted with ICE in 2011 to house detainees. In December 2019, ICE entered into a new direct contract with GEO Group that included the Desert View Annex (Desert View), which opened in 2021 and operates in a former state prison adjacent to Adelanto's East building.[85] In December 2023, ICE modified its contract with GEO Group and issued a 60-day task order to continue operating Adelanto until mid-February 2024.[86] In January 2024, ICE issued a further task order to at least June 19, 2024.[87] In May 2024, ICE announced that it planned on extending the order through September 30, 2024.[88] Then, on October 4, 2024, GEO Group announced that ICE was exercising its five-year option period extending the contract for Adelanto through December 19, 2029.[89]

Because Adelanto and Desert View share most of the same staff and essentially operate together, this report assesses them together.

Following a lawsuit over a dangerous outbreak of COVID-19 at Adelanto, in April 2020, a federal judge ordered the release of some detainees, a suspension of new intakes, and a reduction of Adelanto's detainee population.[90] Following a preliminary approval of a settlement agreement reached in late 2024, the court ordered a temporary lift of the ban on new intakes on January 24, 2025.[91] As a result, the detainee population of Adelanto is likely to increase dramatically over the next several years.

At the time of Cal DOJ's visit in November 2023, Adelanto's population had been dramatically reduced by the April 2020 order. When Cal DOJ visited the facility, Adelanto housed only seven detainees, despite the facility's maximum capacity of 1,940 detainees. According to its fiscal year 2024 budget justification, ICE paid GEO Group for a guaranteed minimum of 640 beds at Adelanto, meaning that GEO Group received a daily payment for 633 empty beds.[92] At the time of Cal DOJ's site visit, detainees at Adelanto represented five different countries: El Salvador, Honduras, Philippines, Jamaica, and China. Those detainees had been held at Adelanto an average of 1,492 days.

85 The GEO Group, *The GEO Group Signs Contracts With U.S. Immigration and Customs Enforcement for Five Facilities in California Totaling 4,490 Beds* (Dec. 23, 2019) <https://investors.geogroup.com/node/6511/pdf> (as of Apr. 10, 2025).
86 The GEO Group, 2023 Annual Report, p. 79 <https://www.sec.gov/Archives/edgar/data/923796/000119312524074565/d812088dars.pdf> (as of Apr. 10, 2025).
87 *Id.*
88 The GEO Group, *The GEO Group Announces Funding Extension for Adelanto ICE Processing Center Contract* (May 20, 2024) <https://investors.geogroup.com/node/17711/pdf> (as of Apr. 10, 2025).
89 The GEO Group, *The GEO Group Announces Exercise of Five-Year Option Period for Adelanto ICE Processing Center* (Oct. 4, 2024) <https://investors.geogroup.com/node/17926/pdf> (as of Apr. 10, 2025).
90 *Roman v. Wolf* (C.D.Cal. Apr. 23, 2020, No. 5:20-cv-00768-TJH) ECF No. 55.
91 *Roman v. Wolf* (C.D.Cal. Dec. 23, 2024, No. 5:20-cv-00768-TJH) ECF No. 2636; see *Roman v. Wolf* (C.D.Cal. Jan. 24, 2025, 5:20-cv-00768-TJH) ECF No. 2670 (temporarily lifting ban on new detainee intakes at Adelanto, pending final approval of the settlement agreement); see Castillo, *Once on the Brink of Closure, Adelanto Facility Will Resume Detaining Immigrants*, L.A. Times (Jan. 29, 2025) <https://www.latimes.com/california/story/2025-01-29/adelanto-immigration-facility-to-resume-housing-migrants> (as of Apr. 10, 2025).
92 ICE, Fiscal Year 2024 Detention Statistics <https://www.ice.gov/doclib/detention/FY24_detentionStats.xlsx> (as of Apr. 10, 2025).

Table 4. Key Data Points, Adelanto ICE Processing Center

Facility:	Adelanto ICE Processing Center
Operator:	GEO Group
Housing Detainees Since:	2010
Bed Capacity:	1,940
Type(s) of Detainees Facility Can Hold:	Female and Male Adults
Snapshot of Detainees Housed at Adelanto ICE Processing Center on November 13, 2023	
No. of Countries of Origin:	5
No. of Detainees by Sex[93]:	Female: 1 Male: 6
Average Age:	Data not provided
Average Length of Detention:	1,492 days
Longest Length of Detention	1,789 days

Desert View Annex

At the time of Cal DOJ's visit, Desert View housed approximately 419 detainees out of a maximum capacity of 750 detainees. ICE pays GEO Group a guaranteed minimum of 480 detainees which means, during the time of the visit, GEO Group received a daily payment for 61 empty beds.[94]

At the time of Cal DOJ's site visit, detainees at Desert View represented 54 different countries. The top ten countries of origin were Mexico (100 detainees), El Salvador (38), India (31), Honduras (31), Guatemala (26), Colombia (25), Mauritania (25), Ecuador (14), Russia (11), and Bolivia (10). In Fiscal Year 2024, Desert View detainees were held at the facility an average of 25 days. While most detainees (230 out of 417) at the facility during Cal DOJ's visit had been held there for 30 days or less, the overall average was 68 days.

Table 5. Key Data Points, Desert View Annex

Facility:	Desert View Annex
Operator:	GEO Group
Housing Detainees Since:	2021
Bed Capacity:	750
Type(s) of Detainees:	Male Adults (currently)
Snapshot of Detainees Housed at Desert View Annex on November 14, 2023	
No. of Countries of Origin:	54
No. of Detainees by Sex[95]:	Female: 0 Male: 417
Average Age:	Data not provided
Average Length of Detention:	68 days
Longest Length of Detention:	712 days

93 Facility logs do not report transgender status.
94 ICE, Fiscal Year 2024 Detention Statistics <https://www.ice.gov/doclib/detention/FY24_detentionStats.xlsx> (as of Apr. 11, 2025).
95 Logs do not report transgender status.

Cal DOJ conducted a three-day site visit of Adelanto and Desert View in November 2023, and made the following key findings regarding the two facilities:

- The facilities provided adequate mental health and medical care overall compared to the remainder of the facilities, including individual psychotherapy and group therapy sessions. However, Cal DOJ's medical, mental health, and detention experts all noted that if the population of the facilities dramatically increases, as is expected in the coming years, the current staffing levels of the facilities will be far below what is necessary to provide adequate care.

- In some instances, Cal DOJ saw conflicting diagnoses provided by mental health staff and prescriptions that did not match diagnoses.

- Mental health staff sometimes demonstrated inconsistencies in record-keeping and in documenting care and psychotherapy sessions.

- Detention staff at Desert View appeared to use more force than justified.

- Detention staff failed to consult with medical and mental health staff and to consider a detainee's mental health condition before calculated uses of force and before placing a detainee into disciplinary segregation.

Methodology and Limitations

Cal DOJ arrived at its findings after collecting data and observing conditions at a site visit, interviewing detainees and the facilities' staff, reviewing documents provided by the facilities, and analyzing survey responses from attorneys and legal services providers who had worked with and represented detainees housed at Adelanto and Desert View. In preparation for the site visit, Cal DOJ submitted a request to GEO Group for pertinent records and documents from the facility, many of which were initially denied, although most of the requests were satisfied following negotiations before and during the site visit. Cal DOJ and GEO Group's counsel were able to exchange information before the site visit although GEO Group's counsel did not respond to Cal DOJ's requests for a preparatory meeting before the site visit.

Cal DOJ staff and experts visited the two facilities November 14-16, 2023. During the site visit, Cal DOJ staff and experts toured the facilities and observed pill call and other routine procedures. However, GEO Group did not allow observation of shift briefings at either facility. Cal DOJ also conducted interviews of the executive staff, operational managers and department heads, medical and mental health care providers, detention staff and supervisors, and detainees.

Most of the administrative, executive, medical, and mental health staff work in both facilities. Cal DOJ's medical expert interviewed the Health Services Administrator, Medical Director, Quality Assurance Nurse, Medical Compliance Officer, Nurse Practitioner, and detainees housed at Desert View, and reviewed a sampling of Desert View detainees' electronic medical records with the Quality Assurance nurse navigating the records.

Given the small number of detainees at Adelanto at the time of the site visit, Cal DOJ did not implement a sampling methodology in the selection of the interviewees. Instead, Cal DOJ aimed to interview all detainees present at the facility. All but one agreed to participate in interviews focused on mental health with Cal DOJ staff. Detainees with whom Cal DOJ spoke at Adelanto represented five different countries and spoke English, Mandarin, and Spanish.

Cal DOJ selected some detainees at Desert View to interview based on the detainee's appearance in

mental health logs provided by the facility, to support the mental health focus of this review. Other detainees were selected by using a quota sampling procedure that drew from the general facility roster (excluding detainees who appeared on mental health logs) and sampled by subregion of origin to ensure participation of a broad range of detainees. At Desert View, interviewed detainees represented over 15 countries and spoke Arabic, Bengali, English, Igbo, Jamaican Patois, Khmer, Russian, Soninke, Spanish, Tamil, and Wolof. Cal DOJ conducted all interviews at Adelanto and Desert View in the detainee's preferred language by fluent interviewers or with the assistance of a language line.

Three attorneys who represented 36 clients at Desert View between January 1, 2021, and March 3, 2023, also responded to Cal DOJ's attorney survey. Although Cal DOJ's corrections expert was unable to attend the site visit, she guided Cal DOJ staff in reviewing use of force and custody records of detainees at the facilities and interviewed relevant facility leadership and staff telephonically.

Cal DOJ's review was limited in certain respects by GEO Group. Particularly, GEO Group did not allow one of Cal DOJ's experts to interview detainees in person at either facility, curtailing the expert's ability to assess detainees' physical appearance and limiting their interaction with detainees. GEO Group representatives informed Cal DOJ that ICE had instructed GEO Group to limit the expert's access, but did not provide the name or contact information of the ICE official who gave the instruction or the reason for the limitation when asked by Cal DOJ. Instead, the expert conducted interviews with four detainees through a landline phone located in a conference room and only when a telephone line was available. GEO Group also prevented Cal DOJ from having any interaction with detention officers, health care staff, or detainees during the tour.

Following the site visit, Cal DOJ submitted correspondence with the Department of Homeland Security Office of Civil Rights and Civil Liberties (CRCL) regarding the restrictions placed by GEO Group. CRCL responded that following a complaint investigation, CRCL "had concerns about ICE and the facilities' interpretation of the [PBNDS], and the GEO Group's Entrance Control Policy. In September 2024, CRCL issued advice to ICE related to ensuring compliance with applicable state law and detention standards when facilitating Cal DOJ's mandated inspections of ICE detention facilities in California."

Access to Medical and Mental Health Care

Intake and Mental Health Screenings

The first point at which a detainee's mental health needs can be identified is during the intake process when a detainee first arrives at the facility. PBNDS 4.3 requires facilities to screen for mental health concerns when a detainee first arrives at the facility and throughout a detainee's time at the facility.[96] Additionally, the facility must provide the means for a detainee to request mental health services when they need it.[97]

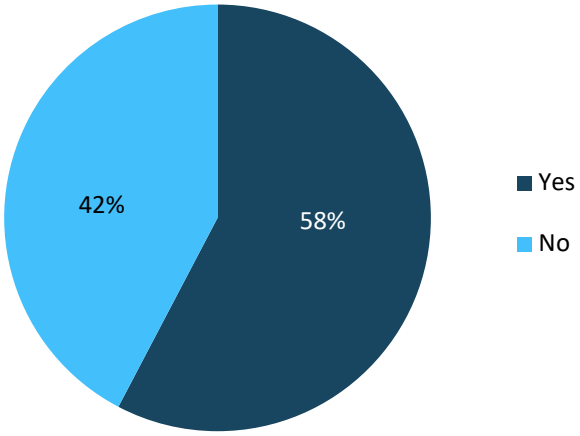
Due to the court-ordered injunction discussed above in the *Background and Summary of Key Findings* section, during our review Adelanto had not received new detainees since April 2020, and intake records for the detainees held at the facility at the time of Cal DOJ's visit were completed under a different records system and thus were unavailable for review. At the time of Cal DOJ's tour, Adelanto's intake area included two exam rooms, allowing for private and confidential health screenings, and several holding cells with capacity ranging from four detainees to 38 detainees. Medical intakes and mental health screenings may be conducted in this space.

Desert View's intake area is identical to that of Adelanto, with several holding cells and areas for private intakes and mental health screenings. Intake forms included questions about previous suicide attempts, previous psychiatric hospitalizations, previous mental health counseling, history of physical

96 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, pp. 266-268.
97 *Id.* § S, pp. 271-272.

and sexual abuse, head trauma, suicidal ideation, and drug abuse. A review of some detainees' intake forms indicate that these questions were asked on the day or evening of an inmate's arrival to the facility. However, it remains unclear whether questions pertaining to detainees' current mental health status are consistently asked during intake screenings, or at any other times. For example, five out of six interviewees (83%) at Adelanto, but only 15 out of 26 (58%) interviewees at Desert View, indicated that they had been asked questions about their mental health during intake at their facility. Also, 18 out of 26 (69%) of Desert View interviewees and four of the six (67%) Adelanto interviewees reported that they had been asked about their mental health by a medical provider at some point since their arrival at their facility.

Figure 4: Detainee Reports of Mental Health Questions Asked During Intake, Desert View.



Identifying Mental Health Concerns During Detention

To access mental health services during detention, individuals can submit requests by paper, tablet, or verbally through custody staff. Desert View housing units typically had nine tablets each for detainee use, and Adelanto had tablets available in the housing units, although Cal DOJ could not verify the number per unit. At both facilities, the paper request form was available in English and Spanish and included a section for staff to record time received, time triaged, urgency, and the referral or action taken. According to medical staff, these requests were collected nightly and triaged by the medical staff as soon as possible, generally within three hours after receipt. The Health Services Administrator reported that mental health staff officially have seven days to follow up at their discretion, but that staff generally followed up sooner. PBNDS 4.3 requires medical and mental health personnel to be on-call 24 hours for emergencies and it is unclear whether the standard is met in practice.[98]

The facility reported having mental health staff on-call for urgent requests. In one instance at Desert View, a detainee sent an overnight request for mental health services through a tablet and the triaging nurse connected him with mental health staff the following day. The facility reported subsequently reminding the nursing staff of the availability of on-call mental health staff and instructing them to educate detainees on the availability of this staff.

Four of the six (67%) Adelanto interviewees reported that they requested mental health services at the facility, and all but one indicated that they were seen by a mental health professional after their request. All 10 Desert View interviewees who indicated that they had requested mental health services reported that they were seen by a mental health professional after their request. Detainees interviewed by Cal DOJ appeared to know how to access mental health services and seemed to have a good relationship with the behavioral health staff.

98 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § T, pp. 272-273.

However, mental health screening questions do not appear in the form the facility uses for annual medical reviews for detainees held longer than one year, although one Adelanto detainee's medical record did indicate an annual check by a psychologist.

Access to Medical Care

Cal DOJ reviewed access to medical care through the services available at and outside the facility, identification of medical needs, and systems for addressing detainee health needs.

As reported by the facilities, dentistry and dental hygiene, x-rays, ultrasounds, primary care, and telepsychiatry were provided on-site at both facilities at the time of Cal DOJ's site visit. Treatment with medications for opioid use disorder, however, was not provided at either facility.

Adelanto reported sending detainees to external hospitals 57 times between January 2021 and February 2023. Overall, most hospitalizations were due to a medical concern (86%; 49 out of 57 hospitalizations), while 14% (8 out of 57) were due to a mental health concern. Desert View reported sending detainees to external hospitals 198 times between January 2021 and August 2023. Again, most hospitalizations were due to a medical concern (around 90%; 179 out of 198 hospitalizations), while around 10% (19 out of 198) were due to a mental health concern.

Generally, health staff reported that they had not encountered problems receiving authorization to refer detainees to off-site specialty care, although in several instances, referrals were not approved by the facility until months after the medical staff made the request. For advanced imaging and medical care, including specialist consultations, detainees were referred to appointments in the community. Availability of local hospital beds, however, proved to be a barrier for out-of-facility treatment.

Detainee Knowledge of How to Access Medical and Mental Health Care

The process for receiving and triaging medical requests mirrors the process for mental health requests described previously. Cal DOJ could not confirm whether specific mental health manuals or handbooks were available to detainees at either facility as required by PBNDS 4.3.[99] In interviews with Cal DOJ, most detainees at both facilities reported that they did know how to request mental health services. However, some number of detainees (one of six at Adelanto, and six of 26 at Desert View) stated that they did not know how to access these services. This breakdown suggests that while the practices the facilities are using to share this information with detainees is generally functioning well, some additional targeted efforts may be needed to reach the full detainee population in a manner that allows them to retain this information.

Continuity of Care

Continuity of care refers to the degree to which a health care system can offer coordinated care over time and minimize disruption as a patient receives care from different providers. Generally, Adelanto and Desert View demonstrated adequate continuity of medical and mental health care from previous facilities. However, there were several deficiencies in cognitive testing and monitoring, and gaps in post-hospitalization care at the facility.

When available, transfer summary documents were scanned into a detainee's medical record upon intake. According to health care staff, nurses try to determine non-psychotropic medication equivalent or similar to medication a detainee was receiving in their country of origin. The Medical Director stated that the facility preferred to wait for a psychiatric evaluation before ordering medication prescribed outside of the United States. The facility reported that the clinical director and physician alternate the responsibility of providing verbal orders for continuation of medication upon intake. Cal DOJ observed

99 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § D, p. 264.

errors in prescribing lower doses of a drug upon intake than the detainee had previously received or needed.

Case review demonstrated a good ability to arrange for outside needs of detainees. Desert View providers generally appeared to advocate for patients to receive adequate community care by calling hospital staff and specialists directly to negotiate treatment plans, including sending a detainee back to a hospital when necessary. For example, the clinical physician at Desert View twice contacted a hospital physician to arrange for a colonoscopy that they deemed necessary but that the detainee, who had a mental health condition, had declined on a previous hospital visit. However, low availability of community medical resources at times limited opportunity to receive outside care. At least one Adelanto detainee was not able to transfer to an inpatient bed at the local community hospital for mental health care and had to wait for weeks before transferring to a hospital located over 150 miles from the facility.

Providing continuous care upon a detainee's return from community hospitalization was an area of weakness at Adelanto and Desert View. Psychologists and psychiatrists did not appear to immediately perform psychological or cognitive testing after a detainee has been hospitalized for psychiatric reasons, leading to missed opportunities to diagnose detainees with cognitive deficits. File review uncovered instances in which both psychiatry and psychology professionals did not make a record of reviewing detainee mental health charts after the detainee returned from the hospital. As a result, detainees returning from external treatment may experience a lapse in care. In one case, psychotropic medication that was first given to a detainee during hospitalization was not routinely continued when the detainee returned to detention, with no documented reasoning why the medication was not continued. Similarly, detainees who received a diagnosis or treatment at a hospital that differed from the initial diagnosis or treatment at the detention facility would revert to the treatment they received before hospitalization without continuing the treatment started during the hospital visit. The medical staff had an appropriate policy of scheduling detainee visits with a physician or Advanced Practitioner (such as a nurse practitioner) within two days of a detainee's return from off-site care. However, Cal DOJ's file review revealed that records or results of offsite care were not reliably available by the time of this visit.

Additionally, in several records reviewed, Cal DOJ was unable to confirm that these visits occurred. In one case at Adelanto, a detainee with a severe mental impairment and a history of traumatic brain injury was treated surgically in the community. After the operation, he returned to the facility and subsequently suffered a wound infection requiring a second surgery, as well as a psychiatric hospitalization. The detainee's medical file did not include details of the detainee's post-operative care transitions or wound care, which could have played a role in the post-operation wound infection and psychiatric complications.

According to staff, when a detainee at either facility is released to the community from detention, they are provided with a printout of their release summary of care plan and a supply of medications obtained from the local pharmacy. However, staff do not arrange follow-up appointments for detainees, which would be best practice. Nor did staff make an effort to send a detainee lab results the facility received after a detainee's release, as required by PBNDS 4.3.[100] Staff stated that policy is to provide information about health care resources in the destination community, although Cal DOJ could not verify this practice through chart review. Additionally, in at least one instance, Desert View released a detainee who was diagnosed with an infectious disease without reporting the infection to the county health department, as required by California Code of Regulations, title 17, section 2500 and PBNDS 4.3.[101]

100 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § BB, p. 279.
101 Cal. Code Regs., tit. 17, § 2500 (2022); ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § C, p. 261.

Mental Health Care

Adelanto and Desert View have a mental health unit that, at the time of the site visit, consisted of a behavioral health manager, two psychologists, two part-time psychiatrists, two licensed clinical social workers, three substance abuse counselors, and one data analyst. The mental health clinical space includes two offices in the medical unit for psychotherapy use.

Cal DOJ's mental health expert found that Adelanto and Desert View appeared to have the most comprehensive and competent mental health services out of the six facilities visited. Generally, any improvements recommended below for the provision of mental health services at Adelanto and Desert View could be realized by consistent implementation of record-keeping policies and regular communication between all levels of mental health staff.

This section of the report details mental health care provided to detainees and discusses practices with respect to: (1) mental health care staffing; (2) the identification of the mental health needs of detainees; (3) treatment of detainees, including planning, psychiatric services, and therapy; and (4) suicide prevention and response.

Staffing

The facilities share mental health staff. A licensed clinical psychologist oversees all aspects of mental health services at the two facilities in his capacity as Behavioral Health Manager (BHM). According to the organizational chart provided by the facilities, the BHM supervises four licensed clinical social workers, two psychiatrists, two psychologists, three substance abuse counselors, and a data analyst. At the time of Cal DOJ's visit at Adelanto, there were two unfilled psychologist positions and two unfilled licensed clinical social workers positions. At Desert View, there was one unfilled psychologist and one unfilled licensed clinical social worker position.

The Mental Health Services overview document for the two facilities that GEO Group provided to Cal DOJ describes "2 full-time psychiatrists" (suggesting 80 hours per week), which was echoed by the Health Services Administrator (HSA) in interviews. However, according to the facilities' schedules GEO Group provided to Cal DOJ there are only 27 psychiatrist hours per week, provided through telehealth: one psychiatrist covers one 8-hour shift, while the other covers two 8-hour shifts and one 3-hour shift per week. Psychiatry appointments were available four days per week at both facilities, but only during the specified shifts.

Although mental health staff appear able to adequately serve the detainees, Cal DOJ's experts found the staffing levels insufficient to serve the combined population of the facilities. If the combined detainee population increases any further it should be a priority to fill those positions to maintain the current level of care.

Identification of Mental Health Needs of Detainees

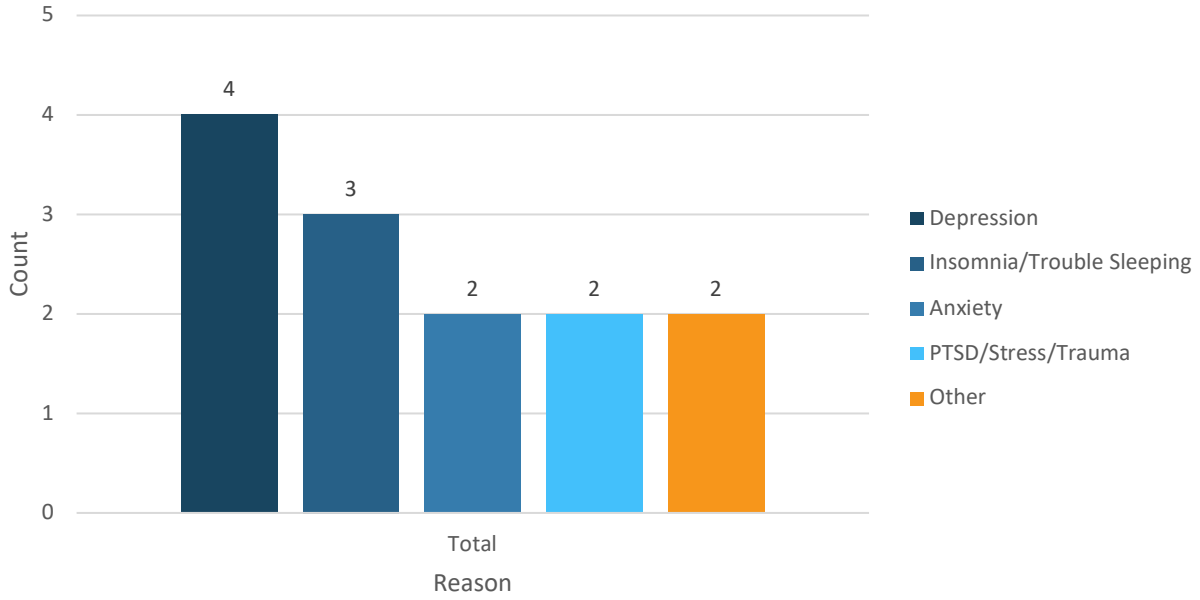
Prevalence of Mental Health Concerns

GEO Group provided a mental health log identifying detainees at Adelanto who had been diagnosed with one or more mental health conditions and who commenced treatment at the facility between October 2020 and February 2022. The conditions included major depressive disorder, an unspecified psychosis disorder, and "other", which was not specified in the log or in any other document provided by GEO Group.

GEO Group also provided a mental health log including 66 detainees at Desert View who had mental health disorder diagnoses and commenced treatment at the facility between October 2022 and

December 2023. Of those 66 individuals, 39% were diagnosed with major depressive disorder (26 out of 66 detainees), 15% with Adjustment Disorder (10 out of 66 detainees) and 15% with post-traumatic stress disorder (10 out of 66 detainees). At Desert View, the reasons for requesting mental health services were depression, insomnia, anxiety, and PTSD, as seen below in **Figure 5**.

Figure 5: Reasons for Requesting an Appointment with a Mental Health Specialist, Desert View



Of the 36 clients represented by the attorney respondents to our attorney survey, the attorneys reported that six had been diagnosed with at least one mental health condition or had exhibited symptoms associated with at least one mental health condition while at the facility. GEO Group identified 32 detainees at Desert View who had commenced medication to treat mental health conditions between July 2022 and November 2023. The most common mental health condition of detainees receiving medication was major depressive disorder (59%; 19 out of 32 detainees).

Mental Health Evaluations and Diagnoses

If a mental health screening raises concerns about a detainee's mental health, the facility must conduct a more thorough mental health evaluation of the detainee.[102]

At Desert View, based on Cal DOJ's chart review, it appeared that urgent evaluations of mental health screenings that indicated possible mental health issues occur within the appropriate time window required by PBNDS 4.3. Within 72 hours, the facilities' psychologists collected more details on patient history as needed and sufficiently documented their findings. For example, one detainee at Desert View indicated in his intake interview that he had attempted suicide in the past. The next day, a facility psychologist evaluated him, gathered more detail, and referred him to the psychiatrist. Two days later, the psychiatrist evaluated him and prescribed appropriate medication.

In the medical charts Cal DOJ reviewed, the notes and documentation by the non-psychiatry staff were adequate. The staff appropriately noted symptoms and suicide risk assessments.

102 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, pp. 266-267.

Cal DOJ's review of the mental health providers' records revealed some lapses in screening or diagnostic inconsistencies that suggest some weaknesses in identifying the mental health needs of detainees. In several of the records reviewed, the psychiatry staff gave a diagnosis that differed from that of psychological staff without an acknowledgement or explanation of the differing diagnoses. There is also a lack of screening for co-morbid or related mental illness for both psychologists and psychiatrists, especially after initial evaluation. Screening for co-morbid and related mental illnesses can help mental health and medical professionals identify or rule out causes for a mental health ailment, allowing for more effective treatment.

The facility staff appeared to be over-reliant on screening tools that do not provide an in-depth treatment of a detainee's mental health condition, which may result in conflicting or missing diagnoses. One patient at Desert View, for example, who had been receiving general health care through his detention, raised to a nurse that he had concerns over neurological issues such as "losing time," and had been observed as having a "disorganized thought process." However, the nurse practitioner treating him ruled out a diagnosis of dementia after utilizing only a brief screening tool and without obtaining records of evaluations that the chart indicated had occurred prior to detention. The patient was eventually referred to an off-site neurologist after an off-site psychologist conducted a thorough evaluation and noted the discrepancies in his diagnoses and symptoms, including that a dementia diagnosis should not have been ruled out.

Treatment Planning

Multidisciplinary treatment planning, where the various health care providers meet to discuss and coordinate the various medical and mental health needs and treatment of each detainee, was an area of relative weakness for Adelanto and Desert View. Psychiatric evaluations do not routinely include chart review before treatment decisions are made. Neither facility has weekly multidisciplinary treatment meetings that are typical in carceral settings. The lack of multidisciplinary treatment planning indicates deficiencies in the coordination of care among the various health and custody staff to provide the most comprehensive and efficient care for detainees as possible. In at least one instance, review of a detainee's file reflected disagreement between the documented psychiatric diagnoses in the progress notes versus the diagnoses of record entered by the psychologist in the patient's electronic medical record.

However, based on a review of detainee medical charts, Adelanto and Desert View providers appear to advocate for patients to receive adequate community care by contacting hospital staff and specialists directly to discuss individual treatment plans and by maintaining relationships between the patients, facility practitioners, and outside practitioners.

Psychiatric Care

Cal DOJ reviewed the facility's provision of psychiatric care and related prescription protocols for individuals with mental health conditions. While the facilities provided some adequate mental health care through therapy and psychology services, Cal DOJ noted some deficiencies in psychotropic prescribing practices, consistency of laboratory testing, and maintenance of mental health records. Nevertheless, the majority (11 out of 12) of the interviewed detainees who received mental health treatment reported that the treatment had been helpful to them.

Figure 6: Medical exam space

Medication Distribution

Cal DOJ's staff and experts observed an organized medication distribution, otherwise known as "pill call" or "pill pass," in one of the housing units at Desert View. Ideally during this process, a nurse enters the housing unit and administers medication to each detainee who needs it, while also providing water. The nurse then observes and verifies that every detainee who should be receiving medication does so and checks each detainee's mouth to ensure that they swallowed the medication.

At Desert View, water was available at medication administration and a nurse used an electronic medication administration record to record doses after visually verifying a detainee's wristband. A detention officer prompted detainees to form a line, and the nurse conducted a mouth check for each dose by using a laminated card picturing an open mouth. However, some detainees appeared surprised and unsure about the mouth check, suggesting that mouth checks were not regularly taking place.

A review of the stock medication list gave the impression that the medication had not been recently curated. For example, it included older diabetes medications, medications rarely, if ever, prescribed (including fenofibrate and prenatal vitamins), and medications which would never be urgently needed (such as cholesterol medications).

Further, the pharmaceutical storage area at Adelanto was hot, and the refrigerator was broken; a second, functional refrigerator was available in a nearby area for storing medications. During the Desert View site visit, Cal DOJ's medical expert and the Cal DOJ team were unable to inspect the medication storage area or emergency medication kit because GEO's representatives rushed the tour group through without allowing Cal DOJ or its experts time to fully inspect the area. The Health Services Administrator was willing to return to the pharmaceutical storage area when the lapse was noted, but GEO's representatives would not allow a return to the area, ostensibly out of deference to a patient in a suicide watch cell in the clinic.

Psychotropic Prescribing and Medication Management

Overall, the prescribing practices at the facilities were adequate, and among the best of the facilities Cal DOJ reviewed. For the most part, medications were properly prescribed and dosed for the detainees' symptoms. There were, however, several notable exceptions that posed health risks to detainees.

Figure 7: Pharmacy

Of the interviewed detainees who were prescribed psychotropic medication, most (8 out of 11) felt that the staff sufficiently explained the medication to them. The response pattern broken down by facility suggests that explanations may be more thorough at Desert View, where seven of eight detainees felt explanations were sufficient, than at Adelanto, where one of three detainees felt this way.

It appears that the facilities may not prescribe medication that are not included in their formularies, or list of preapproved medications. Upon arrival, one detainee was taking a specific antidepressant; the psychiatrist discontinued this medication and prescribed a substitute in the facility's formulary without assessing whether the detainee had any history of treatment with the substitute medication, even though the original antidepressant was effective and not causing any side effects. The detainee was told that his original antidepressant was "not given here." The detainee's medical chart did not contain a request for permission to continue the original medication, nor any notes of a discussion with the detainee on how long he had been taking the medication or any alternatives the detainee had tried to manage his condition. Later notes in the chart indicated that the detainee had previously tried the substitute medication, which had initially worked, but later lost effect.

In at least one case, psychotropic medicine prescribed to a detainee at Desert View did not match the detainee's symptoms without clear justification and alongside evidence that significant health concerns were being overlooked. The detainee showed signs of delirium, a state of confusion that can occur for multiple reasons, some of which include life- or health-threatening medical problems. Instead of noting and requesting treatment for the detainee's untreated liver problems (which may have contributed to the delirium), the psychiatrist noted that the detainee was uncooperative and continued the same treatment. The psychiatrist continued this same approach and prescribed medication for "unspecific psychosis" even after the detainee was seen at an outside hospital where providers noted delirium and diagnosed a liver condition.

In other cases, psychotropic medication, specifically antidepressant medication, was dosed at levels lower than what would be expected to be an effective amount. While initial low dosage may vary by clinical judgment in each case, this prescribing decision should be accompanied by ongoing monitoring of symptoms and increases of dosage when the patient is not improving, which was not always evident on medical chart review.

Laboratory and AIMS Testing

Mental health ailments may be a result of medical causes, such as vitamin deficiencies. In most of the files reviewed at both facilities, the psychiatrist did not order labs to test for possible causes for a detainee's symptoms beyond what was initially diagnosed. These underlying medical causes can be detected through comprehensive blood work, which should be ordered and completed before a new medication, psychotropic or otherwise, is introduced because it can worsen an underlying condition, or initiate other physiological changes that may make the original condition hard to detect. Several of the charts reviewed by Cal DOJ indicated that blood tests for detainees were ordered late (after a medication had been prescribed) or not at all by mental health staff. For example, one detainee did not have their medication dosage adjusted after blood work results indicated that the prescription should have been altered. Another detainee under psychiatric observation did not receive a blood test until a year after admittance to the facility and did not receive results until their final day at the facility, three months after the test had been administered.

Documentation

Facility medical leadership demonstrates a generally high quality of documentation of mental health incidents and diagnoses with some important exceptions. Some notes indicated that mental health staff monitored diagnoses, symptoms, and maintained communication among the staff members. However, diagnoses were not consistently entered into the Electronic Medical Record (EMR) by some mental health providers. Additionally, some medical records included unhelpful commentary from the psychiatrist; for example, descriptions of detainees as "uncooperative" or "melodramatic" without connection to mental health outcomes or recommendations for treatment.

Therapy and Other Non-Medication Intervention

Psychotropic medication is only one part of mental health care. Facilities are also required to provide psychotherapy and other mental health services to detainees.[103] Adelanto and Desert View had a sufficient quantity of psychotherapy offerings for the volume of detainees at the time of Cal DOJ's visit, although these services were not always offered with the regularity and duration recommended for the most common mental health conditions encountered at the facilities. However, if the number of detainees rises dramatically, as expected, the facilities will need to offer more.

Availability and Quality of Psychotherapy

Generally, individual psychotherapy is provided in one-hour sessions on a weekly to monthly basis and appeared, based on medical chart review, to be responsive to the needs of the detainees. Social workers and substance abuse counselors provide group psychotherapy for the detainees. Adelanto and Desert View reported providing individual and group psychotherapy options for detainees, which is an area in which the other facilities struggle.

However, we had concerns about the adequacy of mental health care notes and whether the treatments and diagnoses from mental health care sessions were being properly shared with other medical and mental health staff. For example, psychiatrists and psychologists did not indicate whether they reviewed a detainee's medical charts before making a diagnosis or making a treatment decision and did not indicate whether they screened for comorbid or related mental illnesses. Additionally, mental health diagnoses are often not entered into a detainee's electronic medical record, which is a primary form of sharing information with other providers. Our mental health expert determined that the notes taken at individual psychotherapy sessions were not as detailed as they ideally should be, leading to risk of redundancy of therapy and miscommunication between staff members treating the same patient. In at least one case, the psychologist and psychiatrist made conflicting diagnoses in the same detainee's medical chart without any acknowledgment or explanation of the difference.

103 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § O, pp. 269-270.

Rapport and Cultural Competence

Based on a review of the records, the presence of a multicultural mental health staff appeared to benefit patient care, particularly providing therapeutic rapport. Thirteen out of the 15 interviewed detainees who were asked (87%) described positive interactions with the mental health professionals at the facilities; one was more neutral about their feelings towards the interactions with the staff and one described their interactions negatively.

Suicide Prevention and Response

Suicide Risk Assessments, Intervention, and Prevention

Overall, Adelanto and Desert View were adequately prepared for suicide prevention and response with accessible cut down tools, comprehensive suicide risk assessments, and safety planning, but needed to improve staffing coverage. The Health Services Administrator at Desert View was unfamiliar with the location of the emergency response tools; they reported incorrectly that they were held in the main clinic, but Cal DOJ later observed the tools in another space during the tour. Staff reported that the Behavioral Health Director leads a quarterly "Scenario Based Training Drill" of suicide scenarios for training of the mental health care and detention staff, and the mental health care team reported that when possible, staff were available for de-escalation of agitated detainees.

The suicide prevention approach of Adelanto and Desert View's mental health providers is comprehensive and structured. Cal DOJ experts found structured and clinically appropriate risk assessments present in medical files reviewed. Safety planning also followed a structured Crisis Response Plan with a focus on coping skills and safety.

Suicide Watch

In Adelanto, six detainees were placed on suicide watch between January 2021 and March 2022. At Desert View, 13 detainees were placed on suicide watch a total of 18 times between January 2021 and August 2023.

There are two medical observation rooms in the Desert View medical unit that are used for suicide watch. Nursing checks are performed at least once per each shift for individuals under suicide watch. However, since there are two twelve-hour nursing shifts per day, and other staff do not generally visit the detainees, this schedule does not appear to meet the PBNDS 4.6 requirement that clinical staff perform welfare checks at least every eight hours in all cases. Other medical care appeared to be provided as needed.

The facilities' process for discontinuing suicide watch should be more firmly rooted in the clinical judgment of a qualified mental health provider. According to the Health Services Administrator, the Suicide Prevention Team at Desert View meets weekly to discuss releases from suicide watch and grading of suicide watch levels. The HSA described the decision by the team, which included detention staff, the Behavioral Health Manager, and the treating psychologist, as a "consensus" that could be overridden by the decision of the psychologist. Framing a decision regarding suicide as a consensus is unusual because the treating psychologist is the only member of the team licensed and trained to assess and manage suicidal intent.

Medical Care

In reviewing the provision of medical care at Adelanto and Desert View, Cal DOJ reviewed medical staffing and quality of medical care, as they impact mental health services and treatment. Generally, Cal DOJ's chart review suggested an adequate quality of medical care, with some gaps related to targeted medical services, staffing, management of infectious diseases, and monitoring during hunger strikes.

Staffing

As discussed above under *Mental Health Care: Staffing*, the facilities generally share the same medical staff. PBNDS 4.3 requires sufficient medical staff to meet care standards,[104] which in this case would need to meet the combined needs of both facilities. At the time of Cal DOJ's visit, the facilities reported employing a Health Services Administrator, an assistant Health Services Administrator, a Medical Director, a clinical physician, a medical compliance officer, three Advanced Practitioners (medical providers such as a physician's assistant or nurse practitioner) with one vacancy, 11 Registered Nurses with seven vacancies, and 20 Licensed Vocational Nurses with four vacancies. Cal DOJ has concerns that the number of health staff vacancies and the need to manage existing staff across two facilities may impact care. At the time of Cal DOJ's site visit, the Director of Nursing position was vacant, along with the vacancies listed above.

The Health Services Administrator for the two facilities reported being in the position since March of 2022. However, the Health Services Administrator had an administrative background rather than clinical training. This type of experience does not meet the standard for Designation of Authority set forth in the PBNDS 4.3, which requires an HSA to be a physician or health care professional.[105]

The Medical Director for the two facilities reported being in the position for three years and six months at the time of Cal DOJ's visit. He was not board certified but had three years of experience in preventive and public health medicine and previously practiced in family medicine. Board certification is a general standard for clinical directors but is not required by the PBNDS.

The Health Services Administrator also reported that medical staff receive pre-service and annual trainings, which include cultural diversity, suicide prevention, and mental health screening. Advanced Practitioners (such as a physician's assistant or nurse practitioner) reported that they complete 40 hours per year of Continuing Medical Education. However, staff also reported that GEO Group does not reimburse for the cost of Continuing Medical Education, nor cover costs for subscriptions to decision support resources that provide high quality references to guide current practices.

Quality of Medical Care

Cal DOJ evaluated quality of medical care through review of in-facility treatments including medical and mental health observation, availability of out-of-facility treatment, medications, and care for chronic conditions as observed in medical files and policies related to these issues.

In some instances, detainees were treated with unnecessary or improperly targeted medical services. For example, one detainee received four magnetic resonance imaging (MRI) studies of his neck and shoulder, at least some of which were not likely to benefit the treatment plan. Two of the studies were duplicated due to what appeared to be a lapse of communication between the radiology provider and the treating medical team. Additionally, one year after the first MRI was ordered, the detainee was still awaiting a test of their nerves to investigate a potential cause of arm pain.

104 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § B, p. 261.
105 *Ibid*.

Figure 8: Blood draw station

In a different case where a detainee had refused blood pressure medications and had a diagnosis of adjustment disorder, depression, and anxiety, the Advanced Practitioner in charge of the detainee's treatment did not make efforts to reschedule or re-engage a visit after the detainee initially declined. Three weeks later, a different Advanced Practitioner noticed that the detainee had not been taking the medication, but by that point the detainee had been released before he could be re-engaged.

Both facilities have Special Medical Units (SMU) in which detainees are held alone for psychological observation. Adelanto staff reported that its SMU had not held any detainees for around three months before Cal DOJ's site visit. Between January 2021 and January 2023, 25 detainees were placed in medical observation 31 times in Adelanto. At Adelanto, 11 of the 31 instances of medical observation were attributed to psychological observation. The Desert View SMU, consisting of six cells, is used for restrictive housing and includes suicide resistant showers with no tie off points. It was unoccupied at the time of Cal DOJ's site visit. Cal DOJ received a log from GEO Group with 69 entries based on 60 detainees placed under medical observation between August 2021 and October 2023 at Desert View. At Desert View, 39 of the 69 instances of medical observation were attributed to psychological observation. GEO Group did not provide further information as to the reasons for the medical observation placements.

The Health Services Administrator reported that medical observation was available in up to two rooms officially designated for patient stays up to 72 hours, after which the patient must be assessed for release or a higher level of care. However, the 72-hour threshold was exceeded in at least four of the medical charts reviewed by Cal DOJ at the two facilities.

There were some lapses with respect to the management of infectious diseases that were of concern in a facility seeing a high volume and high turnover of detainees who need appropriate treatment. For example, a detainee at Desert View reported a hepatitis C infection diagnosed a year prior. A nurse practitioner ordered a limited hepatitis test panel that could not detect whether a patient was immune to hepatitis A or B, which could have guided vaccination recommendations. In another case, a Desert View detainee's syphilis was not correctly reported or managed until a medical administrator intervened.

Primary care for chronic illnesses such as diabetes and hypertension was provided on site by staff physicians and other qualified medical providers, per facility report. File review demonstrated that at least one patient with an HIV diagnosis who was not on treatment at intake was provided appropriate medications while at Desert View. Other chronic conditions such as hepatitis C were addressed to a limited extent, as health staff explained that most detainees are not at the facility long enough to receive the full, months-long regimen of medication for hepatitis C.

Barriers to Health Care

In assessing the provision of mental and medical health care, Cal DOJ also reviewed possible barriers that may affect the successful provision of health care or may otherwise exacerbate issues that prevent the successful provision of health care at Adelanto and Desert View. Cal DOJ reviewed possible barriers by assessing: (a) detainees' knowledge of how to access care; (b) language access; (c) privacy; and (d) facility culture as it relates to both mental health and medical services.

Language Access

The facilities were unable to confirm the number of multilingual medical and mental health staff members to Cal DOJ but did report that the Medical Director speaks Spanish and Quechua, and that a staff physician speaks Japanese.

Although most interviewees had positive sentiments regarding the quality of mental health services, several detainees at both facilities expressed that they use English (which is often not their primary language) to communicate with the mental health staff. The facility indicated it uses a language interpretation service, with over 50 languages, as necessary. Interviewed detainees, however, indicated that some members of the staff do not like to use languages other than English to communicate with detainees.

Some detainees reported using language interpretation for non-English languages. One participant described the quality of the interpretation as inconsistent. Another participant indicated that they were not able to communicate effectively with providers because nurses, who were not adequately proficient in Spanish, were used for interpretation instead of the language line. PBNDS 4.3 requires that facilities use professional language services as necessary for detainees with limited English proficiency during the provision of any medical or mental health service.[106] Overall, most detainees who were asked reported that they were able to communicate effectively with mental health staff.

Privacy Concerns

Two offices at Desert View and one at Adelanto were used for telehealth psychiatry visits and appeared to afford general confidentiality with the limitation that a stand-by health service staff member was present for telehealth mental health sessions. Detainees interviewed by Cal DOJ's medical experts did not report concerns with the privacy of telehealth appointments.

106 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § A, p. 260.

Facility Culture on Medical and Mental Health Services

Generally, the medical staff at both facilities appeared to provide compassionate care for patients with mental health conditions. However, as noted above in the *Psychiatric Care* section, there were some notes in mental health records that could indicate staff did not always take concerns seriously. Neither the record of medical grievances of detainees, nor the results of detainee interviews raised specific concerns about staff misconduct.[107]

Cal DOJ's review revealed that medical staff attempted to engage the mental health staff when working with a patient with mental impairments. For example, one medical staff member interviewed by Cal DOJ reported maintaining a collaborative relationship with mental health colleagues that allowed for continued learning between the two disciplines. Two detainees at Desert View with severe mental health conditions, and who were interviewed by Cal DOJ medical experts, confirmed that they did not feel disrespected by the medical staff because of their impairments. Further, medical records showed that one physician made several extra visits to a severely mentally ill patient at Desert View under prolonged psychological observation and that medical staff appeared conscientious in engaging agitated detainees who had been subjected to uses of force or who had participated in hunger strikes. For medical exams involving more private or sensitive areas of the body, medical staff reported that same-sex chaperones could be made available to patients on request or when required by policy.

Medical and Mental Health Quality Assurance Process

Cal DOJ's medical and mental health experts assessed the comprehensiveness and effectiveness of the facility's quality assurance processes. PBNDS 4.3 states that a facility's HSA is required to implement a meeting at least quarterly at which the facility accounts for effectiveness of its health care program, a system of internal review and quality assurance, and an intra-organizational external peer review program conducted annually for all independently licensed medical professionals.[108]

At the two facilities, the Medical Director reported that they annually review randomly selected charts from each practitioner to evaluate care quality. As a result of the reviews, the Medical Director has implemented a checklist template to prompt orders such as labs and eye exams at chronic care visits for certain medical conditions. The facility reported that the Compliance Manager performs monthly audits at both facilities and weekly walk-throughs to audit stored medication and emergency equipment, although Cal DOJ observed omissions in these areas as described above in the *Psychiatric Care* and *Suicide Prevention and Response* sections. The Advanced Practitioners have quarterly quality assurance meetings with the staff.

Grievance trends can be used to identify care quality concerns. Four medical grievances were logged at Adelanto and 20 medical grievances were logged at Desert View in 2023, but there were no trends suggesting serious care lapses or detainee mistreatment, and none pertained specifically to medical or mental health care.

Conditions of Confinement

Cal DOJ reviewed conditions of confinement with respect to security classifications and housing, discipline, and use of force. Areas of concern included classification of detainees at higher custody levels than warranted and detention staff failing to consult with medical staff prior to calculated uses of force on potentially vulnerable detainees. The concerns about custody classification were previously

107 Cal DOJ reviewed medical records from October 2021 to the time of the site visit. Records prior to October 2021 were unavailable due to GEO Group's transition from its previous contractor, WellPath, at that time. Records prior to November 2020 were inaccessible.

108 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § EE, pp. 279-280.

noted in Adelanto in Cal DOJ's 2021 and 2022 Report.[109] Problematic practices in these areas may have a great impact on the well-being of detainees and may create or exacerbate mental health issues.

Classification and Housing

At intake, detainees must be assigned a security classification level pursuant to PBNDS 2.2 and be screened for any special vulnerabilities, which includes serious mental illnesses, or management concerns. This determination impacts housing assignments and degree of restrictiveness, which in turn can limit opportunities for engagement with others, movement around the facility, and participation in various recreation and programming.[110]

Adelanto has two wings, East and West. At the time of Cal DOJ's site visit, detainees were only housed in the West wing. Cal DOJ staff toured an unoccupied housing unit in the West wing. The housing units Cal DOJ observed at Desert View were open-bay dorms with bunk beds and single beds.

Figure 9: Closed cell doors and tables in 2-story housing unit

109 See *Immigration Detention in California* (Jan. 2021), *supra*, p. 118; Cal. Dept. of Justice, Office of the Attorney General, *Immigration Detention in California* (July 2022) p. 61 <https://oag.ca.gov/system/files/media/immigration-detention-2022.pdf> (as of Apr. 23, 2025).

110 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, § D-G, pp. 63-65.

Figure 10: Locking shower door

Figure 11: Phones and notices

During Fiscal Year 2023, around 31% of detainees did not have a criminal conviction and 34% were placed by GEO Group in a "low" or "medium-low" custody level. Further, GEO Group determined that 61% of detainees presented "no threat" when making the determination on their initial custody level classification.[111] At the time of Cal DOJ's visit, 48% of the detainees at Desert View were placed in low custody classification, 16% were in medium classification, and 36% were at high custody classification.

Several concerning patterns emerged regarding classification from Cal DOJ's review of custody files. First, several of the detainees were reclassified to higher custody levels with little justification

111 Threat levels are determined by the specifics of a detainee's criminal record, if any. If a detainee has no criminal convictions, they are generally classified as "no threat." Generally, the recency and severity of a criminal conviction determines whether a detainee is classified at a medium or high threat level.

provided by the facility including, in some cases, overrides of initial custody evaluations. Several of the reclassified detainees appeared to have been victims of aggression by other detainees. Some detainees were placed in higher custody categories as a result of gang affiliation, yet the facility did not provide supporting evidence or explanation of how it reached the conclusion of that affiliation. Finally, several detainees with special vulnerabilities (i.e., sexual orientation, previous victims of assault) were placed at high custody levels that could expose them to increased stressors and risks.

Similar issues were discussed in Cal DOJ's 2021 report.[112] Then, as in this report, the systems for custody level assignment and housing placement of detainees designated as gang-affiliated was opaque and assignments did not always match the information received from GEO Group.

Discipline

Adelanto and Desert View reported 17 incidents of detainee discipline in 2023, with most resulting in 30 days of disciplinary segregation imposed and later reduced such that detainees only remained in segregation for less than two weeks. Two individuals were given 60 days in segregation, but the facility did not provide a reason for the higher punishment. PBNDS 3.1 dictates that a punishment of over 30 days (and a maximum of 60 days) in segregation should be given only to those who commit offenses in the "greatest" offense category, which includes killing, assault, rioting, or severe conduct that disrupts or interferes with the security or orderly administration of the facility.[113] Segregation of more than 72 hours and up to 30 days is given to those detainees who commit offenses in the "high" offense category, which includes fighting and threats of bodily harm.[114]

The facilities appear to consult with medical staff prior to imposing discipline. None of the Desert View detainees Cal DOJ interviewed had been disciplined, and of the interviewed Adelanto detainees, most were disciplined for fighting other detainees, and one was disciplined for unspecified rule breaking. None reported feeling that the allegations that led to discipline were a result of behaviors related to their mental health issues. Neither the facilities, nor the detainees interviewed, indicated other forms of discipline besides segregation.

An attorney with clients detained at Desert View noted that one of their clients had been placed in segregation but had not received disciplinary hearings for all the incidents for which he had been disciplined. Further, the attorney reported not being notified about any disciplinary hearing nor allowed access to the records from the disciplinary hearings by ICE or GEO Group.

Restrictive Housing: Disciplinary and Administrative Segregation and Protective Custody

Segregation is the term used at immigration detention facilities to refer to conditions of solitary confinement. Cal DOJ reviewed the procedures and conditions of segregation at all facilities with particular attention to interactions between mental health status and rate of segregation, compliance with PBNDS 2.12 and related sections that apply to restrictive housing procedures for detainees with mental health conditions, and the impact of segregation on mental health.[115] A facility may place a detainee in a form of segregation or restrictive housing for a number of different reasons, which results in the detainee having reduced access to open space, social interaction, and recreation or other programming. Disciplinary segregation is a form of isolation used to punish a detainee for violation of detention rules or regulations, administrative segregation provides for separation of detainees who may pose a threat to others, and protective custody provides for a vulnerable detainee to be housed separately for their safety and may involve placement in segregation.

112 *Immigration Detention in California* (Jan. 2021), *supra*, pp. 22-23.
113 ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part V, § C, p. 217; § K, p. 221; Appendix 3.1.A, Part I, pp. 224-225.
114 *Ibid*.
115 ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, § P, pp. 182-183.

Placement in Restrictive Housing

Prior to placing a detainee into segregation, PBNDS 2.12 instructs facilities to conduct a mental health screening of the detainee, particularly if the detainee has a history of mental illness.[116] Cal DOJ reviewed mental health screenings and care provided to individuals placed in segregated or restrictive housing and found that Desert View does not consistently screen for mental health issues before placing a detainee in segregated or restrictive housing, whether the placement was due to discipline or medical reasons. However, most charts for patients placed in segregated housing did include a pre-segregation clearance form addressing medical concerns generally. Cal DOJ analyzed data regarding detainee length of stay in segregation at Desert View Annex, and found that disciplinary segregation stays were of similar length when comparing the group of detainees who were present on facility mental health logs and the group of detainees who were not listed in such logs. GEO Group did not provide data allowing Cal DOJ to conduct a similar analysis for Adelanto.

Figure 12: Sink and concrete slab with mattress

Mental Health Conditions and Treatment During Isolation

Once in restrictive housing, there is an initial mental health evaluation. Facility staff described that if a detainee who is placed in restrictive housing has been diagnosed with a severe mental illness, the detainee receives daily mental health checks from a LCSW or psychologist, with weekly check ins by a psychologist. Otherwise, detainees without a severe mental illness are seen by a mental health practitioner at least every 30 days. The degree to which detainees actually received regular medical care while placed in segregation was unclear from the collection of evidence Cal DOJ reviewed. Medical practitioners reported that they continued to conduct visual checks with documentation twice per shift and continued providing care for patients for scheduled chronic care. Tablets were available on the wall of the Special Medical Unit pod if needed for sick call requests. However, a review of documents related to a period of hunger strikes at Adelanto showed gaps in the recording of weight monitoring for at least one detainee, which is required by PBNDS 4.2.[117] Of the four detainees who reported segregation at both facilities, one reported that a medical or mental health specialist checked on them and one reported that no one checked on them; however, all participants who were asked reported that they continued receiving medication during segregation.

116 *Ibid*.
117 ICE, PBNDS 2011, Part 4.2 Hunger Strikes, Part V, § C, pp. 254-255.

Release from Restrictive Housing

GEO Group did not provide information on its policies surrounding release of detainees from restrictive housing. The person responsible for discipline interviewed by Cal DOJ was not involved in decisions for release of detainees from restricted housing, and attributed variances in release times on the investigator's discretion.

Use of Force

Cal DOJ staff and its detention expert reviewed 17 use of force logs for incidents at the facilities that occurred between January 2021 and July 2023.[118] Of the incidents occurring at Desert View, seven were deemed "major" by the facility and nine – 53% of all incidents – involved force used against a detainee with a mental illness or severe mental illness. The mental health status of the detainees in three of the incidents was not reported by the facility.

In one case, medical staff communicated a recommendation to avoid using chemical agents during a use of force incident at Adelanto, but detention staff still used a chemical spray. Further, in the use of force instances at Adelanto and Desert View where the aggrieved detainee had a mental illness or severe mental illness, it appears that responding custody staff failed to use the illness to inform their force response to the detainee, ignoring the medical staff's recommendations.

Facility policy requires including medical providers in all stages of use of force incidents, including communication with the mental health staff when necessary.[119] Staff described a practice whereby custody staff should call for a nurse review of the detainee's chart prior to a calculate use of force, and nurses should document an "after injury" form or an "administrative note" to determine whether medical attention is required after the incident. In practice, however, these procedures were not always followed.

Prison Rape Elimination Act

Cal DOJ reviewed the facilities' Prison Rape Elimination Act (PREA) protocols and policies. PREA provides for establishment and implementation of detention policies to reduce and address instances of sexual abuse, prevention, detection, and response. At the time of Cal DOJ's site visit, the facilities shared a PREA Compliance Coordinator, who had been working in this role for around five years, and a PREA investigator, a former detention officer who had been working as an investigator for one year. The coordinator described her scope of work as conducting PREA investigations, meeting with detainees to educate them on how to file PREA complaints, and training staff on the reporting and filing requirements of PREA. The coordinator reported receiving three weeks of initial training, and that both the coordinator and investigator receive an annual 40-hour training from ICE. The coordinator also reported that the team meets on a weekly basis to discuss complaints and trends.

PREA screenings are usually conducted in the intake area of each facility. The coordinator reported that detainees have the option to call the coordinator, whose number is posted in the housing unit, to make a complaint. Otherwise a detainee can call ICE, tell staff directly, or submit a grievance by paper or tablet. The coordinator reported notifying local law enforcement of complaints received and that the PREA team then begins the administrative investigation by separating the complainant from the environment and interviewing them. The coordinator reported that the team has asked for support from facility mental health specialists if the complainant is struggling during the interview. The PREA team will then collect information from witnesses and videos and prepare and submit a report to GEO Group's corporate administration. Lastly, the coordinator reported that the complainant will then

118 When Cal DOJ last reviewed Adelanto's policies in the January 2021 report (and before Desert View was opened), the facility had 52 separate use of force incidents involving 46 detainees.
119 Intentionally omitted

be reassigned to a different housing unit, if necessary, and that the coordinator will meet with the complainant weekly for at least three months, mainly to ensure that they have not been retaliated against for making the complaint. GEO Group did not provide the specific numbers of complaints.

In May 2023, a third-party company audited the PREA practices at the two facilities and found deficiencies in nine out of 41 standards; the facilities then entered into a 180-day corrective action period.[120] Deficiencies included incomplete screening and training of staff and documentation thereof, inadequate policies of preserving evidence of alleged assaults, and failure to reassess vulnerability risk level for detainees who were alleged victims of sexual abuse.[121] Following the corrective action period the auditor deemed GEO Group had complied with all standards.[122]

Staff and Detainee Relations

The facility reported that staff receives annual training of approximately 40 hours on suicide prevention, mental health screening and identification of mental health concerns, and cultural diversity. Generally, detainees at Desert View reported positive sentiments regarding relations with the staff, particularly with respect to staff's attitudes. However, over half of the eleven Desert View detainees who discussed the attentiveness of staff described them as dismissive and half of the eight participants who discussed respect described staff as disrespectful. Adelanto detainees had more mixed views of facility staff. Three of the six interviewed detainees describe staff as disrespectful or untrustworthy.

Although there has been a significant reduction in the detainee population at Adelanto over the last four years with no reduction in staffing levels, Cal DOJ's expert concluded that the facilities could improve their grievance policies to make them more efficient and effective in addressing the needs of detainees. The facility reported that detainees can submit grievances through tablets in the housing units, or with paper slips. The grievance coordinator reported that they pick up grievances daily and aims to provide a response to the detainee within five days. Staff reported that GEO Group directs medical and mental health care grievances solely to the medical unit, which may reduce the effectiveness of grievances relevant to both health care and detention staff and reduce oversight and accountability by the detention staff for any incidents that may occur between the detention staff and the detainees as a result of medical or mental health issues a detainee is having.

Other programmatic areas

The facilities have a Programs Manager who oversees the recreation, programming, library, and religious services at the facilities. The Program Manager, the recreation specialist, and the chaplain all speak English and Spanish. The facilities provide puzzles, bingo, video games and weekly arts and crafts classes. Interviewed detainees gave conflicting reports regarding whether they received access to programming with about a third of detainees who answered this question from each facility (2 of 6 at Adelanto, 33%, and 8 of 26 at Desert View, 31%) reporting not having such access. Six of the ten detainees who were asked (60%) indicated that access to programming impacts their mental health. Of these six detainees, five elaborated that access to programming positively affects their mental health, or conversely, that lack of programming negatively impacts their mental health. Two detainees reported that the lack of programming in languages other than English limits their access to information and/or negatively affects their mental health.

Adelanto has a large outdoor recreation area with a soccer field and a basketball court, and a workout area. Desert View has a large outdoor area with gym equipment, a volleyball court, a soccer net, and a basketball court. Nearly all detainees who were asked reported having recreation access (six of six

120 U.S. Dept. of Homeland Security, *PREA Audit: Adelanto Corrective Action Plan Final Determination* (Apr. 21, 2023) p. 2 <https://www.geogroup.com/media/aashy2sa/6_3_2023_adipc-dv_ice_pca_fr-1.pdf> (as of Apr. 14, 2025).
121 *Id.*
122 *Id.*

at Adelanto, and 25 of 26 at Desert View). Detainees interviewed by Cal DOJ reported that they were able to use the outdoor recreation area for up to two hours each day, though some participants reported that their yard time was sometimes cut short. Eleven of the thirteen participants who were asked (85%) reported that access to recreation impacts their mental health.

Detainees reported that being outdoors and having access to the yard helped them manage their medical or mental health condition and may also have improved their outlook on their circumstances, or conversely, that lack of recreation impacts their mental health.

Figure 13: Basketball hoop and equipment

Figure 14: Toilet/urinal/sink in yard area

Due Process

Although facilities are not responsible for detainees' immigration cases, they must give detainees access to legal materials, legal calls, and mail, and the ability to access legal services and representation; facilitate detainee's attendance to court; and provide detainees access to personal property related to their case. The facilities each have a law library that includes a legal database, and each detainee is allowed to go to the library up to five hours per week. All the interviewees at Adelanto and half of those at Desert View indicated that they were represented by an attorney or other legal representative. Five of the six (83%) detainees interviewed at Adelanto, and sixteen of twenty-six (62%) of those interviewed at Desert View, reported having attended an immigration court hearing since arriving at the facility.

There was some evidence that medical or mental health issues had the potential to result in reducing access to legal resources. One attorney representing detainees at Desert View told Cal DOJ that their client was unavailable for calls with them while the detainee was on suicide watch, and another attorney was unable to meet with their client because of COVID-19 restrictions.

As noted above under *Due Process and Legal Representation for Detained Persons with Mental Health Disabilities*, the terms of the *Franco-Gonzalez* settlement agreement require that the agreement be posted in public areas of the facility so that detainees can access the agreement, understand whether they qualify as class members, and if so, understand their rights under the agreement. At Adelanto, Cal DOJ observed one English-language copy of a *Franco-Gonzalez* opinion posted in the library. The opinion contained a cover page, in English, stating that the opinion was the library's copy and that detainees could request a copy of it from the library. Other than that, there were no signs, postings in any language, nor copies of the *Franco-Gonzalez* settlement agreement providing information on *Franco-Gonzalez* rights in the areas observed by Cal DOJ. At Desert View, Cal DOJ observed a court opinion from the *Franco-Gonzalez* case posted in the cafeteria, in English only and with redactions, but did not observe the *Franco-Gonzalez* settlement agreement posted in an accessible area.

Most detainees Cal DOJ interviewed at both facilities, including those who identified as being diagnosed with mental health illnesses, were unfamiliar with the *Franco-Gonzalez* case. Four of the six (66%) interviewees at Adelanto reported that they were not familiar with the *Franco-Gonzalez v. Holder* case, as did 20 of the 26 interviewees (77%) at Desert View.

Facility Focus: Golden State Annex

Background and Summary of Key Findings

The Golden State Annex (Golden State), located in McFarland, is owned and operated by GEO Group. On December 19, 2019, GEO Group entered into a direct contract with ICE to hold immigrants at Golden State beginning in 2020 following the effective termination of GEO Group's contract with the California Department of Corrections and Rehabilitation (CDCR).[123] The contract between GEO Group and ICE considers Golden State an annex to Mesa Verde, which is located nearly 26 miles away in Bakersfield.

Although Golden State is considered an annex to Mesa Verde, the population restrictions mandated by the court-ordered injunction in *Zepeda Rivas et al. v. Jennings et al*. do not apply to Golden State.[124] Golden State's maximum bed capacity is 700 and ICE pays GEO Group for a guaranteed minimum of 560 beds.[125] In preparation for Cal DOJ's May 3, 2025 visit, GEO Group provided a roster on May 2, 2023, reflecting that at that time the facility held 159 detainees. The facility can hold both female and male adults, but at the time of our visit, there were no female immigrants held at the facility. As with other facilities discussed, ICE's Performance-Based National Detention Standards 2011, and 2016 addendum (PBNDS) apply to this facility.

Table 6. Key Data Points, Golden State

Facility:	Golden State Annex
Operator:	The GEO Group, Inc.
Housing Immigrants Since:	2020
Bed Capacity:	700
Type(s) of Detainees Facility Can Hold:	Female and Male Adults
Snapshot of Detainees Housed at Golden State on May 2, 2023	
No. of Countries of Origin:	26
No. of Detainees by Sex[126]:	Female: 0 Male: 159
Average Age:	Unavailable
Average Length of Detention:	183 days
Longest Detention:	741 days

At the time of Cal DOJ's site visit, people detained at Golden State represented 26 countries, with these four countries representing the greatest number of people: Mexico (74), El Salvador (24), Honduras (19), and Guatemala (14).

123 Cal. Dept. of Corrections and Rehabilitation, *CDCR Announces State Prison Closure* (Sept. 25, 2020) <https://www.cdcr.ca.gov/news/2020/09/25/cdcr-announces-state-prison-closure> (as of Apr. 15, 2025); Cal Dept. of Corrections and Rehabilitation, Reduction/Closure Information <https://www.cdcr.ca.gov/prison-closures> (as of Apr. 15, 2025).

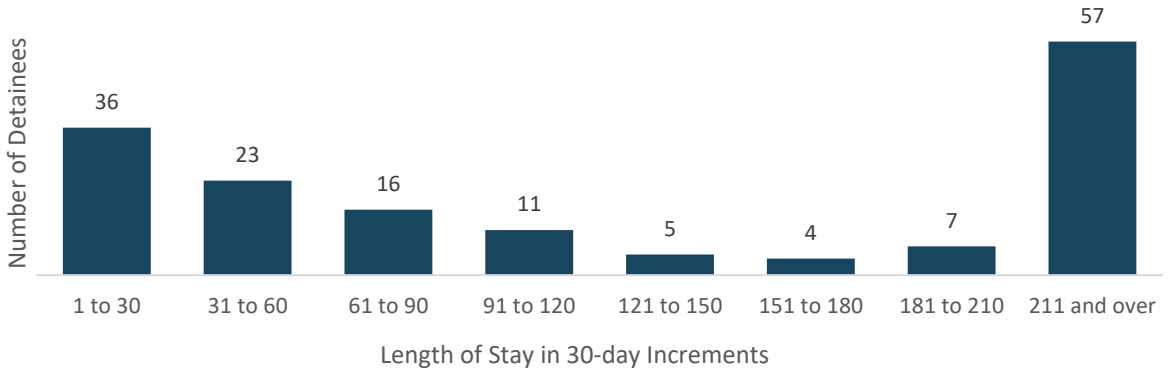
124 See *Zepeda Rivas v. Jennings (N.D. Cal. 2020) 504 F.Supp.3d 1060.*

125 The GEO Group, Locations, Golden State Annex <https://www.geogroup.com/facilities/golden-state-annex> (as of Apr. 15, 2025); ICE, Fiscal Year 2024 Detention Statistics <https://www.ice.gov/doclib/detention/FY24_detentionStats.xlsx> (as of Apr. 15, 2025).

126 Facility logs do not report transgender status.

As Mesa Verde's "annex," Golden State conducts intake for both facilities. Once newly arrived individuals have cleared quarantine they may be transferred to Mesa Verde. At the time of Cal DOJ's visit, more than one-third of the detainees at Golden State had been at the facility for over 211 days, while the newer arrivals comprised the second highest percentage of detainees, as shown in **Figure 15**.

Figure 15. Detainees by Length of Stay in 30-day Increments, May 2, 2023, Golden State.



Cal DOJ conducted a two-day site visit of Golden State in May 2023. This visit represents Cal DOJ's first comprehensive review of this facility. During the site visit and preparation period, Cal DOJ faced obstacles in conducting its review of Golden State, including having to accommodate increased social distancing measures due to exposure to COVID-19 at Mesa Verde during its site visit the previous day.

Cal DOJ's review resulted in the following key findings with respect to mental health care, medical care, and other conditions of confinement:

- The quality of mental health care was impacted by the quality of psychotherapy, inconsistent documentation of psychiatric diagnoses, lack of non-medication interventions, and inadequate medication management.
- Mental health and medical staff did not engage in appropriate treatment planning or multidisciplinary treatment to address detainee needs.
- Suicide prevention and interventions were insufficient due to inconsistent suicide risk assessments, facility related risks, and lack of safety planning.
- The facility overclassified detainees into high custody levels, including detainees with special vulnerabilities.
- Detainees were over-disciplined, including punishment for making complaints.
- The facility failed to adequately assess the mental health of disciplined detainees before placement in restricted housing.

Methodology and Limitations

Cal DOJ arrived at its findings after collecting data prior to and during the site visit, observing operations at the facility, interviewing detainees and facility staff, reviewing documents provided by the facility, and analyzing survey responses. The survey was conducted prior to the site visit and included responses from attorneys and legal services providers who represented and worked with detainees housed at Golden State.

In preparation for the site visit, Cal DOJ submitted a request to GEO Group for pertinent records and documents from the facility, many of which were initially denied by GEO Group's outside counsel. Most of the requests were satisfied following negotiations that occurred before and during the site visit. Cal DOJ held a pre-site visit meeting with GEO Group's outside counsel in April 2023.

Cal DOJ staff and experts visited the facility on May 3-4, 2023. During the site visit, Cal DOJ toured the facility, observed routine operations, and interviewed operational managers and department heads, medical and mental health care providers, detention staff and supervisors, and detainees. While GEO Group's legal counsel initially denied access to medical records of detainees who were no longer housed at Golden State, a remote file review session was permitted after our visit. Cal DOJ's mental health expert and medical health expert reviewed medical charts, other records and files, and interviewed detainees and pertinent facility personnel. Cal DOJ's correctional expert similarly reviewed detention files, use of force files, grievances, where available, and other records, and interviewed detainees and pertinent facility personnel.

Cal DOJ staff spoke with 21 detainees in standard interviews. Cal DOJ experts interviewed six detainees with a focus on areas related to their expertise. Of the 27 Golden State detainees Cal DOJ and its experts interviewed, 21 were classified as high custody and 16 had been at the facility for longer than 211 days.

Detainees who spoke with the Cal DOJ team represented 12 different countries, and spoke English, Ilocáno, and Spanish. All interviews were conducted in the detainee's preferred language by fluent interviewers and/or with the assistance of a language line. The administrators at Golden State limited the number of rooms with telephones available for Cal DOJ to interview detainees; as a result, Cal DOJ chose to prioritize English and Spanish speakers to most efficiently use the limited time and used the language line more sparingly. However, this limited the diversity of detainees that Cal DOJ could interview.

To support the mental health focus of this review, Cal DOJ selected which detainees to interview by using a purposeful sampling approach that was based on the detainee's appearance in mental health logs provided by Golden State. Cal DOJ chose additional detainees using a quota sampling procedure that drew from the general facility roster (excluding detainees who appeared on mental health logs) and sampled by subregion of origin (e.g. Asia, Africa) to ensure participation of a broad range of detainees. Additionally, 10 attorneys who had represented 18 clients at Golden State between January 1, 2021, and March 3, 2023, responded to Cal DOJ's attorney survey.

Access to Medical and Mental Health Care

Cal DOJ evaluated Golden State's systems for providing health care to determine accessibility to medical and mental health care services, starting with intake and during detention generally. Review also focused on continuity of care between facility providers, external health care that the detainee received before or during detention, any offsite care that was provided during detention, and discharge planning. Cal DOJ also considered reports from detainees and other evidence of detainee understanding of the facility's system of accessing health care.

Intake and Mental Health Screenings

Golden State medical staff identify mental health needs during intake and in routine examinations. Detainees arriving at Golden State complete an intake process prior to being assigned to a housing unit. The health care portion of the intake process is conducted by registered nurses in the medical department and they use an intake form that includes questions on medications, medical and surgical history, communicable disease history, substance abuse and transgender care, mental health counseling, hospitalizations, and suicide risk. The suicide risk assessment intake form collects details on any past suicide attempts and requires medical staff to ask detainees whether they are currently considering self-harm. Staff reported that screening intakes are reviewed and signed off by the Medical Director. One detainee with a history of mental health diagnoses declined a mental health intake but was not seen again or even approached to engage with mental health staff for three months after his arrival. This seemed anomalous as Cal DOJ's review showed that Golden State's intake process appeared adequate to identify mental health needs of newly arriving detainees, with some exceptions, which is discussed further in the section on *Continuity of Care*.

Identifying Mental Health Concerns During Detention

When experiencing any health concerns after intake, detainees can submit sick call requests for medical or mental health issues by paper or tablet, according to the Health Services Administrator. For detainees in the restrictive housing units, a tablet is available in the unit to ask for medical or mental health attention. Staff can also make a request on behalf of a detainee. The Director of Nursing reported that paper and electronic requests for medical or mental health services are collected daily and triaged immediately. Night shift nursing staff review the paper and tablet requests and, per staff report, typically brought in a detainee immediately or within 24 hours for evaluation with medical staff, although Cal DOJ's file review showed varied response times. Nursing staff document sick call encounters and reported setting an appointment with the Nurse Practitioner within a week when needed.

Based on staff interviews led by the Cal DOJ's medical expert, when detainees request medical services for symptoms that medical staff identify as being more appropriately classified as mental health issues, the Medical Director described trying "to dialogue" with detainees to overcome any stigma associated with mental health needs. Nurses noted that patients not eating or those on a hunger strike may also have mental health needs.

The Director of Nursing explained that per facility policy and practice, if detainees remain at the facility over a year, the nurses are supposed to generate appointments for the annual wellness visits, which include mental health screening questions. If detainees are identified as having serious mental illness, they are added to a "hot list" with an alert on their medical record so that both future providers and other facility staff are quickly aware of the need for additional care or for accommodations during facility operations. Cal DOJ's medical and mental health file review indicated that referrals to mental health providers were happening; however, the actual visit with mental health staff was not always timely, as discussed further below.

However, some external reports indicate that facility practice is not always successful in identifying detainee mental health needs. In response to Cal DOJ's attorney survey, four attorneys with clients held at Golden State shared that they had clients with self-reported or exhibited symptoms associated with a mental health condition who entered Golden State and remained undiagnosed. Three of those attorneys further reported that they had at least one client each who were diagnosed with a mental health condition prior to entering Golden State, but were then denied a mental health evaluation or treatment in spite of the prior diagnosis.

Access to Medical Care

As described above under *Identifying Mental Health Concerns During Detention*, staff report that medical services are available daily to detainees through the same channels as mental health requests, in paper or tablet form. Golden State offers medical services on site including primary care, sick call, and emergency evaluation. Golden State has a dental office on site that contains one chair, and staff reported it has X-rays available on select days. Although there are medical observation cells in the medical unit, it is not an infirmary and does not offer skilled nursing care. Golden State is not equipped to accept patients that require assistance managing activities of daily living (such as eating, dressing, etc.), patients that require supplemental oxygen or CPAP machines, pregnant patients, patients undergoing chemotherapy treatment, patients experiencing severe withdrawal symptoms, or HIV-positive patients. Golden State is also not equipped to treat individuals with opioid use disorder, and there were no dosing protocols for medication assisted treatment.

Based on Cal DOJ's tour of the facility, Golden State could provide some assistance to detainees with some physical disabilities, and its housing units included accessible showers. If specialized care is necessary, health care staff request approval for off-site care from ICE Health Service Corps. Records indicated detainees went off site for non-urgent needs such as ophthalmology, orthopedic care, and physical therapy but were sent to Delano or Bakersfield hospitals for emergency services. Medical staff reported that orthopedic care was readily accessed but physical therapy, while available, had a waiting period of about two months. The Nurse Practitioner also reported sending detainees to the hospital emergency room for more immediate treatment due to common delays in accessing ophthalmological care in the community.

Detainee Knowledge of How to Access Medical and Mental Health Care

Almost all detainees who were asked (16 out of 21; 76%) reported that they knew how to request to see a mental health professional, with only one detainee reporting that they were not aware of the process. While most detainees appeared knowledgeable about how to request care, there were some challenges identified. One detainee reported that due to problems submitting requests for medical care on the tablet, he instead showed the request on the screen to staff so they could call in a request for care.

Cal DOJ's review of medical grievances revealed additional obstacles to health care access. Detainees reported issues with medical request processing, such as having difficulty getting a medical request to go through the tablet or having paper grievances rejected. For example, in a grievance from 2022 asking for medical attention for a dorm mate, the response from staff stated that one cannot write a grievance for another detainee, without responding to the detainee's underlying medical need.

Continuity of Care

Continuity of care refers to the degree to which a health care system can minimize disruption as a patient receives care from different providers. It involves the 1) consistency of follow up care for detainees just entering Golden State, arriving from other facilities, returning to the facility from the hospital or other specialty care visit, and upon departure from the facility, 2) access and use of information from medical records, and 3) discharge planning as detainees prepare to be transferred or released from the facility. Cal DOJ used medical records and interviews with staff to evaluate the policies and protocols for continuity of care.

Cal DOJ's review found that prior mental health records were not consistently reviewed at Golden State, which reduces the quality of care and raises the risk of misdiagnosis and ineffective treatment. Transfer summaries from the Bureau of Prisons or California Department of Corrections and Rehabilitation are provided to Golden State staff for detainees transferred from corrections' custody

and include diagnostic, treatment, and treatment response information, but did not include all details of a detainee's prior care. Even when provided and scanned into the electronic medical records, progress notes often did not reflect consideration of the prior records' content, especially for the detainees arriving directly from the California Department of Corrections and Rehabilitation (CDCR). During interviews with Cal DOJ staff, five detainees reported not receiving some type of care that they had been receiving prior to arrival at the facility, at least three of whom indicated that they were no longer receiving individual therapy or counseling.

Bridge medication is another element of continuity of care and describes the process of temporarily continuing prescription medication at intake pending a more complete mental health analysis. Bridge medication is offered to new arrivals and transfers to Golden State, but review discovered some lapses in patients receiving these existing prescriptions. Cal DOJ's record review found an example of an instance where the transfer summary that accompanied the detainee on arrival did not include information on the psychotropic medications the detainee was taking. While nursing staff discovered the issue during intake, the facility failed to request an immediate psychiatric evaluation and did not submit an order for bridge medication, resulting in a lapse in antipsychotic medication. For another detainee, psychotropic medication lapsed for at least six days following arrival despite being seen immediately by a doctor who could have prescribed the medication pending follow up with the psychiatrist. Two attorneys also reported having at least one client each, one of whom arrived directly from a CDCR facility, who were unable to continue mental health medication after arrival to Golden State.

Follow up referrals were also sometimes delayed, resulting in gaps in care. For example, one detainee initially reported using psychiatric medications and hearing voices during his intake. Although this patient was referred for a mental health visit for the following day, and saw a psychologist, a psychologist is not qualified to prescribe or evaluate the appropriateness of a patient's use of psychotropic medications. The patient did not see the psychiatrist until six days after arrival, whereas PBNDS guidelines recommend a follow up within 72 hours.[127]

Review of patient records also indicated that continuity of care was inconsistent for detainees returning from off-site care. For one patient who declined an evaluation after a visit to the emergency room there was a gap in follow-up care after the visit, and for at least two other patients, charts were not updated after three weeks or not updated at all.

According to staff, when a detainee is set for release, the registered nursing staff is responsible for preparing an educational packet with community resources and reviewing it with the detainee in an in-person meeting, prior to release. In the case of a transfer, the same staff prepare the transfer sheet. Pharmacy staff are responsible for preparing a 30-day supply of release medications. Cal DOJ's file review of released detainees was too limited to confirm adherence to the stated practices, but one chart indicated nursing staff signed off on documentation as required.

Mental Health Care

Cal DOJ conducted a comprehensive review of mental health treatment at Golden State through review of medical records of a subset of detainees with diagnosed mental health conditions, detainees prescribed psychotropic medications to address mental health conditions, and detainees placed in the medical units and on suicide watch for mental health related reasons, including for abnormal behavior or auditory hallucinations. This section of the report details mental health care provided to the detainees and discusses practices related to (1) staffing, (2) evaluation of mental health needs, (3) treatment planning, (4) psychiatric care, (5) therapy and non-medication interventions, and (6) suicide prevention and response.

127 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § O, p. 269.

Cal DOJ did not observe major issues in staffing, mental health intake screening, confidentiality, and the availability of prescription medication and prescription practices. However, improvements are necessary in several respects including the quality and availability of psychotherapy, mental health evaluation, mental health care documentation, and some suicide prevention and intervention measures.

Mental Health Staffing

Mental health staffing was appropriate for the detainee population at the time of Cal DOJ's visit. Mental health staff consisted of one full-time psychologist and two part-time psychologists. One of the part-time psychologists was shared with Mesa Verde. The psychiatry position was covered by a contract psychiatrist handling a 10-hour telepsychiatry shift once weekly. The psychiatrist, who Cal DOJ interviewed during the May 2023 site visit, no longer worked at Mesa Verde or Golden State as of November 2023. If needed, the facility reported that a psychiatrist from Mesa Verde or GEO Group's Regional Mental Health Director could cover additional care needs, although staff could not recall this ever happening.

The room used for telepsychiatry services was also used by the on-site psychologist, and the resulting scheduling conflicts impacted availability of services on Thursdays when both providers were working, based on the schedules reviewed.

Mental Health Assessment

Cal DOJ reviewed Golden State's processes in identifying detainee mental health conditions and needs at various points of detention. These processes start with (1) intake and (2) identification of mental health needs during detention through detainee requests or medical referrals, both discussed above under *Access to Medical and Mental Health Care.* The quality of mental health evaluations and diagnoses also impacts the facility's ability to respond to detainees' mental health needs. Cal DOJ used staff interviews and detainee mental health file reviews to assess the facility's identification of detainee mental health conditions and needs.

Prevalence of Mental Health Concerns

Cal DOJ received a log from GEO Group including 40 detainees who had a diagnosed mental health condition and were receiving mental health services at Golden State in April 2023. The most frequently diagnosed mental health condition was major depressive disorder (diagnosed in 20 of 40 detainees), followed by generalized anxiety disorder (7), and post-traumatic stress disorder (5). Other disorders less frequently diagnosed included psychotic disorders, bipolar disorder, paranoid personality disorder, and pervasive development disorder.

Mental Health Evaluations and Diagnosis

Psychiatric evaluations were conducted in person or via telehealth visits and typically lasted 30 minutes for an initial evaluation and 15 minutes during follow up appointments. Cal DOJ and its team noted several inadequacies in evaluation and diagnostic practice as reflected in mental health records.

Incomplete documentation made care difficult and appeared to reflect a lack of coordination among providers. Medical records at the facility included a section to record the patient's diagnoses such that it would be easy for other providers and staff to find, but in most files Cal DOJ reviewed the diagnoses were only recorded in the text of the notes from the patient's sessions. During an interview, the psychiatrist did not see an issue with this practice, but it meant that any other medical staff reviewing the chart would not see the diagnosis. For one patient receiving mental health services, not recording the diagnosis later resulted in the psychologist and psychiatrist quickly changing the

diagnosis without documentation of an appropriate evaluation to explain how either clinician reached the noted conclusion. At least one other file lacked sufficient details or symptoms, clinical notes, evaluations, or prior exams explaining how the provider decided the diagnosis was appropriate. In a note in another case, the psychologist documented a disagreement with the psychiatrist's diagnosis, which is uncommon in clinical practice and undermines the treatment team environment. The expected approach is for the providers to discuss their respective diagnostic impressions and come to a consensus to allow coordinated treatment.

Chart review also indicated that mental health providers were insufficiently responsive to detainee reports of symptoms that should have led to further evaluation. Several of the mental health visit notes showed the psychologist glossed over trauma symptoms. In one instance, a detainee reported hearing voices, but the provider did not assess the symptom or discuss it further. In another encounter, a detainee complained of recurring nightmares but there was no questioning or inquiry regarding the nightmares.

Treatment Planning

Mental health providers typically engage in treatment planning that connects to the patient's diagnosis and symptoms, includes setting treatment goals with the patient, and develops and implements interventions to address the patient's symptoms and take steps toward the agreed upon goals. Multidisciplinary treatment planning requires coordination between mental health and medical staff to ensure diagnoses and plans for treatment are shared and consistently addressed across practice areas.

Cal DOJ's file review indicated a lack of proper treatment planning. Psychiatry notes cut and pasted material from prior visits without sufficient updates to track observations from the specific session or establish a plan of care to address symptoms or set a goal for the patient. Exam findings and diagnostic evaluations were also not consistently documented in patients' assessment and plan.

Multidisciplinary treatment was also inadequate, with no sign of any formal process of collaboration among medical and mental health care providers and other facility staff who should have a role in the detainee's well-being. Files showed no sign that the mental health staff were communicating with other medical or facility staff regarding health care access in the units. Instead, the Medical Director described a process of emailing or calling the psychiatrist when there were concerns with mental health medication, but no formal process was established or implemented. The case noted above, in which the psychologist and psychiatrist noted their diagnostic disagreements in the medical records without any corresponding records of attempts to collaborate and agree on a care plan, represents another example of inadequate treatment planning. Beyond informal communication, there was no evidence of multidisciplinary treatment planning, which compromises Golden State's ability to provide comprehensive, efficient, and effective care for detainees.

Psychiatric Care

Cal DOJ reviewed the facility's provision of psychiatric care and related prescription protocols for individuals with mental health conditions. Cal DOJ identified 36 detainees at Golden State who were prescribed medications for mental health conditions in the aforementioned April 2023 log that GEO Group provided. Cal DOJ found some of Golden State's psychiatric care practices to be appropriate while others were of concern such as inconsistent documentation and laboratory and AIMS testing.

Medication Distribution

According to Cal DOJ's interviews with health care staff, stock medications were maintained on site to easily fill common prescriptions, and staff reported no concerns with the availability of formulary, or pre-approved prescription medication for detainees. The facility reported there is a pharmacist available to discuss any non-formulary approval concerns by phone 24 hours a day, seven days a week, if necessary, and staff stated that requests for unapproved medications were typically resolved within 24-48 hours, without disruption to essential medications pending approval. Antipsychotic and mood stabilization medications, including non-formulary medications, were available at Golden State.

Most detainees who discussed medication distribution issues reported being able to receive needed medications, although some reported difficulties. Two of 11 (18%) of detainees who were prescribed medication and were asked about whether they experienced any problems receiving it reported that they did. Of participants who were asked whether they had been denied medication, three of 19 (16%) reported that this had happened to them.

Cal DOJ was unable to review the process of distributing medications to detainees in housing units, known as pill pass. However, health care staff described the procedure as one in which a nurse announces their arrival in the unit, checks detainee identifications, and distributes dosing while performing mouth checks to ensure pills are swallowed.

Psychotropic Prescribing and Medication Management

Medical staff submit orders for most psychiatric medications identified during intake, including antidepressants. Antipsychotic medications are ordered after a call with the psychiatrist. Any detainee prescribed new psychiatric medications was also referred to the psychologist for concurrent psychotherapy. File review indicated that at least one detainee starting on an antidepressant also followed up with the psychologist two weeks later and then with the psychiatrist after one month, consistent with this plan. Detainees with serious mental health needs such as psychosis or high risk suicidal ideation or behavior that were not stabilized through medication were sent to a local hospital for treatment. GEO Group policy required individuals taking psychotropic medications to have psychiatric or medical visits monthly, which according to Cal DOJ's file review appeared to be happening.

Generally, psychotropic prescribing practices to address a detainee's symptoms were appropriate with some exceptions. In one instance, for example, medication prescribed by the psychiatrist was not associated with any specific diagnosis or symptoms noted in the patient's history.

Laboratory and AIMS Testing

Generally, when antipsychotic medication is in use, the medical providers should order lab tests and conduct Abnormal Involuntary Movement Scale (AIMS) testing to monitor any side effects of medication. GEO Group had online forms to use for antipsychotic medication side effect monitoring and medical staff noted that the psychiatrist was responsible for ordering labs.

Cal DOJ observed some discrepancies in AIMS and laboratory testing practices at Golden State. Medical staff reported that the psychiatrist ordered labs, and other staff reported that the medical director reviewed lab results and would schedule follow up for mental health patients, if needed. One psychologist shared that he typically conducted AIMS testing. File review indicated labs and AIMS testing were less consistent. For one detainee, the psychiatrist ordered some, but not all, recommended baseline labs and did not order follow up labs for months despite the initial lab results falling outside of normal range. For another patient prescribed antipsychotic medication, no labs were ordered at all. A third patient, meanwhile, had all follow up labs and AIMS testing documented. Given

these discrepancies, quality control measures are needed to implement uniform practices in this area. This was partially identified as the Health Services Administrator (HSA) noted that one of the quality improvement targets included ensuring AIMS forms, consents, and follow up plans were conducted for any detainees prescribed psychotropic medications.

Documentation

Mental health documentation is comprised of notes from mental health encounters, formal diagnoses, alerts added to a patient file, and consent forms to show detainees were informed of and approved prescription medications. As discussed above, while mental health documentation was present, there were some lapses in documentation of diagnoses and evaluations by the mental health clinicians, and repetitive entries suggesting cutting and pasting raised questions regarding the thoroughness and accuracy of both documentation and the associated care.

The protocol for tracking serious mental illness among detainees appeared to be implemented uniformly. Detainees with serious mental illnesses such as schizophrenia or severe bipolar disorder were appropriately identified on a "hot list" with an alert in their electronic medical records. Staff explained that this alert ensured that these detainees received weekly mental health follow up if they were placed in separate housing units such as disciplinary or administrative segregation. However, not all detainees with mental health diagnoses were on the hot list, which was reserved for more severe diagnoses.

It was unclear whether Golden State providers consistently used required consent forms, which ensure that providers adequately explain the intended effects and expected or possible side effects of medication, and that detainees have an opportunity to state that they do not understand. Cal DOJ found consent forms in the reviewed medical files of most patients prescribed psychotropic medications, but the Health Services Administrator also shared that maintaining consent forms was an area targeted for quality improvement. Cal DOJ also identified at least one grievance filed by a detainee noting that the consent and prescription information was not provided in Spanish. Staff remedied the grievance by following up with Spanish language documentation. Five out of the 13 standard interview participants who were taking mental health medication reported that no professional explained the medication to them, suggesting that improved procedures may be necessary to ensure that the signing of a consent form corresponds to true understanding on the part of the detainee.

Therapy and Other Non-Medication Interventions

Psychotherapy and other interventions may also be used to address mental health conditions and symptoms, and for some conditions are the preferred treatment of choice instead of or concurrently with medication management. Cal DOJ reviewed the availability of non-medication interventions for improving mental health, including the quality of relationship between detainees and providers.

Availability and Quality of Psychotherapy

Non-medication interventions were limited at Golden State. The non-medication mental health interventions available were psychotherapy or brief mental health assessments, offered by the psychologist along with supportive therapy and education on coping skills. These supportive therapy and coping skills sessions provide detainees with information on meditation, deep breathing exercises and other methods to address mental health issues. However, there are no group therapy options.

The frequency and duration of therapy sessions offered at Golden State was of concern. Therapy is only provided on an as needed basis, versus being scheduled weekly, bi-weekly, or in other regular intervals. Therapy sessions that did occur generally lasted less than 15 minutes, which is insufficient to achieve therapeutic impact. For example, typically cognitive behavioral therapy is most effective when

provided in structured and consistent format (e.g. 16 sessions provided once a week). Treatment for post-traumatic stress disorder in particular requires a predictable setting in which a patient has space to develop a trusting relationship with the provider.[128]

Timely access to therapy or mental health staff also appeared to be an issue. One detainee grieved that he had been waiting two weeks to see the psychologist and in response, he was told that he was scheduled to be seen later in the week. This timeframe was outside PBNDS guidelines of 72 hours for mental health follow ups after a referral. Three detainees who participated in interviews with Cal DOJ staff also corroborated concerns with timeliness or frequency of care.

Cal DOJ's survey of attorneys with clients detained at Golden State offered corroboration that therapy services are not easy for detainees to access. One attorney reported having multiple clients who were denied therapy or counseling services but were instead offered sleeping pills. Another attorney reported that a client with PTSD was denied counseling or therapy services because the facility claimed no such services were offered at Golden State. At least two survey participants commented that mental health treatment at Golden State was limited to remote or telehealth appointments and that even when appointments were made, they were not regularly scheduled.

Rapport and Cultural Competence of Mental Health Providers

The quality of relationship between mental health providers and patients is the best predictor of success in mental health treatment.[129] Health care staff shared in interviews with Cal DOJ that efforts were made to support staff in having a "positive tone" with detainees, although it was unclear what these efforts entailed.

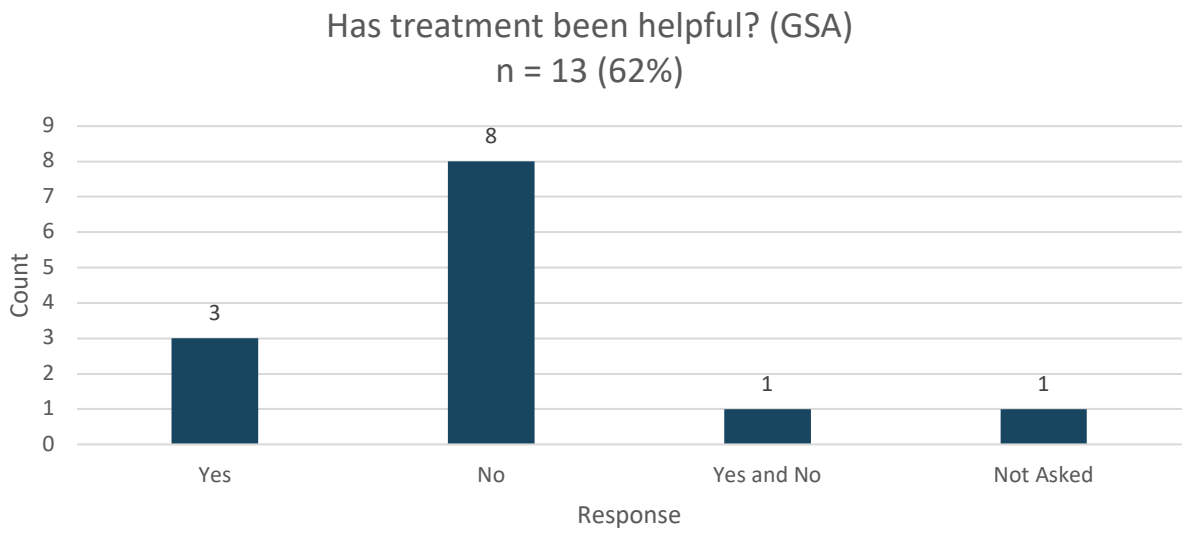
Cal DOJ has concerns about the tone of some mental health notes observed during file review and the resulting impact on quality of care. Many notes made by the psychologist openly questioned detainee experiences and symptoms shared during the encounters. Others by the psychiatrist exhibited bias towards detainees, with notes that were unprofessional and not clinically appropriate. The comments indicated that even if psychotherapy sessions were being conducted, therapeutically appropriate treatment was likely not being provided. As an example, in one note, the psychologist wrote the detainee "presented with a typical gang attitude."

Detainee interviews further highlighted how these mental health encounters impacted their views of treatment. Detainees reported mixed views regarding the adequacy of therapy with four of 10 detainees (40%) describing their interactions with mental health staff as adequate, three of 10 (30%) as inadequate, and three of 10 (30%) as mixed. In review of mental health visit notes, Cal DOJ's mental health expert also identified dismissive and judgmental statements. Additionally, in an analysis of whether mental health treatment at Golden State was helpful, eight of 13 detainees (62%) reported that it was not, as shown in **Figure 16**.

128 See, e.g. Howard et al., *Therapeutic alliance in psychological therapy for post-traumatic stress disorder: A systematic review and meta-analysis* (July 8, 2021) 29 Clinical Psychology & Psychotherapy 373 <https://onlinelibrary.wiley.com/doi/10.1002/cpp.2642> (as of Apr. 22, 2025).

129 Flückiger et al., *The Alliance in Adult Psychotherapy: A Meta-Analytic Synthesis* (2018) 55 Psychotherapy 316 <https://psycnet.apa.org/fulltext/2018-23951-001.html> (as of Apr. 22, 2025); see also Chu et al., *A Systematic Review of Cultural Competence Trainings for Mental Health Providers* (June 2, 2022) National Library of Medicine <https://pmc.ncbi.nlm.nih.gov/articles/PMC10270422/> (as of Apr. 16, 2025).

Figure 16. Detainee reports of whether the mental health treatment they received was helpful, Golden State Annex



Availability and Quality of Non-Medication Interventions

Besides these options, detainees were also advised to speak with the facility's Chaplain to assist with mental health symptoms. Another detainee reported that he had access to online self-help programs. Two interviewed detainees reported that the time spent with providers was too short or that meetings were too infrequent while another detainee shared that the time between requesting an appointment and being seen was too long.

Suicide Prevention and Response

In logs covering a time span between September 2020 and October 2022, GEO Group reported 14 mental health placements in isolation at Golden State, which included suicide watch and instances in which detainees were experiencing auditory hallucinations. Cal DOJ also reviewed records on suicide watch between November 2020 and January 2023, and found 20 entries for 14 detainees with dates of admission during this period. Review of hospital send-out records also indicated there had been one suicide attempt, although some staff disputed that characterization.

Suicide Risk Assessments, Intervention, and Prevention

Cal DOJ's review found that while some components of Golden State's suicide prevention protocols were appropriate, such as staff training, others such as physical features in the facility, the monitoring of individuals on suicide watch, the determination to discontinue suicide watch, suicide risk assessments, and safety planning did not appear adequate.

Training as reported by staff appeared adequate. GEO Group requires all staff to undergo training on mental health screening and recognizing suicidality, and medical staff who conduct intakes receive additional trainings on suicide watch and side-effects of mental health medications. Golden State's other intervention and prevention measures included weekly training meetings, staff drills, and accessible cut down tools, which were available in the housing units. GEO Group held weekly suicide prevention meetings which included the Assistant Facility Administrator and Safety Officer, along with mental health and medical staff. The Health Services Administrator shared that Golden State held "man down" or suicide drills throughout the year to handle potential suicide situations, but was unable to describe the frequency of such drills.

During a tour of Golden State, in one empty unit Cal DOJ observed that the bars in the showers could all serve as tie off points to hang oneself, posing further risks for detainee suicide attempts. In addition, the ADA shower bar was not suicide safe. Such features could be modified with suicide resistant shower heads and handles to prevent these potential situations.

There was one documented attempted suicide, which occurred in January 2023 and involved an individual who wrapped a sheet around their neck and was sent to the hospital for attempted strangulation. When asked about this incident staff dismissed the seriousness of the attempt and responded that the detainee was "playing with it." Despite records of this incident occurring just prior to Cal DOJ's May 2023 visit, medical and mental health staff interviewed could not recall engaging in any suicide attempt review process.

Cal DOJ's review of at least one patient file showed that while the comprehensive risk assessment form, which includes questions about whether a detainee is having thoughts of self-harm, was completed, the patient was not seen by a psychologist or psychiatrist for the 15 days they remained on suicide watch. While the complete risk assessment questionnaire and documentation of responses was appropriate, it was not clear if the evaluation was conducted by a qualified mental health professional as required by PBNDS.[130]

Suicide Watch

Detainees who are deemed to be a threat to themselves, following a comprehensive suicide risk assessment, are placed on suicide watch – placement in a solitary cell for close monitoring. Medical staff, including nursing staff, or mental health staff may place a detainee under suicide watch pending further mental health evaluation. Following this designation, the psychologist or psychiatrist conducts an evaluation to classify as a level one or level two, suicide watch. Suicide watch cells at Golden State consist of two medical observation rooms, that both had access to an ADA shower. Staff nearby maintained an emergency rescue bag with cut down materials and an external defibrillator. Inventory of the contents of the emergency bag were monitored through a log.

Cal DOJ was concerned by Golden State's practices related to suicide watch. PBNDS requires that detainees placed on suicide watch be placed in a special isolation room for evaluation with continuous monitoring, documented every 15 minutes or more frequently, with welfare checks every eight hours, and daily mental health treatment by a qualified clinician.[131] While some of these measures were observed such as placement in an isolation room with constant monitoring and regular welfare checks, mental health treatment was not offered. The Director of Nursing explained that registered nurses are assigned to address the needs of detainees on suicide watch, including medical and mental health issues, as well as being "available for listening." A registered nurse does not generally constitute a qualified mental health clinician unless they receive additional specialized training and education. Mental health staff confirmed they were not involved in the process. The psychiatrist reported not normally seeing detainees on suicide watch and that medical issues were a more common focus, rather than mental health care, in appointments that did occur. The lack of mental health treatment did not appear to conform to PBNDS.

Cal DOJ received a log of detainees placed on suicide watch between November 2020 and January 2023. As shown in **Table 77** below, the number of detainees placed on suicide watch increased slightly between 2020 and 2022, while the average length of stay remained stable between 2020 and 2021 and grew notably in 2022. In 2022, the average length of stay reached 13 days, a concerning increase compared to previous years, with one detainee spending 50 total days in mental health isolation. These increases in both frequency and duration of suicide watch placements amplify concerns about the

130 ICE, PBNDS 2011, Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, § D, p. 334.
131 ICE, PBNDS 2011, Part 4.6 Significant Self-harm and Suicide Prevention and Intervention, Part V, § F, p. 334.

impact of prolonged stays on detainee well-being, especially given Cal DOJ's observations that mental health care during suicide watch was limited.

Table 7. Summary of Number of Days[132] Placed in Suicide Watch, Golden State, November 2020 to January 2023

Admit Year	Count of Placements	Average Days	Minimum Days	Maximum Days
2020	4	2.50	0	6
2021	6	2.17	0	5
2022	7	13.00	0	50
2023	1	7.00	7	7

Cal DOJ also had concerns about the process of terminating suicide watch. At Golden State, the process involves several staff outside of the mental health staff, which could undermine the psychologist's or psychiatrist's professional judgment in a clinical decision that is typically made by a licensed mental health professional. The psychologist, Medical Director, Director of Nursing, Health Services Administrator, and the Facility Administrator, make up a committee of reviewers who decide by consensus whether suicide watch should continue, and GEO Group policy requires the Health Services Administrator to sign off on termination of suicide watch. The Health Services Administrator's qualifications as a registered nurse are not adequate to approve or authorize such a call.

Concerns with multidisciplinary communications and management of suicide watch determination stemmed from two examples. In one instance the Medical Director terminated suicide watch after getting a report from the nurse that the detainee was not really suicidal, without assessment or input from mental health staff. In another instance, the Nurse Practitioner was contacted as the on-call provider, after the psychiatrist did not respond, to determine whether a detainee on suicide watch should have certain restrictions lifted and be permitted to use the recreation yard, which may have been outside the scope of their practice.

Safety planning is another critical component of suicide watch. Safety plans are treatment plans that mental health providers create with the patient to identify clear steps the patient agrees to take in response to that individual's particular triggers for suicide risk. PBNDS establishes that detainees discharged from suicide watch should be reassessed within 72 hours and at intervals prescribed by the treatment or safety plan consistent with the finding of trained and qualified medical staff member.[133] Cal DOJ file review did not observe evidence of safety planning occurring once a detainee is removed from suicide watch, despite such plans being a standard clinical intervention that is especially necessary during the high risk period immediately following suicide watch.

Review of Suicides and Other Fatalities

While there were no suicides during the review period, there was one suicide attempt, which was disputed by staff. As described previously, when staff were asked about suicide attempts at Golden State, the Health Services Administrator denied that any had occurred. However, when asked about the specific incident in which a detainee wrapped a sheet around their neck, the Health Services Administrator dismissed the specifics and described it as "playing," despite the detainee being sent out to the hospital for further assessment and treatment.

132 In logs provided by Golden State Annex, "days" are calculated by calendar date, such that a detainee will appear in the log with a length of stay of zero days if they are released from suicide watch later in the same day the suicide watch begins.

133 ICE, PBNDS 2011, Part 4.6 Significant Self-harm and Suicide Prevention and Intervention, Part V, § F, p. 4.

The Nurse Practitioner shared that they were not involved in review of suicide attempts. Cal DOJ received no other information about suicide or suicide attempt review process other than the weekly suicide prevention meeting, which included the Facility Administrator and Safety Officer.

Medical Care

Golden State operates a medical unit described as a level 1 facility by the site's Health Services Administrator, meaning that it is a smaller unit that may not offer the full scope of services potentially available at hospitals. The Medical Director is board certified in internal medicine and oversees facility operations. The Medical Director, however, believed the Golden State medical unit was operating as a level 2 or level 3 facility with a broader scope of practice, based on staffing and the availability of medical observation cells to allow for detainees to remain for an unspecified time.

Golden State received the National Commission on Correctional Health Care (NCCHC) accreditation in January 2023. The Office of Immigration Detention Ombudsman also completed a compliance inspection in January 2023 based on PBNDS and found that Golden State was not deficient in medical care, suicide prevention, terminal illness management, disability accommodation, or required NCCHC accreditation.

Medical Staffing

Overall, staffing was adequate to meet the needs of the current low population at Golden State. However, the facility has experienced periods where staff members were required to hold multiple roles temporarily or permanently; this would not be a suitable policy if the facility population was at capacity. Golden State appeared to have had one physician available to treat patients who split their time between Mesa Verde and Golden State until a second doctor joined one to two months prior to Cal DOJ's visit. The Health Services Administrator was able to devote full attention to one position at the time of Cal DOJ's site visit but had also served in a dual role on an interim basis between 2022 and 2023, during which time they were also required to perform nursing duties. At the time of Cal DOJ's visit, Golden State was staffed by a Health Services Administrator, a board certified medical director, one nurse practitioner, a Director of Nursing and three additional full-time registered nurses (RNs), seven part-time RNs, and seven licensed vocational nurses (LVNs) and others. Staff reported that a physician or nurse practitioner was only on site from Monday to Thursday, but that nurses can contact on-call staff when needed between Friday and Sunday. Staff described nursing staffing patterns as including a day shift covered by two to three RNs and four LVNs and a night shift consisting of one RN and one LVN.

At the time of Cal DOJ's visit, there appeared to be a fair amount of staff turnover in progress. Half of the full-time nurse positions were vacant and covered by part-time RNs. Golden State was in the process of hiring one nurse practitioner, three RNs, and one LVN. The Medical Director was newly hired but was an experienced internal medicine specialist with prior experience in California corrections. Similarly, the Director of Nursing had started at Golden State approximately six months prior to Cal DOJ's site visit but had years of correctional nursing experience.

Quality of Medical Care

Cal DOJ and its experts assessed the quality of medical care through review of medical charts and other records, focusing on medical and mental health observations, availability of off-site facility treatment, medications, and management of chronic conditions. Despite facility staffing levels that were adequate for the current population level, Cal DOJ observed delays in care, disruptions to the continuity of care, and appropriate tracking of detainee health issues. Several of the issues mirrored those already discussed in the above evaluation of Golden State's mental health care services.

First, some grievances showed that there were prolonged wait times for on-site care and for sick visits which were behind from several days up to two weeks. However this pattern did not appear to be pervasive.

Second, continuity of care appeared to be an issue, in part due to staff turnover. One detainee who reported a history of heavy alcohol use that put him at high risk for withdrawal was not monitored or referred for prompt medical or mental health assessment. For another detainee, it took staff two months to request medical records, only doing so after the detainee had been sent to the emergency room. In another instance, for a detainee who transferred from prison, staff did not request the detainee's medical records until 10 weeks after his arrival, delaying assessment of a growing mass on his body and other health concerns that could have been due to cancer. Even after a Golden State doctor evaluated this detainee and recommended a same-day evaluation at the emergency room of a local hospital, the hospital visit and evaluation never happened, medical staff did not attend to the detainee again for at least three months, and no evaluation of the mass was set until six weeks later.

Lastly, Cal DOJ observed gaps in medical notes in some detainee medical files, leading to problems in the administration of care to detainees. For example, one detainee experienced anaphylaxis after a bee sting at Golden State, as documented by nursing staff, but staff did not administer an EpiPen or document that the detainee had a bee sting allergy in his chart, even after he had returned from the hospital. Another detainee had been prescribed dementia medication by a treating psychiatrist who was no longer working at Golden State, but there were no notes in the patient chart specifying why the medication was prescribed.

Golden State's treatment of chronic conditions appeared to be better. Detainees with chronic medical conditions were seen in regular appointments set every 90 days and the Medical Director reviewed all lab results, refill prescriptions, and consulted with the psychiatrist as needed. Screenings for age-specific health conditions were conducted to identify high cholesterol and diabetes.

Barriers to Health Care

Cal DOJ observed potential barriers to detainees receiving health care at the facilities. First, language and privacy concerns arose at times but were not persistent obstacles to care. Second, staff attitudes and generally poor culture around health services did interfere with detainees receiving care to properly address their mental health needs.

Language Access

Language access appeared to be generally adequate at the facility although some detainees reported some difficulties. In describing language access practices in health service delivery, medical staff noted that a language translation line was accessible in the office and through a tablet for language line and American Sign Language video interpretation in the restrictive housing unit. Medical staff also identified that clinical staff spoke Hindi, Punjabi, Yoruba, and Spanish.

However, at least one detainee interviewed by Cal DOJ staff reported receiving teletherapy services without also receiving interpretation services. In addition, Cal DOJ reviewed a 2022 grievance from a detainee who was not receiving information about his medication in Spanish. Golden State staff resolved the grievance by providing the detainee with a medication pamphlet in Spanish, but there was no evidence that the detainee received an opportunity to discuss and ask questions about the medication in his native language. In interviews, most detainees confirmed that they could communicate with staff in Spanish either through an interpreter or through Spanish-speaking staff. However, one detainee reported that providers spoke to them "in poor Spanish," suggesting that providers' Spanish proficiency may not have been consistently adequate for the services rendered.

Additionally, one detainee reported that they were not able to communicate effectively with mental health providers because of audio quality issues with the language line.

Confidentiality and Privacy Concerns

Generally, appointments for medical and mental health services occur in private rooms. However, privacy concerns were raised in Cal DOJ's attorney survey and by medical staff when discussing care practices for detainees who have been on hunger strike. In Cal DOJ's survey, one attorney shared that their clients reported that medical and mental health staff shared their confidential health information with other staff and detainees. Medical staff reported that a confidential space was available for detainees to receive counseling while on hunger strike, but that detainees who did not want to leave their housing units would receive semi-confidential conversations with medical staff in spaces separated by screens.

Facility Culture on Medical and Mental Health Services

Improvements are needed in health care culture as evident by discrepancies between information staff shared in interviews and information gleaned from grievance records and reports from recent incidents. The facility culture, and in particular, actions that dismiss detainees' health care issues could deter detainees from requesting health care services.

Although the staff interviewed denied seeing many, if any, medical-related grievances, Cal DOJ's review of grievances indicated several issues with facility culture related to health services. Between December 2021 and March 2023, detainees submitted over 70 grievances classified under "conduct of healthcare staff", three of which were substantiated. The three substantiated grievances related to one physician who provided "inappropriate advice" and "acted without professionalism towards the detainee situation."

Grievances that were unsubstantiated or rejected and related to staff conduct showed a widespread lack of therapeutic rapport and unprofessionalism. One grievance alleged that staff made jokes about the detainee, which was rejected as a non-medical grievance, while another grievance about a nurse with bad character was rejected for not requesting any relief. Other grievances alleging that staff did not follow protocol were closed out with the response that the medical team did follow guidelines. Overall, the tone of grievance responses indicated that staff did not use the opportunity to learn any more about the detainee experiences or address any systemic problems with access and care.

Review of mental health visit notes, described in the Psychiatric Care section above, generated results consistent with these reports. As noted above, this review revealed chart notes in which the psychologist exhibited bias against detainees or a judgmental stance toward them. The notes often discredited symptoms described by detainees which in turn posed harm as the provider failed to provide necessary treatment to address legitimate mental health issues.

In Cal DOJ's attorney survey, attorneys for detainees at Golden State also reported that detainees described unprofessional treatment by medical and mental health staff.

One attorney commented that several of their clients shared that mental health staff had pressured them to accept voluntary deportation. Another attorney reported that in response to their client's request for mental health treatment, staff told the detainee that if they were unhappy, they should sign their deportation papers and leave.

That same client met with an external therapist who diagnosed their client with depression and noted that the mistreatment by Golden State medical and mental health staff had contributed to their client's mental health difficulties.

Detainees did not feel that medical providers could provide trauma-informed care. One detainee explained that he had been victimized and requested psychological help at Golden State. This detainee was told by the psychologist that he was "ok" and his feelings would "go away." When he further described his trauma to the psychologist, he was told, "the sun also rises in Mexico, you can go there and get another wife." After that meeting, the detainee did not know who he could talk to if he needed help. When asked whether detainees felt that medical staff provided respectful care, one individual responded no, because "they make fun of you," and then detailed an exchange he had with a practitioner who dismissed his symptoms.

Medical and Mental Health Quality Assurance Process

Cal DOJ observed some quality assurance process in place for medical staff but no comparable process for mental health staff.

The Facility Administrator, Health Services Administrator, Medical Director, compliance administrator, and safety officer reported engaging in quarterly Continuous Quality Improvement (CQI) meetings, but mental health staff were not part of this meeting. Corporate staff from GEO Group reportedly analyzes trends and provides the facility with corrective action plans.

The Director of Nursing (DON) noted that medical staff conducted weekly chart audits to ensure that chronic care conditions were followed up every 90 days and tuberculosis skin tests were checked and recorded per PBNDS section 4.3. The DON also shared that quality assurance checking included review of emergency bags daily for tampering, checking new locks monthly, and conducting quarterly emergency drills.

At the time of Cal DOJ's visit, the Health Services Administrator identified two quality improvement targets: (1) timeliness of intake labs, and (2) ensuring AIMS forms, consent forms, and follow up plans were present in the charts of detainees who were prescribed psychotropic medications. There had also been a noted trend in detainees declining off-site care when conflicting legal appointments were scheduled, and staff mentioned they were trying to better manage such scheduling challenges.

After review of mental health visit notes, it was evident that a mental health-specific quality improvement process is needed to correct the clinical issues identified during file reviews. Such quality improvement requires an experienced mental health provider with a master's degree or higher to provide necessary feedback.

Conditions of Confinement

Cal DOJ conducted a review of custody and disciplinary practices at Golden State, including classification and housing assignments, discipline, segregated housing, use of force, PREA, staff and detainee relations, and programming and recreation. Cal DOJ found issues with placement of detainees with special vulnerabilities in high-risk housing, over-disciplining detainees, and placement of detainees with severe mental illness in administrative segregation.

Classification and Housing

Security classifications are one major factor in determining a detainee's housing assignment and can impact access to other programs and services. Detainees typically are classified as low, medium, medium-high, or high security levels and are held in a unit with similarly-classified detainees.

As of May 3, 2023, Golden State only held detainees classified in the medium-high and high custody levels. At the time of DOJ's visit, Golden State held 159 male detainees, 50 classified in the medium-high custody level and 111 in the high custody level. Cal DOJ and its expert reviewed custody classification files for several detainees to evaluate how Golden State staff conducted classification determinations. Files indicated that GEO Group occasionally classified and reclassified detainees to high custody levels without providing a justification for the classification or reclassification. Other detainees requested protective custody, including some with special vulnerabilities including mental health conditions, but were placed in restrictive housing instead. Additionally, several detainees with special vulnerabilities (e.g. those identifying as transgender, gay, or bisexual) were not identified as a detainee with a special vulnerability and were placed in high-level custody.

PBNDS section 2.2, Classification, requires that "classification decisions should be provided to the detainee along with information on the appeal process in a language and manner understood by the detainee. Classification systems shall include procedures for detainees to appeal their classification levels through written detainee request forms or by filing formal grievances."[134] The facility handbook, however, states that "[i]f a detainee wishes to appeal their classification level, they should write a request to ICE, and ICE will determine what, if any, changes will be made."[135] There is no indication that the facility entertains internal appeals of detainee classifications. Cal DOJ identified this deficient appeals process at Adelanto, another GEO Group facility, in its 2021 Report.[136]

Discipline

Cal DOJ reviewed administrative segregation and other discipline-related protocols, reviewed twelve disciplinary files, and interviewed detainees, and found concerning practices with respect to over-discipline of detainees. Of the detainees interviewed by Cal DOJ, seven reported being disciplined. Of these detainees, three believed that they were punished due to behaviors related to their mental health condition.

While discipline is commonly the result of violations of facility rules or policies, file review and detainee interviews revealed that discipline sometimes reflected facility staff's objections to detainee cultural practices. Cal DOJ interviewed detainees who the facility had punished by placing them in restrictive housing, revoking privileges, and limiting access to the commissary. For example, one detainee reported being disciplined for refusing food that did not correspond to his religious diet. Another detainee reported that they were disciplined after being accused of practicing Santa Muerte, a religious practice, and summoning demons. Whether the detainee actually engaged in the religious practice is irrelevant; PBNDS 3.1 forbids discipline based on religion.[137] Another detainee was disciplined for "engaging in a demonstration."

In interviews, detainees also reported perceiving disciplinary action to be inappropriately imposed. For example, one detainee reported being challenged to a fight in the housing unit by another detainee with a known mental health condition. After refusing the challenge and reporting the detainee with the mental health condition to a detention officer, the detainee reported that the detention officer told them to fight the other detainee: "You want him out, you know what to do." To avoid a fight, the

134 ICE, PBNDS 2011, Section 2.2 Classification, Part I, p. 66.
135 The GEO Group, Supplement to the National Detainee Handbook, Golden State Annex (2022/2023) p. 4 <https://lccrsf.org/wp-content/uploads/2024/12/GEO-GSA-Handbook-5.24.22.pdf> (as of Apr. 14, 2025).
136 *Immigration Detention in California* (Jan. 2021), *supra*, p. 23
137 ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, § P, pp. 182-183.

detainee went out into the recreation yard instead. This detainee indicated they were later disciplined for disobeying the orders of the detention officer by refusing to come in from the yard. Two other detainees reported being disciplined for making complaints: one detainee complained that the walkie-talkies used by detention officers were too loud, for which he received a citation, while the other detainee complained that detention officers were opening envelopes clearly marked as confidential legal material during searches of housing units.

In response to Cal DOJ's survey, three attorneys reported that four of their clients had been subjected to discipline while detained at Golden State in retaliation for submitting grievances regarding the conditions at the facility or for participating in a hunger strike. The punished detainees were either denied use of the commissary or other loss of privileges or were transferred to restrictive housing. Another attorney reported that their client had been punished and placed in administrative segregation after he refused to relocate to another housing unit. Although the detainee had felt safe in his housing unit, the facility alleged that he was receiving threats and forced him to move housing units.

In addition to the substance of disciplinary actions, the process of imposing discipline at Golden State, as reported by attorneys responding to Cal DOJ's survey, also raised concerns. Two of the attorneys reported that there were "sometimes" disciplinary hearings before a punishment was imposed on their client; while the other attorney reported that their clients had "never" received such a hearing. All three attorneys further reported that they had never been notified by the facility prior to the punishment of their clients. The attorneys also reported that they had heard from their clients that the disciplinary proceedings, when they did occur, were often deficient due to lack of paperwork with the accusations made against them, the facility refusing to call witnesses offered by the punished detainee, or disciplinary paperwork prepared after the punishment had been served. PBNDS 3.1 requires due process for a detainee before a facility imposes a punishment, including a hearing before the Unit Disciplinary Committee within 24 hours after the conclusion of an investigation into alleged wrongdoing and a hearing before the Institution Disciplinary Panel within 24 hours of the conclusion of the Unit Disciplinary Committee or within 48 hours of the conclusion of the investigation. Detainees are further entitled to present statements and evidence on their own behalf, including witness testimony. Additionally, GEO's detainee handbook entitles a detainee to a disciplinary hearing within 24 hours of the detainee's receipt of a written statement of charges and specific rules allegedly violated.[138]

Restrictive Housing: Disciplinary and Administrative Segregation and Protective Custody

As part of our review at Golden State, Cal DOJ reviewed policies and procedures and conditions of segregation, separately evaluating conditions of administrative segregation and disciplinary segregation.

138 Intentionally omitted

Figure 17: Enclosed phones

Placement in Restrictive Housing

Disciplinary segregation is a form of isolation used as a result of a detainee's violation of detention rules or regulations. Administrative segregation provides for separation of detainees who may pose a threat to others, and protective custody provides for a vulnerable detainee to be housed separately for their safety.

The restrictive housing unit for detainees placed on administrative or disciplinary segregation has six beds in separate cells. Following PBNDS section 2.12, facilities can place detainees in administrative segregation when a detainee "represents an immediate significant threat to safety, security or good order" or for the purpose of "protective custody" when necessary to protect a detainee from harm and there are no reasonable alternatives available.[139] Staff reported that detainees designated as having serious mental illness are not placed in restrictive housing, as required by PBNDS section 3.1.[140] Cal DOJ's review did reveal some detainees with mental health conditions placed in restrictive housing, but it was not clear from the data reviewed whether these conditions included serious mental illness. In 2022, 15 out of 48 administrative segregation placements were due to non-disciplinary protective custody, while two out of 24 disciplinary segregations were of detainees with mental health conditions. In 2021, nine out of 61 administrative placements were of detainees with mental health conditions and seven out of 27 disciplinary placements were also of detainees with mental health conditions.

The pre-disciplinary mental health evaluations reviewed by Cal DOJ were insufficient. PBNDS section 2.12 requires that a medical professional evaluate detainees prior to placement in segregation.[141] Before taking disciplinary action, such as placing the individual in restrictive housing, the facility's reported practice is that a psychologist reviews detainee charts and prepares a note for facility leadership regarding the role of a mental illness in the disciplinary incident or whether restricted housing placement is appropriate. The psychologist at Golden State made a determination on a detainee's suitability for segregation based only on a review of health care records, and not in a face-to-face evaluation of the detainee. In his interview with Cal DOJ, the psychologist stated that the facility used to conduct face-to-face evaluations of the detainee, but changed the practice because of the

139 ICE, PBNDS 2011, Part 2.12 Special Management Units, Part II, p. 171.
140 ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part V, § A, pp. 216-217.
141 ICE, PBNDS 2011, Part 2.12 Special Management Units, Part II, pp. 171-172.

conflict he perceived between his clinical role and the role of determining whether a detainee could be segregated.

Additionally, there is no indication that facility policy authorized the psychologist to approve or deny placement of a detainee into segregation, nor an indication that the psychologist gave input on whether a detainee's mental health would be impacted by segregation. Golden State's psychologist reported never making a finding that disciplinary action or placement in restrictive housing at Golden State was inappropriate. However, Cal DOJ identified detainees with serious mental illnesses whose placement in administrative segregation was problematic and several detainees who reported worsened mental health conditions after the placement. For example, at least one detainee reported to a nurse evaluating him for potential placement in segregation that he had been hearing voices since arriving at the facility; he was still placed in restrictive housing. Five days later, he reported to the psychologist that he had been hearing voices, and that he was feeling anxious and depressed. The detainee remained in segregation and was eventually diagnosed with unspecified schizophrenia. Likewise, the psychologist never found that a detainee's mental health could have impacted the incident for which the detainee was being punished.

Cal DOJ analyzed data reflecting the lengths of stay experienced by detainees who were present in facility mental health logs and data for those who were not present in such logs. Overall, segregation stays for detainees in the mental health logs group were slightly longer but generally comparable to those in the non-mental health logs group.

Treatment in Restrictive Housing

Placement in restrictive housing can worsen mental health conditions, and Cal DOJ was concerned by treatment disruptions for those in segregation. For those in isolation or segregation, the facility reported that nurses monitor for medical needs one to three times daily and that a doctor and a psychologist performed weekly rounds visiting restrictive housing unit patients. However, detainees reported issues with their care.

Four detainees (19%) interviewed by Cal DOJ staff reported that they had been put into segregated housing during their detention. Of the detainees who had been segregated:

- Two detainees (50%) reported that a medical or mental health professional had checked on them during their segregation, while one detainee (25%) said that a professional had not.
- Three detainees (75%) reported that they had not received their continued mental health or medical treatment while in segregated housing.
- The two detainees who were receiving medical or mental health medication when they were put in segregated housing continued receiving the medicine.
- Two detainees (50%) reported that the placement worsened their mental health. One detainee reported feeling scared, bored, and sad. Another detainee stated that his feelings about detention had been improving before the segregation but that his placement in segregation "sent everything back to zero."

In response to Cal DOJ's attorney survey, one attorney noted that one client detained at Golden State was placed in solitary confinement in retaliation for his involvement in advocating for better conditions, which exacerbated his symptoms of PTSD. Another attorney reported that one client was placed in solitary confinement and deprived of any mental health care despite having a previously diagnosed mental health condition that had gone untreated at Golden State.

Use of Force

Between January 2022 and April 2023, GEO Group reported 10 use of force incidents at Golden State. Cal DOJ reviewed use of force files and observed issues with use of force documentation and with communication with medical or mental health staff prior to using force.

GEO Group limited Cal DOJ's review of the use of force files. Initially, Cal DOJ was not permitted to review the requested use of force files. GEO Group later allowed remote review of these reports but limited this review to a time-limited video call on October 4, 2023, and did not present corresponding disciplinary files, administrative and disciplinary segregation logs, or video recordings of the use of force incidents. On the video call, GEO Group limited Cal DOJ and its expert to only view handwritten summaries of use of force reports, and consolidated individual reports by GEO Group employees involved in the incident. None of the forms generated by GEO Group and provided to Cal DOJ included statements by detainees who were subjects of or witnessed the incident, or even a space to collect those statements. In contrast, during review of the Adelanto and Desert View Annex facilities, GEO Group provided a General Incident Report, a Medical Report on Injuries and Non-Injuries, and the After-Action Review—which included multiple detainee statements. This indicates that GEO Group facilities do maintain this information, but Golden State did not provide it for these inquiries.

Additionally, Cal DOJ staff and its expert observed that the GEO Group did not number the use of force reports in a sequential order, and the names of the detainees subjected to force did not always correspond to the name of the report in which they appeared. For example, the ten files reviewed did not include hunger striking detainees who were forcibly removed from the facility. Of the ten incidents, three were found to be excessive or unnecessary by the Facility Administrator given the precipitating actions of the detainee. Cal DOJ and its expert were only able to make an assessment of the validity of the reports based on a review of the summaries over video call, and were unable to corroborate the accuracy of these summaries by reviewing video footage of the incidents or interviewing the detainees.[142]

Within these limitations, Cal DOJ identified some aspects of GEO Group's use of force practice at Golden State that were functioning appropriately, alongside some areas of concern. In the files reviewed, the use of planned force as opposed to spontaneous force was higher than at other facilities, which is a preferred practice. According to staff, when a use of force is planned, the Director of Nursing or Health Services Administrator conducts a health care chart review to check whether the involved detainee has a serious mental illness and determine on a case by case basis whether the detainee should be subjected to this course of action. The Director of Nursing reported that when a detainee is subjected to use of force, a full nursing assessment is conducted, including a whole body and skin check. However, in an inspection by the Office of Detention Oversight (ODO) in July 2023, a calculated use of force file review found that there were no recorded notes of medical encounters or assessments following the incident, and that Golden State's compliance had trended down overall since its January 2023 inspection.[143] It was difficult for Cal DOJ to confirm ODO's findings given that GEO Group did not share all relevant information with Cal DOJ.

142 The ICE Office of Detention Oversight issued a report of its unannounced compliance inspection to Golden State Annex in July 2023. (See generally ICE, Office of Detention Oversight, Unannounced Follow-up Compliance Inspection, 2023-002-153, Enforcement and Removal Operations, ERO San Francisco Field Office, Golden State Annex, McFarland, California (July 18-20, 2023) <https://www.ice.gov/doclib/foia/odo-compliance-inspections/goldenStateAnnexMcFarlandTX_Jul18-20_2023.pdf> (as of Apr. 18, 2025).) During this inspection, the ODO reviewed calculated use of force files and found deficiencies in the video recordings: one of the recordings did not show the faces of all the staff involved or closeups of the detainees during post-incident medical examinations, and one recording did not include the medical examination at all, nor a recording of the detainee's escort to the medical unit.

143 ICE, Office of Detention Oversight, Unannounced Follow Up Compliance Inspection, 2023-002-153, *supra*.

Prison Rape Elimination Act

Cal DOJ reviewed Golden State's practices related to preventing and investigating sexual abuse, pursuant to the Prison Rape and Elimination Act (PREA). The facility had some positives with respect to PREA considerations, though there was still areas for improvement. Notably, there were no PREA complaints filed at Golden State for a year preceding Cal DOJ's visit (April 2022 to April 2023). The Facility Administrator was well-versed in the requirements of PREA. The facility utilizes tablets for reporting harassment or abuse. Facility policy also complies with PBNDS in requiring staff to announce themselves before entering different-gender housing.

However, Golden State staff did not adequately consider mental health needs of detainees at risk for PREA incidents. One detainee who was identified as more vulnerable due to cognitive issues and serious mental illness remained housed with the general population, resulting in a PREA incident, and remained in general population housing even after the incident occurred. After the incident, the psychiatrist requested and recommended a disability accommodation for separate housing, but as of the time of Cal DOJ's visit, the detainee still remained in a general population unit.

According to staff, detainees allegedly involved in a PREA incident are referred to mental health staff. Mental health staff, specifically a psychologist, see detainees after reported PREA incidents. However, the responses and resolutions for PREA incidents were not always appropriate, as described previously in the section on *Facility Culture on Medical and Mental Health Services*.

Staff and Detainee Relations

As described in the *Facility Culture on Medical and Mental Health Services* section, staff and detainee relations at Golden State appear strained, especially with respect to health care. The dynamics described above were corroborated by Cal DOJ's survey in which one attorney reported that at least one of their clients was subjected to threatening and racist comments by facility staff. Five detainees (42% of the 12 who were asked) believed that they were treated differently by detention staff at the facility because of a mental health condition.

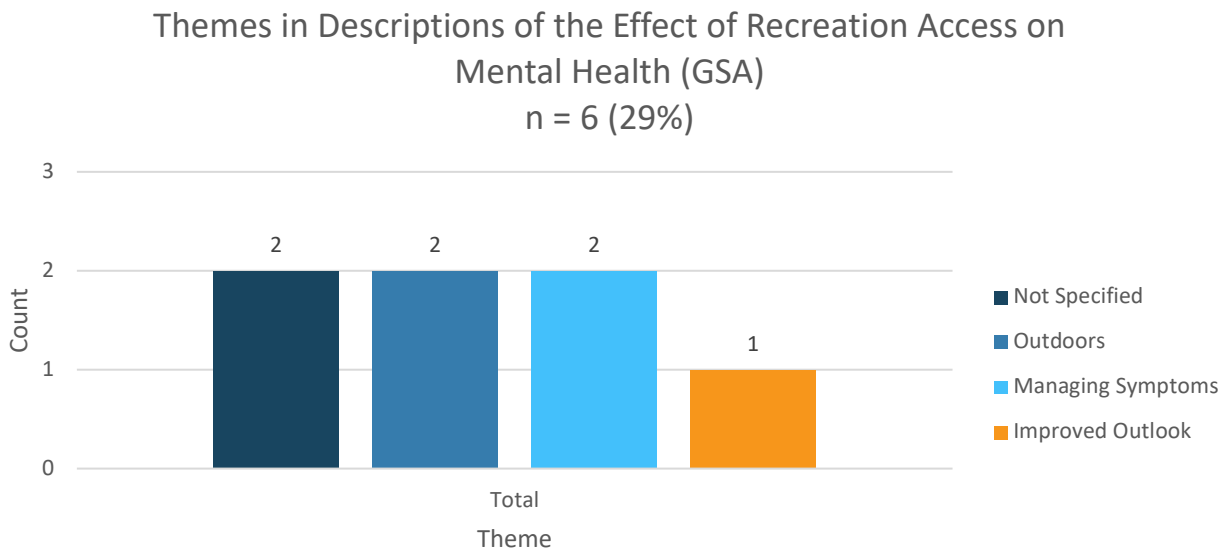
Aside from these significant concerns, the most frequent grievances by detainees involved food quality and quantity, sanitation of the units (including questions over who is responsible for the cleanliness of the units and detainee wages for the Voluntary Work Program), and staff, specifically the behavior of staff during the detainee hunger strike and work stoppage.

Programming, Recreation, and Voluntary Work

Cal DOJ observed that detainees' access to programming and recreation positively impacted conditions of confinement. Interviewed detainees reported that they received access to programming and recreation including the voluntary work program, self-help and GED classes, soccer, volleyball, and indoor and outdoor recreation. Cal DOJ's corrections expert noted that the indoor recreation area was new but seemed small for the population and appeared underutilized, as most supplies were unopened. Detainees reported also having access to religious services, but at least two detainees expressed frustration that these services consisted of only a video.

Six detainees reported that recreation had a positive effect on their mental health. Three detainees elaborated, explaining that being outdoors and having access to the yard helped them manage their medical or mental health condition or that it improved their outlook on their circumstances.

Figure 18. Frequency of themes detected in participants' descriptions of the relationship between recreation and mental health, Golden State Annex



According to detainees, detention staff often deprived detainees of access to the outdoor area as punishment, withholding around four hours of outdoor recreation daily. Detainees also complained that the products and equipment issued to them to clean the housing units for voluntary work assignments were diluted or in disrepair, restricting their effectiveness and, as a result, increasing the difficulty level of the work.

Figure 19: Printed manuals with instructions

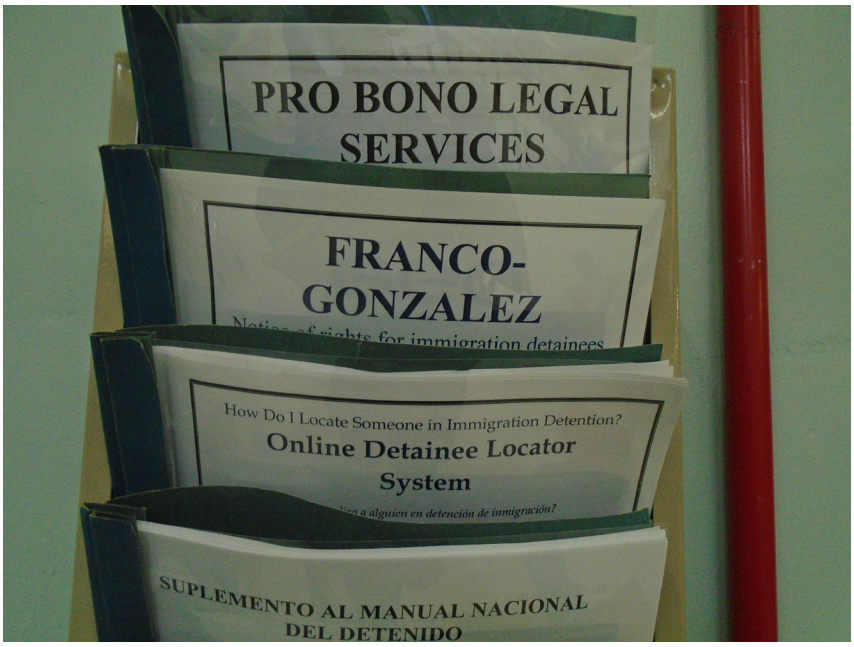


Figure 20: Outdoor yard and exercise equipment

Figure 21: Bathroom facilities for use by detainees while engaging in outdoor recreation

Due Process

Cal DOJ reviewed whether Golden State afforded sufficient due process to detainees, such as access to immigration legal services, and whether information regarding the *Franco-Gonzalez* settlement agreement was available and accessible. Facilities must provide detainees access to legal materials, legal calls, and mail. Facilities must also ensure the opportunity to access legal services and representation; facilitate detainee's attendance to court; and provide detainees access to personal property related to their case.

Some detainees at Golden State reported to Cal DOJ that the facility or ICE had prevented them from communicating with their attorneys. Of the detainees interviewed, a majority (57%) reported that they were being represented by an attorney or other legal representative, and 11 (52%) reported attending an immigration court hearing while at Golden State.

Several attorneys corroborated this testimony in Cal DOJ's survey, reporting that ICE and the facility had impeded their clients' ability to communicate with their legal representative. One attorney reported that ICE had failed to provide their client with a required PIN number to make confidential legal calls, and that ICE was unresponsive to emails from the representative. Another attorney alleged that the facility, on multiple occasions, had disconnected the dorm phones that allow detainees to make unmonitored legal calls and restricted use of the tablets detainees use to make calls after detainee protests or complaints. Other detainees had video calls cancelled or were told by the facility that there were no more appointments available for video calls, according to their lawyers. Two detainees described access problems to Cal DOJ staff, such as calls cut short, difficulty setting up calls due to room unavailability, and not being permitted to speak to their attorney while on hunger strike.

Cal DOJ assessed whether facilities were fulfilling the requirements to post notice of the *Franco-Gonzalez v. Holder* settlement. During a tour of the facility, Cal DOJ observed pamphlets in English and posters in Spanish providing information on *Franco-Gonzalez* rights in the housing units. Most detainees who participated in standard interviews with Cal DOJ (62%; 13 out of 21) reported familiarity with the *Franco-Gonzalez v. Holder* case and the implications of that litigation's settlement agreement. Of the 16 detainees who were asked, seven (44%) reported that they believed they are class members in the *Franco-Gonzalez* litigation settlement. However, Cal DOJ recognizes that the standard for a detainee to qualify as a class member is a high bar and mere belief of qualification is not enough for class membership.

There were also reports that detainees with serious mental health conditions had trouble—in a few instances due to mental health treatment provided by the facility—participating in their immigration court hearings. Of the seven attorneys who responded to Cal DOJ's attorney survey and represented Golden State detainees with a diagnosed mental health condition, four reported that their client was unable to meaningfully participate in preparing for court and during the hearing itself due to lack of treatment. One attorney reported that on the day of their client's asylum hearing, the facility did not provide the detainee with required psychiatric medication because it was "out of stock." As a result, the detainee suffered severe symptoms during his hearing, and was unable to testify. Another attorney reported that their client had not been provided the appropriate treatment and medication for their diagnosed mental health condition and that, as a result, the client was unable to meaningfully testify during immigration court proceedings.

Facility Focus: Mesa Verde ICE Processing Center

Background and Summary of Key Findings

The Mesa Verde ICE Processing Center (Mesa Verde), located in Bakersfield, CA, is owned and operated by GEO Group. ICE began detaining immigrants at Mesa Verde in 2015 through an Intergovernmental Services Agreement (IGSA) with the City of McFarland.[144] The facility's contract was converted from an IGSA to a direct contract with GEO Group in December 2019 after the City of McFarland chose to terminate the contract following changes in state law. Mesa Verde's maximum capacity is 400 detainees.[145] A new contract added annexes Central Valley and Golden State Modified Community Correctional Facility (Golden State) to Mesa Verde, such that the total bed capacity across Mesa Verde and its annexes is 1,800.[146] Although Mesa Verde and Golden State are on the same contract, they are not physically proximate like GEO Group's other two facilities – Adelanto and Desert View – which share staff. Instead, GEO Group treats these facilities as distinct and, thus, this report discusses them separately.[147] ICE's Performance-Based National Detention Standards 2011 and 2016 addendum (PBNDS) apply to this facility.

Mesa Verde can house both female and male adults, and during previous visits 10% of the detainees were female.[148] Given the court ordered injunction in *Zepeda Rivas v. Jennings*,[149] which significantly limited the number of detainees that can be held at Mesa Verde, during Cal DOJ's 2023 visit the facility only held 41 male detainees. ICE pays GEO Group for a guaranteed minimum of 320 beds at Mesa Verde,[150] such that GEO Group received a daily payment for 279 empty beds.

At the time of Cal DOJ's site visit, people detained at the facility represented 11 countries, including Mexico, El Salvador, Cambodia, Honduras, Nicaragua, Philippines, Thailand, Egypt, Vietnam, India, and Iran. Individuals from Mexico were the largest group (22 detainees) at the facility during our visit. Individuals held at Mesa Verde had been there for an average of 225 days, with the longest detention being 1,118 days.

144 DHS, Office of Inspector General, *Limited-Scope Unannounced Inspection of Mesa Verde ICE Processing Center in Bakersfield, CA* (Nov. 2, 2023) p. 1 <https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-03-Nov23.pdf> (as of Apr. 18, 2025). The City of McFarland is about 26 miles north of the City of Bakersfield, both located in Kern County.

145 ICE, Fiscal Year 2024 Detention Statistics <https://www.ice.gov/doclib/detention/FY24_detentionStats.xlsx> (as of Apr. 18, 2025).

146 While the new Mesa Verde contract expanded the total bed capacity, it did so by incorporating both Central Valley and Golden State as "annexes." Mesa Verde itself, through this contract, remained limited to a capacity and guaranteed minimum of 400 immigration detainees, while the two annexes would each house 700 detainees. (DHS, *ICE Budget Overview, Fiscal Year 2022 Congressional Justification, Operations and Support* (2022) p. 118 <https://www.dhs.gov/sites/default/files/publications/u.s._immigration_and_customs_enforcement.pdf> (as of Apr. 18, 2025).)

147 Central Valley is not currently being used to house ICE detainees, so that facility will not be discussed in this report despite it being an "annex" to Mesa Verde.

148 *Immigration Detention in California* (Feb. 2019), *supra*, p. 16.

149 *Zepeda Rivas v. Jennings* (N.D.Cal. June 9, 2020, No. 20-CV-02731-VC) ECF 357.

150 ICE, Fiscal Year 2024 Detention Statistics <https://www.ice.gov/doclib/detention/FY24_detentionStats.xlsx> (as of Apr. 18, 2025).

Table 8. Key Data Points, Mesa Verde.

Facility:	Mesa Verde ICE Processing Center
Operator:	GEO Group, Inc.
Housing Immigrants Since:	2015
Bed Capacity:	400
Type(s) of Detainees Facility Can Hold:	Female and Male Adults
Snapshot of Detainees Held at Mesa Verde on May 1, 2023	
No. of Countries of Origin:	11
No. of Detainees by Sex[151]:	Female: 0 Male: 41
Average Age:	42
Average Length of Detention:	255 days
Longest Detention:	1,118 days

Cal DOJ was scheduled to conduct a comprehensive review of Mesa Verde in early 2020, but due to the onset of the COVID-19 pandemic, Cal DOJ did not proceed with its review. Once it was safe to do so, Cal DOJ conducted a COVID-19 response focused visit in November 2021. Most recently, Cal DOJ conducted a two-day site visit of Mesa Verde in May 2023. During the May 2023 site visit and preparation period, Cal DOJ faced some obstacles in conducting its review of Mesa Verde, described where relevant throughout this section. Nonetheless, Cal DOJ made the following key findings:

- The quality of mental health care is impacted by the timing and quality of mental health evaluations and diagnoses, the quality of psychological testing, the absences of multidisciplinary treatment planning, the absence of cognitive testing, the inconsistent ordering of crucial laboratory and AIMS testing in connection with prescription of psychotropic medications, and the quality of responses to reasonable accommodations.

- There are deficiencies in medical record documentation, where the facility does not acquire and review offsite care and medical records in a timely manner to ensure adequate treatment; additionally, notes and information in medical charts appeared to be copied and pasted instead of containing updates after each appointment.

- Detainees experience prolonged wait times for some out-of-facility care for health care issues.

- GEO Group informed Cal DOJ there had been no use of force incidents between August 2021 and September 2023. However, Cal DOJ discovered a calculated use of force incident involving hunger strikers, which occurred without first consulting medical staff.

- Suicide prevention procedures and response practices are inconsistent and concerning.

- The facility failed to adequately assess the mental health of detainees before their placement in restricted housing.

151 Facility logs do not report transgender status.

Methodology and Limitations

Cal DOJ arrived at its findings after collecting data and observing conditions at a site visit, interviewing detainees and Mesa Verde staff, reviewing documents provided by the facility, and analyzing survey responses from attorneys and legal services providers who had worked with detainees held at Mesa Verde. In preparation for the site visit, Cal DOJ submitted a request to GEO Group for pertinent records and documents from the facility. Many were initially denied by GEO Group, but most of the requests were satisfied following negotiations that occurred before and during the site visit. Cal DOJ also held a pre-site visit meeting with the facility's outside counsel in April 2023.

Cal DOJ staff and experts visited Mesa Verde May 1-2, 2023. During the two-day site visit, Cal DOJ toured the facility, observed routine operations, reviewed medical charts, and interviewed executive staff, operational managers and department heads, medical and mental health care providers, detention staff and supervisors, and detainees. Both Cal DOJ's mental health expert and medical expert reviewed medical charts, records, and other files, and conducted detainee interviews. Cal DOJ's corrections expert reviewed detention files, grievances where available, other records, and also interviewed detainees.

During the site visit, GEO Group prevented Cal DOJ experts from reviewing health care files of individuals who were no longer detained at the facility. GEO Group ultimately allowed our experts to review those files during a virtual file review five months later.

Cal DOJ interviewed 22 detainees. Cal DOJ staff conducted 14 standard interviews and Cal DOJ's experts conducted eight interviews related to their areas of expertise. While Mesa Verde did not provide information on the languages spoken by the detainees, detainees reported that they spoke English, Punjabi, and Spanish. All interviews were conducted in the detainees' preferred language by fluent interviewers and/or with the assistance of a language line.

To support the mental health focus of this review, Cal DOJ selected detainees to be interviewed using two methods: (1) individuals chosen based on their presence in mental health logs provided by Mesa Verde (purposeful sampling approach); and (2) in order to ensure participation of a broad range of individuals, individuals were also selected based on their housing unit, country of origin, and/or language spoken. Five attorneys who had represented 14 clients at Mesa Verde between January 1, 2021, and March 3, 2023, also responded to Cal DOJ's attorney survey.

Access to Medical and Mental Health Care

Cal DOJ evaluated Mesa Verde's systems of providing health care for ease of access to medical and mental health care services, both at intake and during detention generally. Review also focused on continuity of care between facility providers, external providers of any health care the detainee received before or after detention, and providers of any offsite care that was required during detention. Cal DOJ also considered reports from detainees or other evidence of detainee understanding of the facility's system of accessing care.

Intake and Mental Health Screenings

Upon arrival at Mesa Verde detainees undergo an intake process that includes a mental health screening, a medical intake, and a brief suicide screening. A detainee may be referred for a comprehensive mental health evaluation or sent to the hospital from intake before they are accepted at the facility, or a psychiatrist may be called for acute needs. When a detainee's transfer summary or a nursing intake screening reveals a chronic condition such as diabetes, staff reported that the medical history and physical examination is completed within 48 hours, and within 24 hours for diabetic individuals on insulin.

While the intake process may occur at any time of day, timelines for mental health intake for new detainees varied. At least one detainee, who was identified as having mental health issues, did not get a mental health follow up appointment for 13 days. Another detainee who did not report any mental health issues at intake waited for a follow up visit 12 days later to report a history of depression and a suicide attempt. This gap may result in other undetected medical or mental health issues to go unnoticed and unaddressed while detainees wait to be evaluated.

Distribution of "bridge medicine"—the medication offered to a detainee who was taking medication prior to their arrival to cover the medication gap between their intake and when they can be fully assessed by a medical provider—appeared adequate.[152] The facility reported that during the intake process, a registered nurse (RN) calls the provider to bridge medications that have been verified with an outside pharmacy or facility. This information is also found on the detainee transfer sheet when applicable. One nurse noted that new detainees with medications from outside the country were not generally routed to Mesa Verde. According to facility staff, bridge medication prescriptions are filled by the on-call health care provider, the medical director, or the psychiatrist. Additionally, the medical director shared that while she had previously ordered bridging mental health medications, she had not done so in the last few years.

Access to Mental Health Care During Detention

To request mental health care, individuals must submit a request via a tablet or by a paper form. There were 10 tablets per 100-bed housing unit. Health staff reported that mental health sick call requests are picked up daily and triaged by nursing staff. Triaging may include face-to-face conversations with the requester. After triage, the psychologist performs mental health sick call visits usually within 24 hours of the request or when next on site. While the mechanism is the same, the response time to requests for mental health care was sometimes longer than that of medical care. For example, one detainee reported requesting mental health care, and had an appointment with a medical provider within one day but was not seen by a mental health provider for 15 days. However, at least one detainee's medical chart and a detainee interview confirmed that the detainee was seen the same or next day in the clinic after requesting care through the tablet.

When medical staff see any behavior necessitating a mental health referral, they may schedule a mental health appointment through a referral function available in Sapphire (the facility's electronic medical record software). This software allows practitioners to select a referral and choose the time frame for the detainee to be seen. One detention officer also reported that they had provided mental health referrals for a detainee they believed was displaying odd behavior.

Timelines for mental health evaluations after a referral to mental health varied and sometimes did not meet the PBNDS requirements. PBNDS requires a mental health evaluation no later than 72 hours after a referral. In medical charts Cal DOJ reviewed, timelines for mental health evaluations after the initial intake screenings sometimes occurred after much longer periods of time. For example, one detainee was not evaluated for 11 days despite a history of long-term hospitalization, and another waited 13 days to see mental health after a requested referral. Another detainee was evaluated almost two months after they were referred to mental health based on the intake screening that included history of mental health hospitalization and sexual abuse. By the time the detainee was seen, a nurse outside of the mental health unit had already initiated suicide watch, because the detainee had reported stress and paranoia. Interviews with detainees corroborated the existence of delays, as only two of the nine detainees who were asked about how long it took to receive an appointment after a mental health care request reported receiving such care in three or fewer days.

152 If an individual arrives with prescription medication it will be confiscated, and they can only take the medication provided to them by the facility through "pill pass" unless it is a form of medication they can keep on their person.

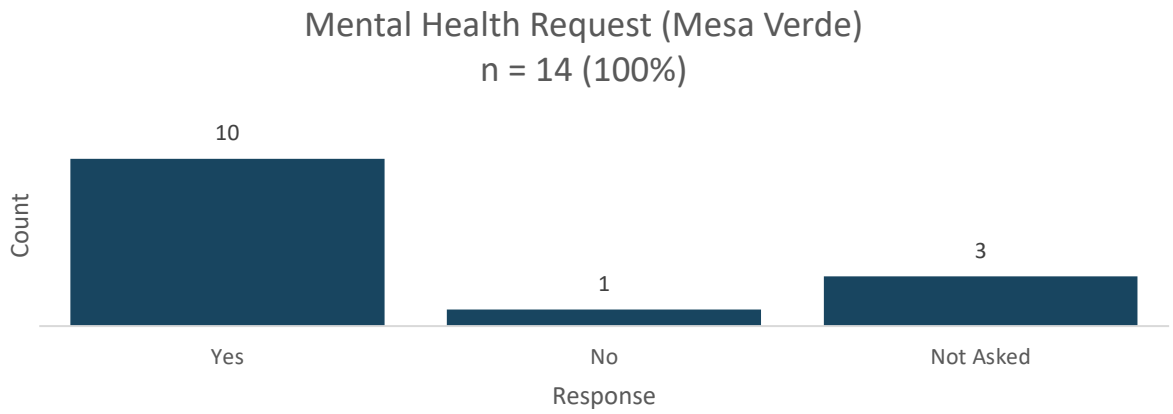
Access to Medical Care

Requests for medical care are also submitted via a tablet or a paper form and per facility report nursing staff review them daily. According to health care staff, response times are same day or the next day, but if there is an urgent need for medical attention, detainees may also alert staff who can call the medical unit. After a second sick call nurse visit for the same concern, facility policy is for nurses to escalate care of unresolved matters to a practitioner.

Detainee Knowledge of How to Access Medical and Mental Health Services

Ten out of 14 (71%) detainees who were interviewed by Cal DOJ staff reported that they knew how to request a mental health doctor or therapist at Mesa Verde (Figure 22). Nine detainees (64%) reported that they had requested an appointment with a mental health professional during their time at Mesa Verde. Two of these detainees reported that they did not receive the mental health services they requested.

Figure 22. Detainee reports of whether they knew how to submit a request to see a mental health professional, Mesa Verde



The PBNDS also provide procedures and protections for grievances.[153] Pursuant to the PBNDS 6.2, it is appropriate for a registered nurse or a Grievance Officer to be the first to review a grievance regarding mental health or medical care related issues.[154] However, PBNDS 6.2 also requires that when a medically related grievance is on appeal, a medical professional should be involved in its review.[155] At Mesa Verde, detainees may submit grievances through a tablet or a paper form. Detainees, including those with mental health conditions, may ask detention officers for assistance in filling out grievances. Additionally, a physician is involved in reviewing grievances to determine issues they can address with medical staff.

During file reviews Cal DOJ did not come across any grievances (medical or general) where the detainee complaints were affirmed. The Health Services Administrator reported the top category chosen by detainees was “medical bad service” and frequently “misconduct” by nurses. Medical practitioners at the facility characterized some grievances as repetitive and detainees as challenging.

153 ICE, PBNDS 2011, Part 6.2 Grievance System, Part I, p. 414.
154 ICE, PBNDS 2011, Part 6.2 Grievance System, Part V, § C, p. 418.
155 *Ibid.*

Continuity of Care

Cal DOJ reviewed and evaluated Mesa Verde's provision of health care from the time of intake through time of transfer, removal, or release – known as continuity of care.[156] Cal DOJ's review found that aspects within the continuity of care, like review of prior medical records and discharge procedures did not appear adequate.

All the files Cal DOJ reviewed involved persons at Mesa Verde who were transferred from Golden State. The transfer summaries provided by Golden State did not consistently meet information standards for continuity of care, which is unexpected given that Golden State and Mesa Verde are both operated by GEO Group. Golden State's transfer summaries, which provide key information about a detainee during intake, were often incomplete. In at least one case, no summary was present. Further, transfer of medical records between these two GEO Group facilities is not automatic and requires an extra administrative step to merge and transfer. This procedure slows down the intake process and affects continuity of care. For example, one detainee's health record was not available for six days after he transferred from Golden State to Mesa Verde.

Cal DOJ found that offsite medical care records were not reliably acquired for timely follow up. In at least three detainees' medical charts there was no indication that their offsite medical care records were timely requested or received by Mesa Verde. Another detainee's treatment records from a previous state hospital stay were not part of their medical record at all, nor did the records contain any request for them. For another detainee, records from an emergency room visit and head imaging were not found in their record. Based on psychological and psychiatric progress notes reviewed, Cal DOJ found that prior mental health records were also not regularly requested or acquired. For example, despite uncertainty regarding a detainee's mental health based on their intake and psychiatric evaluation, it appeared that the facility did not request the detainee's hospital records from inpatient mental health treatment within the year before arriving at the facility. These examples are concerning because valuable diagnostic, treatment, and treatment response information are obtained from past treatment records.

Discharge planning services also needed improvement. PBNDS section 4.3 requires that at discharge detainees receive a medical care summary with their health history, up to a 30 day supply of medicine, pending evaluations, tests, procedures, or treatments that have been scheduled, and if they have a communicable disease or other serious medical needs, a list of community resources including several free resource clinics, and clear instructions in easily understood language informing detainees how to obtain their complete medical record.[157] File review showed that some Mesa Verde detainees were provided with only a seven day supply of medication and a list of community medical, mental health, and social resources. Mesa Verde does not assist detainees, even those with severe mental illness, with a complete medical care summary as required under PBNDS section 4.3.[158] For example, one file showed that a detainee who likely had intellectual disabilities among other mental health conditions, was only provided with an inhaler and some over-the-counter medications upon release and not offered the provision of community resources.

156 ICE, PBNDS 2011, Part 4.3 Medical Care, Part II, pp. 257-258; Part V, § Z, p. 276.
157 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § Z, p. 276; § BB, pp. 278-279; Part 2.1 Admission and Release, Part V, § H, p. 57; § I, pp. 58-59.
158 ICE, PBNDS 2011, Part 2.1 Admission and Release, Part V, § I, pp. 58-59.

Mental Health Care

This section of the report details mental health care provided at Mesa Verde and discusses practices within the following topics: (a) medical staffing; (b) mental health assessments; (c) treatment planning; (d) psychiatric care; (e) therapy and other non-medication interventions; and (f) suicide prevention and response. Within each topic area, this section discusses the current facility practices, analyzes and evaluates those practices, and addresses what, if any, improvements are required to improve mental health services at Mesa Verde. Some of Mesa Verde's mental health care practices meet the PBNDS. However, improvements are necessary in several areas, including timely mental health evaluations, quality of those evaluations and diagnoses, psychological and cognitive testing, consistent application of AIMS and laboratory testing that should accompany prescription of psychiatric medications, multidisciplinary treatment planning, psychotherapy services, and suicide prevention measures.

Mental Health Staffing

During Cal DOJ's visit, the population at Mesa Verde was at 10% of its full capacity. Mental health services were staffed according to the staffing plan and appeared adequate for the low census. However, the operations observed may not reflect the quality of care that could be delivered to the expanded population that is currently reported at the facility.

In 2021, GEO Group transitioned to providing mental health services directly rather than through the Wellpath health care company. As of Cal DOJ's visit, Mesa Verde reported its mental health care team consisted of three full-time psychiatrists, and one full-time psychologist. According to health staff, cross coverage for overnight and weekend call is covered by the psychiatrists and psychologist on alternating shifts. Alternatively, staff may call GEO Group's corporate clinical leadership (e.g., Regional Mental Health Director). Based on review by Cal DOJ's expert, Mesa Verde's mental health staff were qualified for their roles.

Mesa Verde's mental health clinical space includes two mental health offices, used to treat detainees, that also appeared sufficient and confidential.

Cal DOJ's review found inconsistencies between the trainings leadership reports staff are receiving and the trainings clinical staff report receiving. The Health Services Administrator reported that trainings on trauma-informed care are provided to clinical staff once a year. The Health Service Administrator also reported that medical staff received annual training on de-escalation. However, the psychiatrist who participated in an interview with Cal DOJ denied ever receiving any training since starting the job with GEO. Staff also reported that GEO does not adequately fund continuing medical education and clinical decision support or prescription tools and fails to reimburse personnel for these expenses.

Mental Health Assessment

Prevalence of Mental Health Conditions

In April 2023 GEO Group provided a mental health log identifying detainees who had been diagnosed with one or more mental health conditions and who commenced treatment at the facility. Based on this log, 64 detainees received mental health services and a mental health diagnosis. The most common mental health diagnoses within this log were adjustment disorder (37%; 42 of 114 reported diagnoses), anxiety disorders (20%; 23 reports), unspecified depressive disorder (15%; 17 reports), and schizophrenia (15%; 17 reports). A separate log provided by Mesa Verde included 21 detainees who had been diagnosed with a mental health condition and were receiving mental health services as of

April 2023, a month prior to the Cal DOJ site visit.[159] The prevalence of mental health conditions within this log was similar to the previous log, with the three most frequent diagnoses being unspecified anxiety disorder (28%; 11 of 39 diagnoses reported), adjustment disorder (26%; 10 reports), and unspecified depressive disorder (21%; eight reports).[160]

Half (50%; seven out of 14) of the detainees who participated in standard interviews with Cal DOJ staff reported they had mental health concerns and a majority (71%; 10 out of 14) stated they had been seen by a mental health care professional at Mesa Verde.

Quality of Mental Health Evaluations and Diagnosis

Cal DOJ found inconsistencies in diagnoses and screening for other related issues. The psychologist performs initial mental health evaluations and follow-up visits, diagnoses patients, enters the initial diagnosis into Sapphire, the electronic records system, and lists treatments for issues observed. The psychologist may then refer the detainee to a psychiatrist, in which case the psychiatrist further evaluates the patient and then follows up every 30 to 60 days, or sooner. Cal DOJ's review revealed disagreements between the documented psychiatric diagnoses, written by the psychiatrist, and those of the psychologist. These disagreements resulted in confusion regarding the target diagnosis for purposes of both medication and psychological interventions. Additionally, Cal DOJ observed cases where the psychiatrist regularly included the diagnosis in the text of the progress note, but did not consistently update the diagnosis of record in Sapphire. Such updates are important so that other providers or facility personnel can quickly access the psychiatrist's diagnostic impression and focus of care without having to search in the notes.

Generally, Cal DOJ observed a lack of and inconsistency of screening for co-morbidities or related mental illnesses during initial and subsequent evaluations. For example, it is standard practice to evaluate a detainee for a history of mania when they report depressive symptoms in order to assess whether they have bipolar disorder or unipolar major depressive disorder (MDD). This process is necessary because despite some overlapping symptoms between the two disorders, both the treatment and the course of illness are very different. Failure to properly detect and treat depression with an antidepressant for MDD without first ruling out bipolar disorder may cause a manic episode. Manic episodes may lead to ongoing impairment and even resistance to future treatment. In its review, Cal DOJ encountered one such example in which a detainee did not receive this type of evaluation despite a recorded history of bipolar disorder. As a result, instead of properly addressing and treating the detainee's illness, the detainee was placed in long-term restrictive housing and suicide watch as a result of his symptoms for months before eventually being moved to a hospital for ongoing psychiatric care.

Psychological and Cognitive Testing and Associated Reasonable Accommodations

Cal DOJ's review found that Mesa Verde does not perform psychological or cognitive testing, which is important in some cases for early identification of cognitive limitations. Cognitive testing allows for detainees with cognitive issues to be placed in safe environments so that they are not taken advantage of, and so they are otherwise protected as a more vulnerable detainee. What is appropriate ranges from placing detainees in protective custody, to explaining documents to detainees before they sign, to providing other assistance to detainees who have shown signs of memory problems or dementia. Simple cognitive testing is feasible to administer in a detention setting. Under PBNDS section 4.3, facilities are required to identify and promptly notify the Field Office Director of detainees with Serious Mental Illness (SMI), including those with cognitive disabilities.[161]

159 Mesa Verde produced another mental health log including 'current' detainees with diagnosed mental health disorders. Most of the detainees listed in the April 2023 log were still present at the time of Cal DOJ's May 2023 site visit.
160 Note facility did not specify the date range covered by the logs provided.
161 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § X, pp. 274-275.

The failure to properly identify detainees with cognitive limitations resulted in significant consequences in at least one case involving a detainee who arrived at Mesa Verde from prison with unspecified intellectual disabilities, but no specific diagnosis. At prison, the detainee spent years in protective custody due to the detainee "not understanding the risk" in social situations. Despite this history, at Mesa Verde the detainee was not provided with appropriate cognitive testing, nor placed in protective custody. A chart review covering two years showed doctors acknowledging below average cognition and poor judgment on some occasions and finding no cognitive issues on others. The notes failed to fully address the detainee's vulnerabilities.

This same detainee was assaulted while detained at Mesa Verde. After the detainee reported bullying and manipulation, the psychologist discussed housing needs with facility staff. It was only after the assault that he was placed in protective housing for about two months prior to release or removal. Cal DOJ and its experts observed that Mesa Verde had not been able to provide safe housing accommodations to this detainee as required under PBNDS 4.8. PBNDS section 4.8 requires facility staff to provide appropriate assistance to a detainee with cognitive disabilities, and that detainees with cognitive disabilities be referred to a multidisciplinary treatment to further assess their individual needs for a reasonable accommodation.[162]

Treatment Planning

Cal DOJ experts reviewed treatment planning practices and observed that treatment plans were inconsistent, and staff reported that there is no multidisciplinary treatment planning. A review of treatment plans revealed great variation in quality, with some plans containing a clear statement of treatment interventions for each diagnosis and the associated treatment goals, and others simply referencing medication or therapy without much specificity.

Staff reported that there is no multidisciplinary treatment planning between psychiatrists and other medical staff at Mesa Verde. The lack of multidisciplinary treatment planning is problematic because it is an especially important aspect of care for those experiencing serious mental illnesses. The PBNDS require the use of multidisciplinary teams to conduct treatment planning in several areas including: response to sexual abuse,[163] internal reviews and quality assurance for medical and mental health care,[164] suicide prevention,[165] and assessment of disability cases and reasonable accommodation requests.[166] Mesa Verde health care staff explained that multidisciplinary treatment planning occurred before COVID-19, but did not explain why it was no longer occurring or when exactly it stopped. Appropriate multidisciplinary treatment planning requires that various providers, including case management, nursing, and medical and mental health personal, work together with non-clinical personnel and with the detainee to discuss and agree upon a treatment plan. Having a multidisciplinary treatment plan supports coordinated and supported care decisions and prevents issues such as conflicting or redundant treatments or care directions.

The lack of multidisciplinary treatment planning may have major consequences. For example, in the case of the detainee who was victimized, a multidisciplinary team could have better addressed a comprehensive safety plan as set forth in PBNDS accommodation practice standards.[167]

162 ICE, PBNDS 2011, Part 4.8 Disability Identification, Assessment, and Accommodation, Part V, § F, p. 349.
163 ICE, PBNDS 2011, Part 2.11 Sexual Abuse and Assault Prevention and Intervention, Part V, § J, p. 136; Part VIII, § B, p. 156.
164 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § EE, p. 280.
165 ICE, PBNDS 2011, Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, p. 332.
166 ICE, PBNDS 2011, Part 4.8 Disability Identification, Assessment, and Accommodation, Part II, p. 345; Part V, § F, pp. 349-351.
167 ICE, PBNDS 2011, Part 4.8 Disability Identification, Assessment, and Accommodation, Part V, p. 347.

Psychiatric Care

Cal DOJ reviewed the facility's provision of psychiatric care and related prescription protocols for individuals with mental health conditions. While stock medication management, and psychotropic prescribing based on symptomology and its oversight, were overall appropriate, some improvement is needed, particularly in consistency of documentation, mouth checks during pill pass, and other practices.

Medication Distribution

Stock medication at the facility included an assortment of mental health medications. However, Cal DOJ reviewed at least one example of a detainee prescribed stock medication, whose dose nevertheless lapsed for two days after transferring from Golden State to Mesa Verde.

Medical staff reported that prescription requests made during intake for medications not included on the facility's approved list of drugs (non-formulary) could be continued while the non-formulary request was pending, if needed. Once submitted, non-formulary prescriptions are handled by the pharmaceutical company Correct RX. Mesa Verde also reported that they may order emergency psychotropic medications for detainees as needed, but the Health Services Administrator reported that no emergency medication had been ordered since 2020. Mesa Verde medical staff reports having a local facility to pick up prescriptions that they do not have in stock onsite.

Cal DOJ observed the medication distribution process, otherwise known as "pill call" or "pill pass." During pill pass a licensed vocational nurse enters the housing unit and administers medication to each detainee as prescribed, tracking medication electronically by scanning identification cards of detainees. As the nurse administers medication, they conduct mouth checks to ensure that detainees swallowed the medication. During Mesa Verde's pill pass, Cal DOJ observed inconsistent mouth checks. This inconsistency is concerning because it may lead to hoarding of medications, which can then be used as contraband or to attempt suicide by overdose. Given that some psychotropic medications (e.g., some antidepressants, mood stabilizers, etc.) may be fatal during an overdose, consistent mouth checks are a necessary preventative measure.

Psychotropic Prescribing and Medication Management

In overseeing management of psychotropic prescriptions, the psychiatrist that Cal DOJ interviewed reported that he routinely obtained informed consent and conducted monitoring for clinical side effects. But at least one file reviewed had no consent form. GEO Group policy, like the PBNDS, provides that detainees who are taking psychotropic medication receive monthly visits with a psychiatrist or by a medical practitioner. Additionally, GEO Group policy and the PBNDS both require a follow-up appointment with the prescriber to determine the cause when a detainee misses three doses of their medication. Chart review indicated that the psychiatrists at Mesa Verde were seeing patients receiving psychotropic medications on a monthly basis and after three doses were refused, thereby complying with these policies. Lastly, psychotropic prescribing practices based on symptomology appeared overall appropriate.

Laboratory and AIMS Testing

Cal DOJ reviewed laboratory testing procedures and found that typically Mesa Verde medical and mental health staff ordered and monitored results. Practitioners need to check a patient's baseline laboratory results before treating them to rule out possible medical causes for symptoms, or to detect other conditions that may be worsened by a proposed medication or be hard to detect once the medication has initiated physiological changes. Cal DOJ's file review showed that antipsychotic medication prescriptions were generally accompanied by baseline AIMS (movement side effect

monitoring scale) assessment and the physician would sometimes review labs results to inform a medication plan for a specific patient. The medical director also reported that the psychiatrists ordered blood tests to monitor psychotropics but the on-site practitioners reviewed results for safety actions needed.

Documentation

Cal DOJ's review of detainee medical charts showed significant documentation issues. All the medical records reviewed by Cal DOJ at Mesa Verde were missing at least some elements of complete health records including initial health screenings and assessments as required under the PBNDS.[168]

As noted above under *Psychotropic Prescribing and Medication Management*, documentation of consent or refusal of psychiatric medications appeared adequate. Initiation of psychiatric medications was typically accompanied by medication consent forms in medical charts. When detainees refused medication, refusals were signed by the registered nurse, and sometimes by the detainee or by the detention officer when the detainee refused to sign.

Staff annotations in detainee files were concerningly limited and in some instances staff used identical language across therapy progress notes and visits, which suggests that staff cut and pasted the language instead of reflecting changes and developments in each treatment visit. This pattern of cut and pasted notes also appeared in detainee records regarding PREA incidents, physical assault, mental health diagnoses, and reasonable accommodations and appropriate placement in housing. This practice raises concerns about the quality of care and limits the ability of providers to monitor the efficacy of treatment over time or to coordinate care offered by multiple providers.

Therapy and Other Non-Medication Interventions

Availability and Quality of Psychotherapy Services

Cal DOJ's review found concerns with the quality of Mesa Verde's psychotherapy services. While Mesa Verde's psychologist provides individual therapy, it is only on an as needed basis, which is not adequate for treating all mental health conditions. Psychotherapy sessions are usually about 30 to 45 minutes long, but are sometimes only about 15 minutes, a range which may not be appropriate for some patients or conditions including those present in Mesa Verde's mental health logs. At the time of Cal DOJ's visit, there was no group therapy.

Cognitive Behavioral Therapy, supportive therapy, and education on coping skills (e.g., meditation, deep breathing, exercise, etc.) were the most common interventions. Cognitive Behavioral Therapy is most effective when provided in a structured format over several sessions, which is not typically offered at Mesa Verde.

Rapport and Cultural Competence

Standard detainee interviews conducted by Cal DOJ indicated lack of rapport between patients and providers. The lack of rapport is concerning because it may reduce of treatment success, as rapport is a strong predictor of positive psychotherapy outcomes.[169] The majority of detainees who reported on their interactions with facility mental health staff (61%; five out of seven detainees) described the interactions negatively. Among these detainees, most detainees who reported specifically on the quality of their interactions with mental health staff described the interactions as inadequate

168 ICE, PBNDS 2011, Section 7.1 Detention Files, Part V, § A, pp. 441-442.
169 Flückiger et al., *The Alliance in Adult Psychotherapy: A Meta-Analytic Synthesis* (2018) 55 Psychotherapy 316 <https://psycnet.apa.org/fulltext/2018-23951-001.html> (as of Apr. 22, 2025).

(80%; four of five detainees). Additionally, the majority of detainees who reported in interviews that they received mental health treatment indicated that they found their treatment at the facility to be unhelpful. Mesa Verde's grievance log also suggested a lack of therapeutic rapport between detainees and nursing staff.

The Health Services Administrator reported that staff and nurses receive periodic training, including a yearly five-day in-service session that has presentation on cultural diversity. A few other detention and health care staff reported that they received cultural sensitivity trainings. The one detainee who was asked indicated that they did not feel their mental health provider tried to understand their culture.

Availability of Other Non-Medication Interventions

The facility has recreation yards and offers some programming. Most detainees interviewed by Cal DOJ staff reported they had access to programming (13 of 14, 93%) and the recreation area (11 of 14, 79%). The facility reported that detainees in the restrictive housing unit (RHU) receive two hours of out-of-cell time a day but have more limited access to recreation and other services due to location. Those on suicide watch have their own recreation yard separate from the main yard. Section 4.6 of the PBNDS requires that detainees who are suicidal must have access to all programs and services.[170] Two hours is a minimum and insufficient for detainees experiencing serious mental illness or high suicide risk. The need for extended time for recreation should, among other accommodations, be an area of focus when a mental health review occurs before placement in segregation.

Figure 23: Outdoor yard with basketball hoop

Given the small size of cells at this facility, detainees in restrictive housing should also be provided access to the library and other programing to provide detainees the same level of access they have in non-restrictive housing. This recommendation is especially important for detainees with serious mental illness to prevent decompensation.

170 ICE, PBNDS 2011, Part 4.6 Significant Self-harm and Suicide Prevention and Intervention, Part V, § F, p. 335.

Suicide Prevention and Response

Cal DOJ conducted a comprehensive review of suicide prevention and response practices at Mesa Verde. This review was of particular importance as a detainee died by suicide at the facility on May 17, 2020. Mesa Verde's suicide prevention and response practices are inconsistent, and several aspects fail to meet the PBNDS, including: suicide risk assessment, supervision and discontinuing of suicide watch, and reviews of suicides and other fatalities.

Suicide Risk Assessments, Intervention, and Prevention

In assessing the facility's suicide prevention and intervention protocols, Cal DOJ found some concerning issues which failed to meet PBNDS.[171] PBNDS section 4.6 requires that facilities identify detainees at risk of self-harm or suicide not only through an initial mental health screening within 12 hours of intake but also at any time – requiring that staff remain "vigilant" for signs of risk.[172] In reviewing Suicide Risk Assessment forms, Cal DOJ found that while the forms were comprehensive, they were inconsistently completed from evaluation to evaluation. The facility staff shared that medical staff lead staff suicide prevention training and drills, which reportedly occur monthly. This training schedule compared positively to other facilities, which reported less frequent trainings.

Suicide Watch

Between January 2021 and January 2023, five detainees were placed on suicide watch at Mesa Verde.[173] Those five detainees spent an average of 14 days on suicide watch, with one detainee's length of stay lasting 50 days. In Cal DOJ's attorney survey, three attorneys representing detainees at this facility between January 2021 to March 2023 reported that each of their three clients with diagnosed mental health conditions had been placed on suicide watch.

Cal DOJ found that at Mesa Verde, individuals on suicide watch were not consistently monitored by clinical staff or mental health staff as required by PBNDS.[174] Mesa Verde's single safety cell is in its Restrictive Housing Unit (RHU). The RHU is comprised of three cells total. Per PBNDS section 4.6, when a detainee on suicide watch, they are placed in isolated confinement and required to receive continuous one-to-one monitoring, with welfare checks at least every eight hours by clinical staff and daily mental health treatment by a qualified clinician. Cal DOJ observed that these timeframes and standards did not appear to be met.

At Mesa Verde, a detention officer is supposed to remain in front of the cell providing constant observation while another detention officer sits at a desk outside the RHU area keeping the logbook. One of Mesa Verde's psychiatrists informed Cal DOJ that the psychiatrists do not normally see detainees on suicide watch and, when they do, they commonly only address the medical aspects of their mental health care. These check-ins with detainees most commonly occur at the cell door but can also occur in an office setting. It appears then that the work of monitoring the health of detainees on suicide watch falls mainly on the psychologist. However, based on Cal DOJ's assessment and chart review, the psychologist does not normally see detainees on suicide watch daily, as required. For example, one chart review found that a detainee who was placed on suicide watch, was not seen again for 48 hours, and after that was seen approximately every other day. At one point, this detainee was sent out to a hospital, sent back, and then not seen until about 10 days after their return to Mesa Verde. This same detainee spent about 20 days on suicide watch and/or medical observation which is a significant amount of time during which he should have been regularly seen by a psychologist. Another detainee

171 ICE, PBNDS 2011, Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Parts I-II, pp. 331-332; Part V, § A, p. 332.
172 ICE, PBNDS 2011, Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, § B, p. 332.
173 Mesa Verde provided two suicide watch logs, that contained 5 entries, for 5 detainees, between January 2021 to January 2023.
174 ICE, PBNDS 2011, Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, §§ D-E, p. 334.

on suicide watch was only checked in on by a nurse twice a day over a lengthy stay of over a dozen days on suicide watch.

Attorneys who responded to the attorney survey reported having concerns regarding their client's care while placed on suicide watch. One attorney reported that their client's condition deteriorated significantly while on suicide watch, while another reported their client had not received timely responses to requests for care while on suicide watch. Another attorney reported their client did not receive appropriate treatment while on suicide watch, including not receiving immediate medical assistance after the client injured himself. An attorney also reported that in-person and video visitation were not permitted while their client was on suicide watch, leaving phone communication as the sole means of contact with the client.[175]

Cal DOJ found Mesa Verde's process for discontinuing suicide watch concerning. The process consists of a weekly suicide watch meeting that is attended by the psychologist, psychiatrist, Health Services Administrator, and correctional leadership. During the meeting, the team reviews the cases of any detainees on suicide watch and takes a vote regarding removal or continuation on suicide watch. PBNDS require an "appropriately trained and qualified medical staff member" evaluate and treat patients on suicide watch and make decisions to remove patients from suicide watch, often limiting removal decisions to doctoral level clinicians only.[176] While an interdisciplinary group may have value for discussing the holistic state of a detainee, they should not have authority to vote on a treatment decision that would otherwise be traditionally made by a clinician. Further, in the charts and records reviewed Cal DOJ did not observe evidence of safety plans being created in connection with removal from suicide watch.

Medical Care

Cal DOJ also reviewed Mesa Verde's medical staffing and quality of medical care, beyond the provision of mental health care detailed above. As discussed above under *Documentation*, Cal DOJ found some deficiencies with maintenance of medical records and, as discussed below, detainees face prolonged wait times for critical offsite care.

Medical Staffing

PBNDS requires sufficient medical staff to meet care standards.[177] The DHS Office of Immigration Detention Ombudsman (OIDO) reported that Mesa Verde required 24.13 full-time equivalent (FTE) positions. At the time of our review, Mesa Verde reported 22 FTE medical staff with three "as needed" employees to cover for vacancies, including mental health staff. Medical care is overseen by a medical director and Health Services Administrator. At the time of Cal DOJ's visit, the facility reported having six full-time registered nurses (RNs), seven full-time and two on-call licensed vocational nurses (LVNs), one LVN not working at full capacity (see below), two full-time Advanced Practitioners (APs) providing medical care such as a nurse practitioner, and one Health Services Administrator. Additionally, there is a one-chair dental clinic staffed by a dentist and an assistant on Tuesdays and Thursdays.

During our visit, the Director of Nursing role was vacant and covered by the Health Services Administrator. Since 2016, one physician had been covering duties as a physician and the Medical Director at both Mesa Verde and Golden State. At the time of Cal DOJ's visit, that physician was primarily assigned to Mesa Verde, aside from assisting with onboarding a physician recently hired at Golden State.

Staff interviewed by Cal DOJ reported receiving some yearly trainings related to mental health.

175 See ICE, PBNDS 2011, Part 4.6 Significant Self-harm and Suicide Prevention and Intervention, Part V, § F, pp. 334-335.
176 ICE, PBNDS 2011, Part 4.6 Significant Self-Harm and Suicide Prevention and Intervention, Part V, § F, p. 336.
177 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § B, p. 261.

Trainings for medical staff include compassion fatigue and trauma informed care, and suicide prevention and response. However, reports from staff suggested that some of these trainings last only about 15 to 20 minutes. Detention officers also reported receiving quarterly trainings on suicidal ideation and self-harm. Thus, while some trainings were occurring, Cal DOJ found trainings were insufficient and could be improved by increasing depth and scope.

Quality of Medical Care

Mesa Verde reported offering primary care for chronic conditions and preventative health. The facility was not observed having an infirmary for hospital-level care. There were two negative pressure medical beds that could be used for medical or mental health observation or for managing minor conditions such as diarrhea and dehydration. Mesa Verde is equipped to provide care for chronic conditions and preventative health care. At least one chart reviewed by Cal DOJ in 2023 showed that medical visits for chronic care occurred at appropriate intervals, following corrective action taken after a 2022 OIDO inspection identified that follow up was not occurring every 90 days as required.[178]

Mesa Verde does not have an infirmary for hospital-level care. If a detainee needs specialty care, physical therapy, or some other higher level of medical care such as an emergency room evaluation, they are referred outside of the facility. Although Mesa Verde can accommodate mobility impairment and mild cognitive disorders, it does not normally house detainees with dementia. As discussed in the *Mental Health Assessment* section, cognitive testing is lacking, which has caused at least one detainee to not receive accommodations that may have been necessary.

There are some gaps in the formulary for available on-site medications, including common blood thinners and first-line diabetes medications. However, the Health Services Administrator reported that they had previously received authorization to order these medications in the past.

Mesa Verde does not have a program for maintaining detainees on medications for opioid dependence. However, a physician at Mesa Verde has been certified since 2017 to prescribe buprenorphine, which assists individuals diagnosed with opioid dependence. Mesa Verde's Medical Director was certified to prescribe medications for individuals with mild symptoms of opioid withdrawal but there was no program for maintaining medications for opioid dependance and more serious detox symptoms require transfers to an outside hospital.

The files Cal DOJ reviewed showed prolonged wait times for offsite treatment, including for potential serious medical issues. In one notable example, Cal DOJ found delay of treatment for one detainee with a mass located in the groin area, which prevented a timely and appropriate cancer screening. After the detainee first reported finding a lump, facility medical staff informed the detainee that it was a hernia and did not refer the individual to receive a corroborating ultrasound until about three months later when the detainee reported that the lump had grown. At that point, the lump was found to be a lymph node and a surgical appointment to consider whether a biopsy was needed was set for four months later. That appointment was later cancelled, resulting in the detainee filing a medical grievance. In addition to the delays accessing cancer screening, it is not clear from Cal DOJ's review whether providers had conducted other on site diagnostic testing to rule out other possible diagnoses such as sexually transmitted infections.

Prolonged wait times were also apparent in another grievance that a detainee filed after no care was provided to them for four months following a nasal fracture. Cal DOJ's review showed that the Health Services Administrator documented, following an emergency room visit, that an urgent request for "maxillo-facial/orthopedic surgery" care was submitted to ICE. The detainee was then seen two

178 Office of the Immigration Detention Ombudsman, *OIDO Inspection, Mesa Verde ICE Processing Center* (June 16, 2023) pp. 8-9 <https://www.dhs.gov/sites/default/files/2023-06/OIDO%20Final%20Inspection%20Report%20-%20Mesa%20Verde%20ICE%20Processing%20Center.pdf> (as of Apr. 16, 2025)

more times by Mesa Verde staff and, during the second visit, the detainee was told the treatment authorization request "will be submitted to ICE." A month later, and four months after the injury, the detainee filed a grievance after Mesa Verde failed to provide care.

The DHS Office of Inspector General (OIG) found similar issues regarding access to outside care at Mesa Verde. OIG flagged this issue in October 2023, finding that the wait time for detainees to see an optometrist had increased to over four months due to a shortage of providers in the community.[179] ICE responded that, since December 2018, Mesa Verde has contracted with a community provider to treat detainees and that it would continue to monitor and document care. ICE further stated that should the delay continue, staff would work with the field medical coordinator to resolve delivery issues.[180] In its November 2023 report, OIG stated that it would only close the matter "when ICE provides documentation that Mesa Verde has implemented a plan and reduced optometry care wait times successfully."[181]

Barriers to Health Care

Cal DOJ reviewed potential barriers to medical and mental health care with respect to 1) language access; 2) confidentiality and privacy; and 3) facility culture on medical and mental health services. While Mesa Verde's practices were generally appropriate, grievance records demonstrate a contentious culture and poor therapeutic rapport between detainees and nursing staff, consistent with the lack of rapport with mental health providers discussed in the *Rapport and Cultural Competence* section above.

Language Access

Cal DOJ did not identify language access as an area of concern for Mesa Verde. Mental health staff reported using language line services or live interpreter services during visits with detainees who speak a language other than English. Cal DOJ's chart review reflects that this practice occurs, though the seemingly cut-and-pasted language in charts casts doubt on the extent to which charts accurately reflect the provided care. Of the interviewed detainees, 38% (eight of 38) shared that they were able to access translation services, with only one detainee reporting they could not access translation services. Seven participants (33%) were not asked the questions and five participants (24%) did not have a response or it was marked as not applicable. However, two detainees filed grievances reflecting that during a hunger strike some detainees were brusquely or insensitively woken up to answer questions for wellness checks without an interpreter, so they did not understand. Detainees on suicide watch do not have access to phones for the use of language line and must be removed from the suicide watch cell to access one.

Confidentiality and Privacy Concerns

Based on Cal DOJ's review, most detainee visits with a psychologist or psychiatrist are confidential, including for detainees with mental health conditions. However, as explained above, evaluation of detainees on suicide watch most often occurs at the cell door, which raises privacy concerns.

179 DHS, Office of Inspector General, *Limited-Scope Unannounced Inspection of Mesa Verde ICE Processing Center in Bakersfield, CA* (Nov. 2, 2023) p. 5 <https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-03-Nov23.pdf> (as of Apr. 16, 2025).
180 *Id*. pp. 6-7 <https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-03-Nov23.pdf> (as of Apr. 16, 2025).
181 *Ibid*.

Facility Culture on Medical and Mental Health Services

Grievance records suggested a contentious culture and poor therapeutic rapport with at least some of the nursing staff, including allegations of unprofessional conduct that did not appear to be fully investigated. Several detainees filed grievances regarding rude, disrespectful, and unprofessional conduct by nursing staff. How detained persons feel about nursing staff is critical given that nurses are the first line of care. Poor rapport between detainees and nurses may result in detainees not seeking necessary care. Friction between patients and medical personnel regarding the personnel's manner and approach was clear from Cal DOJ's review and only worsened during a hunger strike.

Medical and Mental Health Quality Assurance Process

Cal DOJ's medical and mental health experts assessed Mesa Verde's quality assurance processes. The PBNDS require a facility's Health Services Administrator to implement, at minimum: a quarterly meeting at which the facility accounts for the effectiveness of its health care program; a system of internal review and quality assurance; and an annual intra-organizational external peer review program for all independently licensed medical professionals.[182]

Mesa Verde medical staff reported holding monthly Continuous Quality Improvement (CQI) meetings that include the Health Services Administrator, Facility Administrator, medical staff and dentist, and other health services staff, as needed. However, psychologists and psychiatrists are not directly involved in mental health quality assurance. Inclusion of mental health staff may aid in identifying areas for improvement for mental health care services. As described by staff, the quality review process at Mesa Verde does not focus on cases discovered via grievance nor on working to improve diagnostic error or delay.

The Health Services Administrator was unable to share any current, active corrective action plans based on internal audits focusing on medical health care and could not identify a high priority target for improvement. A DHS Office of the Immigration Detention Ombudsman (OIDO) 2022 inspection resulted in a corrective action memorandum. In 2023, the OIDO acknowledged corrective action taken by Mesa Verde in the areas of medical follow-up for three detainees, confidentiality of health information, and welfare checks for those on suicide watch.[183] However, Cal DOJ observed ongoing concerns that same year regarding suicide watch welfare checks, as discussed above under *Suicide Prevention and Response*.

Conditions of Confinement

Conditions of confinement consist of various factors, policies, and protocols that affect the experiences of detainees held at Mesa Verde, including their mental health. The conditions reviewed below include 1) classification and housing assignments, 2) discipline, 3) restrictive housing: disciplinary and administrative segregation and protective custody, 4) use of force, 5) PREA, 6) staff and detainee relations, and 7) other aspects of confinement.

Mesa Verde has four dorms, known as A through D, each with 100 beds. During Cal DOJ's visit, detainees were held in two of the dorms, and facility practice was to house all detainees in the voluntary work program together in one dorm. Housing assignments in these dorms were based in part by security classification.

182 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § EE, pp. 279-280.

183 Office of the Immigration Detention Ombudsman, *OIDO Inspection Mesa Verde ICE Processing Center* (June 16, 2023) <https://www.dhs.gov/sites/default/files/2023-06/OIDO%20Final%20Inspection%20Report%20-%20Mesa%20Verde%20ICE%20Processing%20Center.pdf> (as of Apr. 17, 2025). Note Cal DOJ continued to have concerns about suicide watch protocols around the same time that the OIDO acknowledged corrective actions; because both reviews were based on at least some overlapping time periods it is not possible to evaluate whether the specific corrective actions noted by the OIDO should have demonstrated impact for Cal DOJ's review.

Classification and Housing

Mesa Verde's security classifications do not appear to be objective or supported by verifiable information, and regular reviews of the classification do not appear to occur consistently. PBNDS require a formal classification process for managing and separating detainees based on verifiable and documented data, and require classification reviews at certain time intervals.[184] At intake, detainees should be assigned a security classification level ("Low", "Medium-Low," "Medium-High", and "High") pursuant to PBNDS section 2.2, and be screened for any special vulnerabilities or management concerns that impact housing assignments and conditions of confinement.[185] Higher security classifications often limit opportunities for engagement with others, movement around the facility, and participation in various recreation and programming.

Cal DOJ was not provided any records or policies for any classification training at Mesa Verde, and detention staff did not report any specific training to conduct the security classification assessments, which may make classification determinations more subjective.

At the time of Cal DOJ's visit in early May 2023, 76% (31 out of 41) of detainees were classified as "High Custody," and 24% (10 out of 41) were classified as "Medium High Custody."

Based on the detainee files reviewed at Mesa Verde, Cal DOJ had concerns about the objectivity of security classifications, and whether they were based on verifiable information. Due to limited documentation found in detention files and records, the rationale as to why classification scores rose or fell, or the true frequency of classification reviews could not be determined. Issues with misclassification may lead to problems accessing care, subject detainees to overly restrictive conditions, and have ill effects on detainees' medical and mental health. For example, a detainee placed in more restrictive housing than needed may have reduced opportunity for recreation and socialization that would otherwise provide non-medication support for symptoms of depression.

Other examples from detainee files and records reviewed by Cal DOJ indicated that individuals diagnosed with mental health conditions may not be served well by the security classification system as implemented. Staff appear to have trouble identifying and distinguishing between detainees with special vulnerabilities; only a few detainees were identified, most often by the label of mental illness, and in these cases, medical charts did not reflect related accommodations or referrals to mental health.

Discipline

PBNDS establishes that immigration facilities must implement a fair and equitable disciplinary system to ensure compliance with facility rules and regulation.[186] Disciplinary measures may range from loss of privileges such as commissary, to placement in restrictive housing (isolated housing units) after appropriate review of the detainee's violation and determination by staff.

Further, a disciplinary review process should typically assess whether mental illness played a role in any detainee-involved incident. When reviewers find that mental illness impacted the incident, the process should result in a recommendation that reduces the detrimental impacts of any disciplinary decision. This process reduces the likelihood of punishing detainees with mental health disabilities for the symptoms of their mental health conditions.

Mesa Verde provided Cal DOJ with a segregation log including detainees who faced disciplinary action at the facility between January 2021 and March 2023. The log included information on 19 disciplinary placements involving 13 detainees. Of these placements, 89% (17 out of 19) involved detainees who

184 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part I, p. 60.
185 *Id.* Part I-II, pp. 60-61.
186 ICE, 2011 PBNDS, Part 3.1 Disciplinary System, Part I, p. 214.

also appeared in the facility's mental health logs. Information regarding the reasons for placement was limited, but for cases involving a specific reason, the most common entry was related to detainee fighting. Overall, 79% (15 out of 19) of disciplinary cases resulted in a sanction, while 24% (four out of 19), were dismissed. These figures were similar when only considering detainees who were also listed in mental health logs (76%, or 13 out of 17, received a sanction), likely because of the large percentage of placements involving detainees present in the logs. On average, sanctioned detainees spent 15 days in disciplinary placement, and sanctioned detainees who were also listed in mental health logs spent an average of 17 days in disciplinary placement.

In addition to reviewing facility records, Cal DOJ also spoke to detainees present during the site visit regarding their experience with discipline at the facility. Four detainees who participated in standard interviews reported that they had been disciplined while at Mesa Verde, with three (75%) reporting they were disciplined for allegations related to refusing food. One detainee specified that they were placed in segregation and had their visitation privileges taken away for participating in a hunger strike. Another detainee explained that they were disciplined for refusing food, breaking rules related to head count by leaving to use the restroom, and for being part of a group protest related to food quality. The third detainee who reported being disciplined for refusing food did not elaborate.

Restrictive Housing: Disciplinary and Administrative Segregation and Protective Custody

Cal DOJ had concerns as to Mesa Verde's compliance with PBNDS regarding restrictive housing, including specific concerns with pre-disciplinary review process for individuals with mental health issues, as well as access to care while in restrictive housing. Analysis of segregation log data also indicated that detainees who were listed on mental health logs experienced longer stays in segregation.

Mesa Verde provided Cal DOJ with a separate segregation log including detainees who were placed in administrative segregation between January 2021 and March 2023. The log included information on 40 administrative placements involving 25 detainees. Of these placements, 73% (29 out of 40) involved detainees who also appeared in the facility's mental health logs. During this time, the most common reason for placement for detainees appearing in a mental health log was protective custody (31%; nine out of 29), followed closely by facility need or pending bed space (24%). On average, detainees who appeared in mental health logs spent 42 days in administrative custody. In 2023, at least one detainee spent about four days in protective custody with the reason for placement being "hunger strike."

Cal DOJ's analysis of length of stay data for restrictive housing at Mesa Verde showed that detainees who were present on the facility's mental health logs had longer lengths of stay than detainees who were not present on such logs. The longest stay for the group not listed in mental health logs was 14 days. In contrast, the group of detainees who were included in mental health logs experienced several lengthy stays ranging from two months to over a year (one stay of 424 days, two stays of 161 days, one of 150 days, and one of 56 days). It is not clear whether these detainees had underlying mental health conditions when placed or if the conditions resulted from the lengthy stays, as these lengths of stay would put any detainee at risk of significant mental health harm. Either case is of great concern.

The Restrictive Housing Unit (RHU) at Mesa Verde is comprised of three cells. Detainees may be placed in RHU for different reasons including discipline (breaking rules), administrative segregation (those who may pose a threat to others), or protective custody (to protect vulnerable detainees). PBNDS 2.12 requires that before an individual is placed in RHU or subject to discipline, the detainee should be medically assessed to determine whether the placement is appropriate, and the practitioner should provide recommendations for care once they are placed.[187]

187 ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, § A, pp. 175-177.

A detention officer who spoke with Cal DOJ described staffing and training practices related to the RHU. According to the officer, there are two officers present on shift in the RHU, one of whom is dedicated to suicide watch. Both officers receive specialized, quarterly trainings to serve in these positions. The officer also explained that safety checks in RHU, in which non-medical staff check on the detainee's well-being, are performed every 30 minutes.

Some files reviewed by Cal DOJ showed that the "pre-segregation/pre-RHU" mental health evaluation conducted by Mesa Verde mental health staff sometimes occurred after the individual had already been placed in restrictive housing. The current practice at Mesa Verde does not allow for approval or denial of the placement before it occurs, nor for recommendations for care once detainees are placed. Regarding the timing of the evaluations, nurses completed pre-segregation history and physical evaluations only after the detainees were already placed in RHU in at least two charts reviewed by Cal DOJ's medical expert.

Further, the evaluations reviewed by Cal DOJ were lacking in thoroughness and accuracy. However, Cal DOJ's review of records found that the placement review process became less involved over time. Prior to 2023, the psychologist's process consisted of reviewing a detainee's chart, entering a write-up of a brief note in the chart, and sending an email to custody leadership stating their opinion on (a) the potential role of mental illness in the disciplinary incident, and (b) the appropriateness of RHU placement given any mental health conditions. As of 2023, the psychologist clearing detainees only reviewed the appropriateness of the placement and only communicated this conclusion via email, without including approval or denial of the placement or recommendations once a detainee was placed. Additionally, in some cases Cal DOJ reviewed, mental health staff cleared detainees diagnosed with serious mental illness and/or who were in acute mental health crisis for placement in restrictive housing, which may not have been appropriate for their conditions. Notably, during an interview with Cal DOJ, a psychologist reported never finding that a detainee with mental illness was unable to be disciplined or placed in RHU. Finally, Cal DOJ's review found that pre-disciplinary and RHU placement reviews were discontinued for unclear reasons shortly before the on-site visit in May 2023.

PBNDS 2.12 requires that mental health staff assess detainees within 72 hours of their placement in the RHU and that staff make face-to-face clinical contact with detainees at least weekly, and more frequently for detainees with serious mental illness.[188] The psychologist reported conducting weekly rounds to assess whether detainees placed in RHU require mental health services, as required by GEO Group's policy at Mesa Verde. Other health practitioners may visit detainees in RHU more regularly to ask about any symptoms. However, in interviews with Cal DOJ staff, two detainees who reported being placed in segregation indicated that no medical or mental health professional checked on them while they were segregated.

Use of Force

Cal DOJ reviewed use of force practices generally, with a particular focus on impact on individuals with mental health conditions. Cal DOJ's biggest concern in this area is related to GEO Group not being forthcoming about use of force incidents with multiple reviewers.

Notably, in response to Cal DOJ's request for all use of force reports since August 2021, GEO Group informed Cal DOJ that no use of force incidents had taken place. In fact, OIG conducted an unannounced review a few weeks prior to Cal DOJ's visit. OIG investigated a March 7, 2023, use of force incident at Mesa Verde that GEO Group failed to report to OIG.[189]

188 ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, § P, p. 183.
189 Dept. of Homeland Security, Office of Inspector General, *Limited-Scope Unannounced Inspection of Mesa Verde ICE Processing Center in Bakersfield, CA* (Nov. 2, 2023) pp. 3-5 <https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-03-Nov23.pdf> (as of Apr. 16, 2025).

The facility's denial of any use of force to Cal DOJ and OIG is troubling, as it suggests that other use of force incidents may have occurred at the facility that were not reported to Cal DOJ, despite a lawful request for this information under Government Code section 12532.

OIG's unannounced limited-scope visit in April 2023 revealed that on March 7, 2023, four Mesa Verde detainees engaged in a hunger strike were removed through a calculated use of force incident in the middle of the night and transferred to an ICE facility in El Paso, Texas.[190] OIG released its report and findings on November 2, 2023. OIG determined that Mesa Verde had engaged in calculated use of force, based on their review of closed-circuit television (CCTV) footage that showed staff takedowns, restraints, and hold techniques classified as use of force in the PBNDS.[191] OIG also found that Mesa Verde failed to comply with the PBNDS to report use of force or to appropriately record and preserve the use of force files under the PBNDS.[192] Instead, Mesa Verde claimed that no use of force incidents had occurred in the past two years.[193] OIG explained that the CCTV footage it reviewed only existed because the recording system preserves video recordings for 90 days.[194] Had the visit taken place later, OIG would have had to rely on staff prepared documents and interviews with detainees and staff.[195]

Although various Mesa Verde staff participated in and witnessed this use of force incident, and PBNDS requires that the facility report on and preserve unedited recordings, Cal DOJ did not see or review any use of force reports regarding the incident despite requesting that such reports be provided.[196] At least two detainees' medical charts indicated some connection to the use of force incident. However, the charts revealed that 1) those detainees were not properly assessed before the use of force; and 2) while they were visited and assessed by a nurse after the above use of force incident, their charts did not reflect any mention of the use of force despite at least one detainee showing visible injuries.[197] Despite PBNDS and GEO Group's own policies requiring consultation with medical staff "prior to staff using chemical agents, pepper spray, or non-lethal weapons," Cal DOJ did not see documentation that medical staff was consulted prior to this calculated use of force.

Cal DOJ also reviewed the use of clinical restraints and force used to control detainees in mental health crises. While Mesa Verde reported not using clinical restraints, Cal DOJ reviewed disciplinary files that indicated that detention officers do restrain detainees using flex cuffs. GEO Group reported that in instances where flex cuffs are used, they perform circulation checks. Mesa Verde also reported having safety helmets that are to be used when a detainee is banging their head in self-harm but also reported sending detainees out to the hospital when they have engaged in self-harm.

Prison Rape Elimination Act

Cal DOJ reviewed the facility's practices related to preventing and investigating sexual abuse, pursuant to the Prison Rape and Elimination Act (PREA). PREA protects individuals against sexual assault and ensures prompt investigation of and response to any allegation thereof. Facilities like Mesa Verde, that only hold adult immigration detainees, are subject to PREA standards.[198] Cal DOJ was concerned with reports of an intrusive pat down search policy at Mesa Verde, with the facility's handling of PREA complaints generally, and with reports of retaliation against detainees who file PREA and other complaints.

190 *Id*. pp. 1, 3; see also Hendricks, *ICE Abruptly Transfers 4 Detainee Hunger Strikers From California to Texas, Sparking Fears of Force-Feeding*, KQED (Mar. 9, 2024) <https://www.kqed.org/news/11943030/ice-aburptly-transfers-4-detainee-hunger-strikers-from-california-to-texas-sparking-fears-of-force-feeding> (as of Apr. 18, 2025).
191 Dept. of Homeland Security, Office of Inspector General, *Limited-Scope Unannounced Inspection of Mesa Verde ICE Processing Center in Bakersfield, CA* (Nov. 2, 2023) pp. 3-4 <https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-03-Nov23.pdf> (as of Apr. 16, 2025).
192 *Id*. pp. 3-5.
193 *Id*. pp. 3-4.
194 *Id*. pp. 4-5.
195 *Ibid*.
196 *Id*. p. 4; ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, § I, p. 207.
197 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, § I, pp. 206-207.
198 See National Standards to Prevent, Detect, and Respond to Prison Rape, 77 Fed. Reg. 37106 (June 20, 2012).

A baseline difficulty for Mesa Verde's PREA response is that the facility PREA coordinator and warden appeared to lack substantial knowledge of PREA investigations. Based on Cal DOJ's discussion with the coordinator, he did not appear to have any prior experience handling PREA complaints, nor in investigating complaints or overseeing investigations, and reported that he did not receive any specialized training in assuming the role beyond the regular PREA training all staff receive.

Cal DOJ's most significant concern involved detainee reports of regular invasive pat downs that GEO Group did not address in a manner that indicated that detainee safety is a priority. Mesa Verde's policy calls for pat down searches any time an individual leaves their housing unit — including when they enter and exit the dining hall. This practice has resulted in several complaints that certain male staff members performed pat down searches that were sexual in nature and were reported to involve encircling and cupping detainees' nipple area, intentionally touching their penis and testicles, and lingering in areas of those detainees' bodies that cannot be captured on video.

Some detainees complained of experiencing post-traumatic stress disorder (PTSD) symptoms after being subject to these searches and reported that the psychologist did not listen to their complaints or properly evaluate their trauma, and that the sessions with the psychologist did not help. Detainees reported heightened symptoms after not receiving helpful treatment, including one detainee being placed on suicide watch.

Because these searches occur whenever individuals leave their dorm, detainees are in the unacceptable position of choosing between eating or being subject to inappropriate searches that may worsen their mental health. Detainees reported avoiding exiting the dorm in order not to be subject to the inappropriate searches, resulting in foregoing meals or other enrichment opportunities, and at times missing meetings with their attorney.

GEO Group's response to detainee complaints regarding the pat downs appeared to have worsened the dynamic between staff and detainees at the facility. Additionally, GEO Group's response did not appear to adequately consider how to handle cases involving PREA allegations and mental health concerns. Cal DOJ's understanding is that detainees made several PREA complaints, including multiple complaints lodged against a single officer for allegedly sexually abusive searches, yet all were deemed unfounded. The aforementioned officer remained assigned to conduct the searches and work in areas with access to the detainees after the complaints that specifically named this individual. Detainees interpreted this action as GEO Group's support for involved staff members. Instead of changing this policy or taking actions to ensure that the potentially aggravating staff members were no longer conducting the searches, Mesa Verde placed a video camera at the entryway to the dining room to film the pat downs as detainees leave the area after each meal. Cal DOJ does not know whether detainees were informed of the purpose for the placement of the video camera, and there is no indication whether anyone reviews or preserves the footage.

Medical chart review identified a case that provided additional evidence of GEO Group's difficulty handling the overlap between PREA allegations and detainee mental health. In this case, a detainee (whose chart indicated serious mental illness) discussed a PREA allegation with medical staff, explaining several incidents of sexual assault by another detainee. The detainee was sent for a sexual assault nurse examination and was placed in protective custody upon return; the accompanying progress note recommended a mental health follow-up in 30 days, but was identical to a previous note, suggesting the note was cut from a prior visit and the provider did not attend to and account for the particularities of that patient interaction. The detainee was released from the facility about two months later without any notes showing that a mental health follow-up took place.

In addition to the physical incidents discussed above, during Cal DOJ's visit, detainees also reported that they had been subjected to verbal harassment by staff, such as being referred to as property, having statements made about their appearance, or having lewd comments directed at them. These inappropriate statements may fall under the broad criteria for sexual misconduct under PREA and should be addressed.

Mesa Verde staff also did not consistently follow PREA requirements to protect detainee privacy. During Cal DOJ's visit several women staff members in both custody and medical roles were observed announcing themselves as they walked through the door into units holding men, instead of before they entered. This approach defeats the PREA policy's purpose, which is to afford detainees the opportunity to cover themselves before entry of staff of a different gender.

Staff and Detainee Relations

Communication between custody staff and detainees at Mesa Verde appears poor. For example, and as noted above, Mesa Verde personnel did not explain to detainees that it installed a camera at the entryway to the dining hall to address concerns and complaints over pat downs, despite this action occurring in the context of existing distrust between detainees and the facility. Poor rapport between staff and detainees is concerning as it can affect the provision and success of medical care, along with the overall quality of daily experience.

Based on Cal DOJ's review of grievances made available by Mesa Verde, the most frequent complaints centered around food quality and quantity, sanitation, and staff demeanor (including the staff's response to the hunger strike and work stoppage and sexually aggressive pat downs).

During interviews with Cal DOJ staff, 11 detainees described their interactions with Mesa Verde custody staff. Concerns about "respect" were discussed more often than any other theme, with 60% (three detainees) of those speaking on this topic stating that facility staff was disrespectful. Other topics discussed by multiple detainees included complaints (e.g. PREA, grievances), bullying, discrimination, and fairness. Among the four detainees who discussed complaints, two reported filing grievances, one reported at least one PREA case (as well as an incident report), and another reported a PREA case and a grievance. All three detainees who mentioned bullying reported verbal abuse, such as officers mocking detainees, making fun of how many medications they take, and calling them "stupid." Among the three detainees who discussed discrimination, one described language discrimination, specifically that officers make fun of detainees' lack of English skills. The second detainee also reported that officers mock detainees' English proficiency, in addition to sharing an incident in which an officer had subjected the detainee to additional searches at the time of a family visit after suggesting without evidence that the detainee's sister was a drug dealer. The third detainee mentioned two specific officers, but did not specify why they felt these officers are discriminatory to them. Lastly, two of the three (67%) detainees who discussed fairness characterized facility staff as unfair.

Voluntary Work Program and Hunger Strike

Mesa Verde's Voluntary Work Program and the treatment of the workers led to a work stoppage and hunger strike that resulted in the March 2023 use of force incident. Mesa Verde's Voluntary Work Program pays its detained workers $1 for each workday. A workday consists of any amount of time up to eight hours, and a workweek cannot be more than five eight-hour shifts. All workers are housed together in a dorm and are afforded benefits such as movie nights and popcorn, while those who choose not to work are housed in the other dorm. Thus, although the Voluntary Work Program is characterized as "voluntary" and has nothing to do with institutional conduct, it does appear that the individuals who choose to not work are punished (i.e., the withholding of activities and programming) for not volunteering. From Cal DOJ's review, it also appears that workers are expected to forgo other activities, such as indoor or outdoor recreation, that are offered when they are scheduled to work to not interfere with their workday. This tradeoff does not adequately support detainee mental health.

Detainees in Mesa Verde started a hunger strike in February 2023 to bring attention to worker conditions in the facility and low wages for the Voluntary Work Program.[199] In response, there was a directive to provide detainees on hunger strike with Ensure and electrolytes, to provide detainees with counseling and handouts, and to explain health concerns to detainees. A physician assistant recalled to Cal DOJ staff that all detainees engaged in the hunger strike were referred to mental health. Additionally, a physician who spoke to Cal DOJ stated that nurses assessed the detainees on hunger strike daily.

Nevertheless, Cal DOJ's review of medical and detention records, as well as interviews with detainees, revealed that, in response to this strike, both ICE agents and GEO Group entered the housing units in the middle of the night, where several striking detainees were sleeping, and used force to transport detainees to a facility in El Paso, Texas where they would be force-fed. As noted above in the *Use of Force* section, GEO Group failed to adequately record and report this use of force when it occurred, resulting in an unannounced visit from and report by OIG with findings consistent with those of Cal DOJ's review. Cal DOJ learned that detainees removed from Mesa Verde and transferred to El Paso, Texas were threatened with force feeding and force-fed during the hunger strike. Additionally, some detainees were still reporting suffering physical aftereffects following those feeding practices at the time of Cal DOJ's visit, and Mesa Verde's own medical unit diagnosed some detainees' condition as "mild to moderate refeeding syndrome." These actions violated PBNDS 4.2 regarding hunger strikes, which requires that each case be evaluated on its own merits and specific circumstances and that treatment must be given in accordance with accepted medical practice.[200]

Cal DOJ reviewed documentation indicating that detainees on hunger strike received medical care related to their condition, but did not see documentation confirming that all PBNDS medical requirements in cases of hunger strike were met. PBNDS 4.2 requires monitoring of food and liquid intake and output.[201] Furthermore, the PBNDS require that involuntary medical treatment must be administered only with medical, psychiatric, and legal safeguards.[202] Evidence of the full scope of these requirements was not always present, but there was some evidence of an attempt to mitigate risk through the provision of vitamins and electrolytes (Squincher) and nutritional (Ensure) supplements, which appeared to be requested and consumed by the detainees. There was also some documentation in detainee charts of counseling on physiologic risks of a hunger strike, and evidence of handouts regarding hunger strike risk counseling being provided. Additionally, Mesa Verde reported that a 1200 kcal refeeding diet, with monitoring, was provided post-hunger strike to mitigate risk of refeeding syndrome.

In letters sent on September 14, 2022, May 4, 2023, and October 8, 2024, members of Congress expressed their concerns to the U.S. Department of Homeland Security and ICE regarding "repeated violations" of PBNDS by GEO Group. Concerns included that detainee workers at Mesa Verde had "been on labor strike for more than 100 days," as well as "disturbing conditions and abusive and retaliatory behavior towards detainees by facility staff."[203] The letters demanded ICE address complaints regarding the voluntary work program across GEO facilities generally, including Golden State detainees'

199 Dept. of Homeland Security, Office of Inspector General, *Limited-Scope Unannounced Inspection of Mesa Verde ICE Processing Center in Bakersfield, CA* (Nov. 2, 2023) p. 2 <https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-03-Nov23.pdf> (as of Apr. 16, 2025).
200 ICE, PBNDS 2011, Part 4.2 Hunger Strikes, Part V, § C, pp. 254-255.
201 *Id.* § D, p. 255.
202 *Id.* § E, pp. 255-256.
203 Rep. Lofgren, et al., letter to Secretary of Homeland Security Mayorkas and ICE Acting Director Johnson, Sept. 14, 2022, p. 1 <https://7330553c-3dac-4189-926d-9d7bbfbf56ea.usrfiles.com/ugd/733055_1506e41723c045b0a3924140f1268b56.pdf> (as of Apr. 16, 2025); Rep. Lofgren, et al., letter to Secretary of Homeland Security Mayorkas and ICE Acting Director Johnson, May 4, 2023, p. 1 <https://7330553c-3dac-4189-926d-9d7bbfbf56ea.usrfiles.com/ugd/733055_6eeb5fed590d44db8e5c02c41102e0b3.pdf> (as of Apr. 16, 2025); Rep. Lofgren, et al., letter to Secretary of Homeland Security Mayorkas and ICE Acting Director Lechleitner, October 8, 2024, p. 1 <https://lofgren.house.gov/sites/evo-subsites/lofgren.house.gov/files/evo-media-document/10.8.24%20-%20Letter%20-%20Dangerous%20Conditions%20at%20GEO%20Detention%20Centers.pdf> (as of Apr. 16, 2025).

allegations of being exposed to health risks through the Voluntary Work Program and Mesa Verde's response to the repeated hunger strikes that had occurred in 2022 and 2023.[204] Most recently, the October 2024 letter reiterated the members' call "for DHS to end contracts with GEO for Mesa Verde and Golden State."[205]

Due Process

Cal DOJ reviewed whether conditions at Mesa Verde impacted due process and particularly examined whether information regarding the *Franco-Gonzalez* settlement agreement was accessible. Although facilities are not responsible for detainees' immigration cases, Mesa Verde must give detainees access to legal materials, legal calls, and mail, and the ability to access legal services and representation; facilitate detainee's attendance to court; and provide detainees access to personal property related to their case.[206] Of the 14 detainees interviewed by Cal DOJ, slightly over half (57%; eight out of 14) reported having had an immigration court hearing since arriving at Mesa Verde. Most detainees (79%; 11 out of 14) reported they were currently represented by an attorney or legal representative. Cal DOJ observed that detainees have access to a law library.

As noted above, the terms of the *Franco-Gonzalez* settlement agreement require that the agreement be posted in public areas of the facility so that detainees can access the materials and understand whether they qualify as class members, and, if so, understand the scope of their rights under the agreement. Cal DOJ observed several notices placed at the front of each housing unit, displayed as an open book with its spine affixed to the wall near the detention officers' station and fairly high off the floor. Of these, one addressed *Franco-Gonzalez* but its placement made access to its content difficult for Cal DOJ and presumably for detainees. Of the 14 detainees interviewed by Cal DOJ staff, slightly over half (57%; eight out of 14) reported they were familiar with the *Franco-Gonzalez* settlement.

Based on detainee records, Cal DOJ found that there were a number of detainees who met the length of stay criteria under *Franco-Gonzalez*, and several who appeared to have mental health conditions which may qualify them as a *Franco-Gonzalez* case member. A detention officer interviewed by Cal DOJ reported receiving training on *Franco-Gonzalez* on an annual basis and stated that they maintained a decent understanding of the case. Cal DOJ found that *Franco-Gonzalez* referrals by clinical staff usually occur once detainees are severely symptomatic (e.g., manic or psychotic and not responding well to treatment), instead of occurring once a detainee receives a diagnosis that would qualify them as a *Franco-Gonzalez* class member. It was unclear from Cal DOJ's review of records and interviews whether Mesa Verde or GEO Group regularly flag cases for *Franco-Gonzalez* either at intake or when diagnoses are made, or whether it conducts periodic file reviews for compliance with *Franco-Gonzalez*.

204 Rep. Lofgren, et al., letter to Secretary of Homeland Security Mayorkas and ICE Acting Director Johnson, Sept. 14, 2022, *supra*, p. 2; Rep. Lofgren, et al., letter to Secretary of Homeland Security Mayorkas and ICE Acting Director Johnson, May 4, 2023, *supra*, p. 1.
205 Rep. Lofgren, et al., letter to Secretary of Homeland Security Mayorkas and ICE Acting Director Lechleitner, October 8, 2024, *supra*, pp. 1-2 (emphasis added).
206 ICE, 2011 PBNDS, Part 6.3 Law Libraries and Legal Material, Part V, pp. 422-428.

Facility Focus: Imperial Regional Detention Facility

Background and Summary of Key Findings

The Imperial Regional Detention Facility (Imperial), located in Calexico, is owned by the City of Holtville and operated by the Management and Training Corporation (MTC). Imperial opened in 2014, and ICE entered into a new direct contract with MTC in 2019 for three five-year terms, totaling 15 years.

In its fiscal year 2022 budget justification, ICE reported that it pays $155.65 per bed per day for a guaranteed minimum of 640 beds, and $45.46 for any additional beds.[207] The facility has a maximum bed capacity of 782.[208] At the time of Cal DOJ's site visit, Imperial held 492 male detainees, and therefore was being paid by ICE for 148 unoccupied beds in the facility.

The 2011 PBNDS and 2016 addendum apply to this facility.

Cal DOJ reviewed information related to detainees present at Imperial at any point between January 1, 2021, and February 7, 2023. Cumulatively over this two-year period, 6,981 detainees hailing from 90 different countries and speaking over 20 different languages were held at Imperial, the largest number of whom came from India (967), Colombia (697), and Peru (690). A large majority of this group of detainees spoke Spanish (3,638), followed by Punjabi (468) and Russian (364); Imperial recorded 1,208 detainees as speaking "Other" languages during this time period.

At the time of Cal DOJ's site visit, people detained at the facility came from 63 different countries. The top 10 countries of origin were Senegal (54 detainees), Mexico (42), Egypt (28), Peru (27), Guinea (27), China (24), Honduras (24), El Salvador (20), and Afghanistan (19), with Somalia (13) and Colombia (13) tied for tenth most populous. Imperial has the capacity to house both female and male adults, but at the time of our visit, there were no female detainees housed at the facility.

Table 9. Key Data Points, Imperial

Facility:	Imperial
Operator:	Management and Training Corporation
Housing Detainees Since:	2014
Bed Capacity:	782
Type(s) of Detainees Facility Can Hold:	Female and Male Adults
Snapshot of Detainees Housed at Imperial on June 13, 2023	
No. of Countries of Origin:	63
No. of Detainees by Sex[209]:	Female: 0 Male: 492
Average Age:	34
Average Length of Stay:	62 days
Longest Detainee Stay:	1502 days

207 U.S. Immigration and Customs Enforcement, *Budget Overview Fiscal Year 2022 Congressional Justification*, p. 118 <https://www.dhs.gov/sites/default/files/publications/u.s._immigration_and_customs_enforcement.pdf> (as of Apr. 17, 2025).

208 Management & Training Corporation, *Imperial Regional Detention Facility: Preparing Detainees for Successful Re-Entry* (Jan. 2025) <https://www.mtctrains.com/wp-content/uploads/2019/08/imperial-regional-detention-center-overview.pdf> (as of Apr. 17, 2025).

209 Facility logs do not report transgender status.

Cal DOJ conducted a three-day site visit of Imperial in June 2023. During the site visit and preparation period, Imperial management was forthcoming and cooperative in facilitating Cal DOJ's review, which was consistent with Cal DOJ's prior site visits in November 2018, June 2019, and October 2021. Cal DOJ's review made the following key findings with respect to mental health care, medical care, and other conditions of confinement:

- Vacancies in medical and mental health staff positions prevent Imperial from offering the full range of health care options required to treat detained immigrant populations. Psychotherapy is not offered. This problem has remained consistent across Cal DOJ review cycles.

- As of the 2023 site visit, telepsychiatry is the only mental health care regularly available. Psychiatric care shows deficiencies including lack of treatment planning beyond medication management, inadequate screening for comorbid mental health and medical conditions, and inadequate laboratory and AIMS testing required for psychotropic medications. Additionally, our review found that patients were given diagnoses that do not appear to reflect the full severity of their conditions.

- Suicide prevention care also shows deficiencies such as lack of formal risk assessments, minimizing of observable suicide risks, low mental health visit frequency during suicide watch, and lack of safety planning on release from suicide watch.

- Classification procedures at Imperial tend to result in detainees with low threat profiles being assigned to higher classification levels that expose them to restrictive conditions.

- Imperial does not consistently follow PBNDS requirements for mental health review prior to disciplinary action or placement in restrictive housing. On average, detainees receiving mental health care faced more disciplinary actions per person than those who were not. Detainees receiving mental health care also experienced higher rates of and longer stays in segregation, which poses significant risk of mental health harm.

Methodology and Limitations

Cal DOJ arrived at its findings after collecting data and observing conditions at a site visit, interviewing detainees and the facilities' staff, reviewing documents provided by the facilities, and analyzing survey responses from attorneys and legal services providers who had worked with detainees housed at the facilities. Prior to the site visit, Cal DOJ held a pre-site visit meeting with Imperial operational staff in May 2023.

Cal DOJ staff and experts visited the facility June 13-15, 2023. During the site visit, Cal DOJ toured the facility, observed shift briefings and other routine operations, and conducted interviews of executive staff, operational managers and department heads, medical and mental health care providers, detention staff and supervisors, and detainees. Cal DOJ's medical, mental health, and corrections experts reviewed or supervised Cal DOJ staff in review of health care, detention, and use of force records.

Cal DOJ staff interviewed 25 detainees who came from 21 different countries and spoke 12 languages.[210] Cal DOJ experts conducted focused interviews in their areas of expertise with four detainees. All interviews were conducted in the detainee's preferred language by fluent interviewers and/or with the assistance of a language line. To support the mental health focus of this review, Cal DOJ

210 Detainees participating in interviews came from Mexico, El Salvador, Afghanistan, China, Congo, Honduras, Jamaica, Peru, Mozambique, Georgia, Sudan, Guinea, Angola, Cuba, Nigeria, India, Somalia, Iraq, Fiji, Belize, Israel and Palestinian Territories; they spoke Spanish, English, Lingala, Mandarin Chinese, Hindi, French, Somali, Arabic, Georgian, Pashto, Fijian and Portuguese.

selected detainees to be interviewed using two methods: (a) a purposeful sampling approach, based on the detainee's appearance in mental health logs provided by Imperial and (b) a quota sampling procedure which drew from the general facility roster excluding detainees who appeared on mental health logs and sampling by subregion of origin (e.g. Asia, Africa) to ensure participation of a broad range of detainees. Additionally, three attorneys who had represented four clients at Imperial between January 1, 2021, and March 3, 2023, responded to Cal DOJ's attorney survey.

Access to Medical and Mental Health Care

Cal DOJ evaluated Imperial's systems of providing health care for ease of access to medical and mental health care services, both at intake and during detention generally. Review also focused on continuity of care between facility providers, external providers of any health care the detainee received before or after detention, and providers of any offsite care that was required during detention. Cal DOJ also considered reports from detainees or other evidence of detainee understanding of the facility's system of accessing care.

Intake and Mental Health Screenings

Imperial has adequate procedures in place to identify and respond to mental health issues at intake. Mental health intake occurs in a private room in the intake area and is conducted by a registered nurse. Intake assessment instruments include questions addressing the detainee's history of mental health treatment, history of experiences of assault or abuse, substance use history, suicide risk assessment, and past or current experience of thoughts of harming self or others. The instrument was missing questions related to mental health in the first post-partum year. A majority of the 25 detainees that participated in Cal DOJ standard interviews (68%; 17 out of 25) reported being asked about their mental health condition at intake.

Despite relatively well-functioning intake procedures, Imperial may benefit from increasing attention to information available from individuals other than medical staff who interact with the detainee as they arrive at the facility. In one case identified by chart review, a border patrol agent noted unusual behavior by the detainee, but no one followed up on this observation at intake, and the detainee was referred for treatment three weeks later for behavioral reasons.

Detainees arriving with psychotropic medications or history of their use appeared to consistently be referred for psychiatric evaluation. Staff reported that mental health referrals are seen by the psychiatrist within 24 to 72 hours, and at least half of the eight detainees who told Cal DOJ staff that they had requested mental health care reported they were seen within three days. However some detainees reported waiting from one to several weeks for a psychiatry appointment. Mental health medications are ordered by the psychiatrist, though medical staff may provide bridge medications on intake. Medical issues are referred for follow up to the facility physician to sign off, and detainees and medical staff reported a follow up comprehensive medical assessment occurs within 1-2 days.

Identifying Mental Health Concerns During Detention

Procedures to identify mental health concerns during ongoing detention also appeared adequate. The annual medical re-evaluation includes questions regarding mental health. The previous mental health provider had done annual evaluations, although records staff were uncertain whether these evaluations were ongoing at the time of Cal DOJ's site visit as that provider had left the facility and had not been replaced. A majority of detainees interviewed by Cal DOJ (72%) reported being asked about their mental health condition at some point during their detention. Detention officers are also able to request care for a detainee when needed, and chart review reflected some detainees receiving medical or mental health care following a walk-in request by a detention officer. Mental health care appeared

to be delivered mostly in a hybrid in-person and teletherapy format, as reported by four of the seven (57%) detainees who reported that they received mental health treatment at the facility.

Imperial's health staff appeared to be appropriately responsive to sick call requests. Detainees request to be seen by mental health staff by using a tablet, and the tablet request system seemed generally reliable. Detainees interviewed by Cal DOJ's mental health expert reported receiving responses to mental health sick call requests within 24 hours by nursing and within 1-2 days by the psychiatrist; chart review corroborated that medical and mental health sick call requests received attention within 24 hours and at times immediately. Eight detainees who were interviewed by Cal DOJ staff reported submitting a request to see a mental health provider; seven of them were asked about the length of wait time before receiving care. Four detainees reported being seen in 3 or fewer days, and one reported being seen "right after" without quantifying when. One detainee reported that wait time varied but that emergency two-day requests were possible, and another reported that they were still waiting to be seen at the time of the interview.

However, in Cal DOJ's survey, some attorneys with clients detained at Imperial reported instances of the facility failing to identify and respond to their clients' mental health conditions. Identified problems included clients not being diagnosed despite presenting with mental health symptoms, clients deteriorating after not receiving mental health services, or clients' medical records failing to reflect symptoms that the client had self-reported to facility staff.

Detainees reported other potential obstacles to care during interviews with Cal DOJ staff. For example, one detainee described that he was unable to complete a mental health request due to receiving a tablet error message during his attempts and that facility staff did not respond to his reporting the error. This detainee also reported that a medical doctor at the facility had declined to refer him for mental health care when he presented mental health concerns.

Access to Medical Care

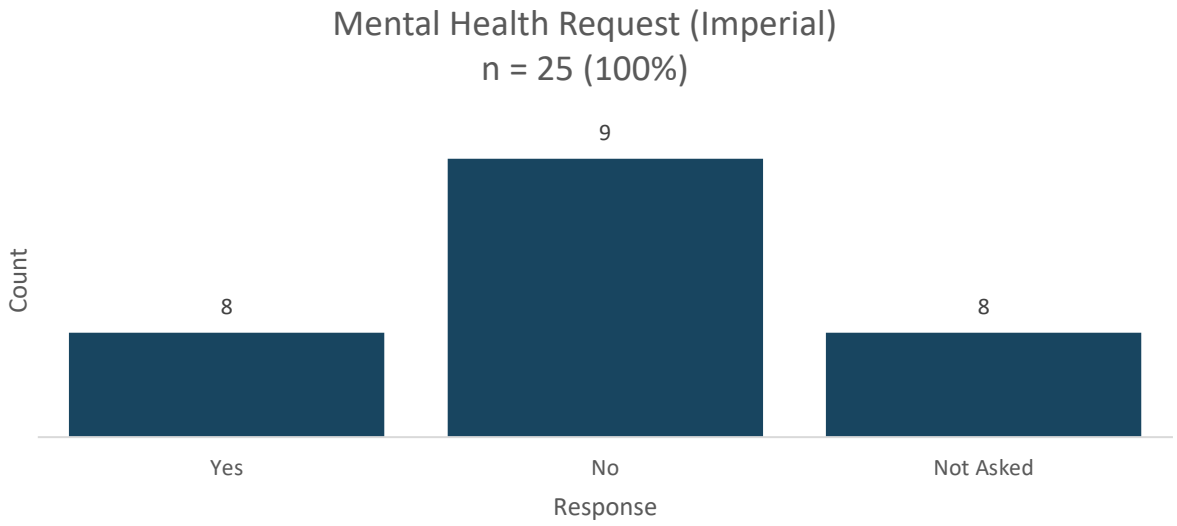
Cal DOJ reviewed access to medical care through the services available at and outside the facility, identification of medical needs, and systems for addressing detainee health needs.

Imperial offers chronic primary care, sick call, dental care, emergency evaluation, and basic life support on site. Imperial does not have an infirmary for inpatient hospital-level care. The facility is therefore not able to provide services for acute inpatient needs and in such cases refers patients to the local hospital. As the local hospital does not provide inpatient psychiatric care, Imperial sends detainees needing mental health hospitalizations to Paradise Valley Hospital in San Diego, which is about a two-hour drive from the facility. Imperial is not equipped to treat detainees experiencing withdrawal from substance abuse, who are also referred to the local hospital for treatment when needed. In addition, the facility is not able to provide long-term buprenorphine treatment for opioid abuse disorders. The reasoning for this gap was unclear, as health care staff reported that they are able to prescribe buprenorphine for tapering purposes when detainees arrive already undergoing medication-assisted treatment for opioid abuse.

Detainee Knowledge of How to Access Medical and Mental Health Care

Detainees' lack of knowledge of how to request mental health services may be an obstacle to receiving care at Imperial. Of 17 detainees who were asked whether they knew how to request to see a mental health doctor or therapist at the facility, a slight majority (nine detainees) reported that they did not.

Figure 24. Detainee reports of whether they know how to submit a request to see a mental health professional, Imperial



The extent to which knowledge of the request process is an obstacle is not clear. Nearly half of this group reported knowing how to make a request, as did the subgroup of detainees that completed targeted interviews with Cal DOJ's medical experts. Overall, the majority of detainees that Cal DOJ staff interviewed reported having seen a mental health professional at the facility (14 of 25 detainees, or 56%). This finding indicates that at least some detainees understood the request process and were successfully accessing care.

It did appear that detainees were not always requesting the mental health care that they needed, and that lack of knowledge was one among several reasons for this pattern. Of the 25 detainees who were interviewed by Cal DOJ staff, 18 (72%) reported having mental health concerns. Among the 18 detainees who reported concerns, only eight (44%) reported that they requested treatment; of these detainees only half of whom requested treatment reported that they received it. Three other detainees with concerns reported that they received treatment even though they did not request it. In other words, only seven (39%) of the 18 detainees who reported mental health concerns indicated that they received treatment.

Across all facilities, the top reason that detainees cited for not requesting care was lack of trust. In contrast, at Imperial, no detainees explicitly attributed their abstention to lack of trust. Of the six Imperial participants who were asked why they had not requested services, two were not interested, one was busy with other activities, two did not know that mental health services were available or how to access them, and one was already receiving the care they needed. Given this heterogeneity in response, the most effective way for Imperial to improve the reach of its services may be a multifaceted approach that includes both helping detainees understand how to access services and learning more from detainees about what kinds of services are a priority for them.

Continuity of Care

Imperial is able to provide continuous care when all appointments occur within the facility but does not generally employ adequate practices to ensure continuity of care across patients' care settings before, during, and after detention, including any external hospitalizations or other treatments.

Follow-up visits within the facility are consistent. Cal DOJ received mental health logs from MTC representing the 43 detainees present at the facility in March 2023 who were receiving some form

of mental health care; nearly all (93%; 40 out of 43) were scheduled for mental health appointments to occur monthly. Medical file review revealed that some lapses did happen when detainees refused follow up care, either inside or external to the facility, and the detainee may have had limited capacity to understand and make an informed refusal. In one case, a detainee receiving treatment for psychosis declined a needed emergency room procedure. There was no process in place to follow up and reassess either the clinical situation or the patient's consent capacity due to their serious mental illness.

However, when dealing with transitions from one care location to another, Imperial does not consistently engage in practices that ensure an individual's care is not interrupted. Based on chart review, Cal DOJ's mental health expert concluded that facility care providers do not consistently review patients' prior mental health records and thus do not avail themselves of information that is already known about the detainee's diagnostic history and what treatments have been effective for that individual. There were also cases when providers did not follow the care plan indicated in prior records. In one case, the detainee reported different medications compared to their record and the provider followed the detainee's request rather than the documented prescription. In addition, multiple patients were transitioned off injectable antipsychotic medications on intake due to formulary preferences without ensuring this change was clinically appropriate.

Transitions to and from offsite care while the patient remains legally detained appear to be a functioning process at Imperial. A records technician is responsible for requesting offsite care records, scanning pages into the detainee's chart, and routing the records to an Advanced Practitioner such as a physician's assistant to sign and acknowledge review. Cal DOJ's medical expert located notes from community clinics and emergency rooms in patient charts, indicating success of these procedures. Based on Cal DOJ's review of hospitalization logs from January 2021 to March 2023, external hospitalizations among the detainee population arise from a mix of medical and mental health causes; 84% (71 out of 85) of hospitalizations during this period were due to a medical concern, 15% (13 out of 85) to a mental health concern, and the remaining cases were due to blended issues (drug overdose or potential self-harm injury).

This process does have one weakness in that psychotropic medications are not always bridged post-psychiatric hospitalization. Cal DOJ's mental health expert noted multiple cases in which the new medications that had helped the detainee stabilize at the hospital and become ready for discharge were then reduced or discontinued upon return to Imperial without a clear clinical justification, sometimes resulting in the detainee's health deteriorating.

Discharge planning is not occurring at Imperial, which risks formerly detained persons suffering health or other harms. Staff report receiving little notice, sometimes just a few hours, that a detainee under their care is being released. Nonetheless, they provide lab results, pending referrals, a one-page summary of care, and a one-week supply of any medications. The facility gives a greater than one week supply of medications if it has medication stock available. Additionally, Imperial provides 14 days of tuberculosis medications or 30 days of HIV medications. However, facility staff do not assist detainees in obtaining new services in their intended location. They also cancel existing pending community health appointments, if any, even when the detainee plans to remain in the same locality as the appointment.

Mental Health Care

In prior reviews of Imperial, Cal DOJ identified numerous substandard facets of the facility's mental health care services. The 2021 Cal DOJ report described poor access to mental health services, largely due to understaffing.[211] Incoming detainees were almost always screened as negative for having mental health concerns, including those with documented mental health diagnoses.[212] Individuals who were treated did not receive proper follow-up and evaluation, and documentation of patients' treatment progress was often incomplete.[213] The Cal DOJ mental health expert found that incidents of self-harm and suicide attempts were not properly addressed.[214] Individuals were often sent to suicide watch cells where they experienced conditions like solitary confinement and did not receive adequate follow-up with mental health professionals.[215]

This mental health focused review conducted in 2023 found similar concerns. Lack of mental health care staff continued to limit the mental health services available to detainees, with psychotherapy not offered in either individual or group form at the time of Cal DOJ's visit. What services were offered did not indicate regular treatment planning, screening for comorbid conditions, or required laboratory and other testing. And suicide risk assessment, care during suicide watch, and safety planning before release to the general population after suicide watch all needed improvement.

Mental Health Staffing

As was true at the time of Cal DOJ's 2021 report, mental health staffing is insufficient for the population level at Imperial. Many of the deficiencies in mental health services are traceable to inadequate staffing. Imperial is located in a remote area, which may complicate the ability to recruit candidates. In an April 2021 letter to DHS, the American Civil Liberties Union recommended closing Imperial due to the difficulty of access to legal services and medical care in Calexico.[216]

At the time of Cal DOJ's review, the only mental health professional working at Imperial was one psychiatrist. There were two unfilled social worker positions that became vacant in December 2022 and January 2023. There was no psychologist on staff, and facility health care leadership reported having recently lost one promising applicant for the position due to the long waiting time required for new hires to complete the ICE background check. MTC reported engaging in active recruiting and incrementally raising the salary offered for the psychologist position. At the time of Cal DOJ's site visit, the facility reported that there were no current applicants.

The lack of mental health professionals results in limitations on the services that are offered to this population. These limitations are especially concerning, given the prevalence of trauma-related mental health symptoms and diagnoses within detainee populations. Psychiatry offers evaluation, diagnosis, treatment planning, prescription of appropriate medication and medication management, and, depending on the specific psychiatrist's experience and availability, some counseling or therapy. At Imperial the absence of a psychologist, social worker, licensed professional counselor, or other professional trained in psychotherapy meant that there was no providers with significant psychotherapy experience. These vacancies hinder Imperial's ability to provide "necessary and appropriate" mental health care as PBNDS section 4.3 requires and to satisfy clinical practice guidelines, as required by NCCHC standards, when such guidelines recommend therapy or combined medication and therapy treatments.

211 *Immigration Detention in California* (January 2021), *supra*, p. 96.
212 *Id*. at p. 91.
213 *Id*. at pp. 91-92.
214 *Id*. at pp. 93-95.
215 *Ibid*.
216 Newman, *Re: Announce the Planned Closure of ICE Detention Facilities in May 2021*, ACLU (Apr. 28, 2021) pp. 3-4 <https://www.aclu.org/sites/default/files/field_document/210427mayorkas_detentionletteraclu.pdf> (as of Apr. 16, 2025).

Limitations on the psychiatrist's availability compounded this weakness in service offerings. The psychiatrist provided remote telepsychiatry services only, with some coverage every day of the week and on weekends, and 24/7 on call availability. MTC's corporate director of psychiatry could be called for telepsychiatry when the regular psychiatrist was not available. As the sole mental health provider the psychiatrist bore full responsibility for mental health assessments and suicide watch release decisions (with some caveats discussed below). No mental health provider was available to observe detainees in person, which is essential to observe symptomatology that is hard to monitor remotely (e.g. nuances of body language that can be diagnostic for mental health disorders). In addition, this arrangement itself was a stop gap measure as the psychiatrist was seeking to retire but remained on staff to help out the facility given the full vacancy in all other mental health staff positions. While this commitment was commendable, during an interview with Cal DOJ's mental health expert the psychiatrist expressed some resistance to being accountable for service weaknesses under these circumstances, despite being ethically responsible as the treating psychiatrist. The psychiatrist did indicate that MTC provides some quality assurance of psychiatric care.

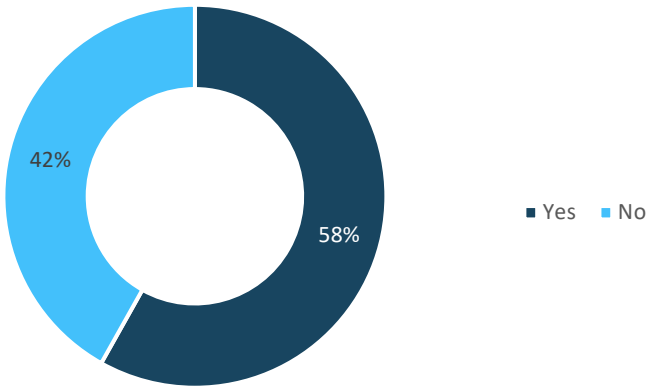
Mental Health Assessment

Prevalence of Mental Health Concerns

Cal DOJ requested information specific to detainee mental health needs and treatment for the purposes of this review and spoke to detainees about their reasons for seeking mental health care. Imperial identified 125 detainees with diagnosed mental health disorders between January 2021 and March 2023. Most detainees in the mental health disorders and services logs provided by Imperial were diagnosed with post-traumatic stress disorder (PTSD) (37%; 46 out of 125 detainees), followed by major depressive disorder (30%; 38 out of 125 detainees), and adjustment disorder (16%; 20 out of 125 detainees). Among the eight detainees who reported that they submitted a request to see a mental health doctor in interviews with Cal DOJ staff, the most common reason cited was insomnia or trouble sleeping. Participants also cited depression, PTSD/stress/trauma, participation in a hunger strike, and wanting to talk to someone about their experience at the facility.

Imperial provided Cal DOJ with a log including detainees who were receiving psychotropic medication at the facility in March 2023. Most (58%, 25 of 43) detainees present in this log were receiving medication to treat their mental health conditions.

Figure 25. Number of Detainees by Medication Status, Mental Health Hotlist, Imperial, March 2023 (43 detainees).



Mental Health Evaluations and Diagnosis

Psychiatric evaluation and diagnostic practices met the standard of care in some respects but fell short in others. The overall evaluation practice appeared adequate. The psychiatrist performs an initial evaluation over the telehealth platform that usually lasts 30 minutes, diagnoses the detainee based on his evaluation, and enters the diagnosis into the electronic medical record (EMR). The psychiatrist then follows up every seven to 30 days, or sooner. Cal DOJ's mental health expert commended the psychiatrist's recognition of trauma symptoms and diagnoses, which is not consistently happening at other facilities.

However, based on chart review, screening for comorbid or related mental health or medical conditions was not occurring regularly, which may result in harm to detainee patients. In one particularly concerning case, a detainee exhibited significant delirium that was not appropriately treated. Delirium may signify a range of severe mental and physical health conditions requiring immediate intervention. The detainee reported no mental health history on intake, but approximately one week later began reporting auditory and visual hallucinations, and thereafter displayed noted memory deficits and challenges completing basic activities of daily living such as eating and sleeping. For several weeks the detainee was seen only by nursing. When he was finally seen by psychiatry, the psychiatrist did not initiate a computed tomography (CT) scan, magnetic resonance imaging (MRI), or other neurological testing that was recommended. The patient continued to decline, losing 16 pounds in two months and becoming increasingly confused. The facility noted that the detainee refused psychiatric care in the two months after the first psychiatric appointment. While a patient has a right to refuse care, involuntary treatment may be provided when the patient exhibits grave disability and there is reason to question their capacity to consent or withhold consent, as may have been likely in this case.[217] Although the patient did eventually receive some neurological testing at a local hospital, his poor condition was ongoing at the time of Cal DOJ's visit.

In other instances, psychiatric diagnoses were incomplete or key evaluations were not conducted. For example, a detainee with PTSD who reported ongoing auditory hallucinations and paranoid delusions was not appropriately diagnosed with a psychotic disorder. In this instance, the provider did begin appropriate treatment for psychosis despite the incomplete diagnosis. In another example, the psychiatrist believed a detainee had a cognitive deficit but did not diagnose the detainee with a cognitive disorder or do any bedside cognitive testing to confirm the diagnosis. In another case, the psychiatrist adjusted the diagnosis of a patient with prior suicide attempts from major depressive disorder (MDD) to adjustment disorder, a generally less severe condition, without clear documentation of the justification for the change. While the documentation noted that the patient reported no longer feeling suicidal, more information is needed in the chart to explain the observed changes, degree of remission, and ongoing risk levels given the patient's history of depression, hospitalization, and suicide attempts.

Treatment Planning

Medical records at Imperial did not contain clear evidence of regular treatment planning. Cal DOJ found no written treatment plans from psychiatric or medical or mental health care staff. The psychiatrist's treatment planning, which at Imperial consists of medication management, follow-up time frame, and sometimes coping skills or education, may be minimally appropriate for a clinician providing solely medication management services. Robust psychiatric treatment planning, however, should include treatment goals and plans for next steps. More importantly, because the psychiatrist is the sole mental health provider, his treatment planning responsibility cannot be limited to medication management tasks and instead must reflect the patient's mental health care needs as a whole, as required by PBNDS.[218] Complete treatment planning must include therapy and psychoeducation, laboratory testing, and a treatment goal or desired outcome.

217 See, e.g., Welf. & Inst. Code § 5150.
218 ICE, PBNDS 2011, Section 4.3 Medical Care, Part V, § O, p. 270.

Imperial also does not engage in multidisciplinary treatment planning, the importance of which, particularly in institutional settings, has been discussed earlier in this report. There is no structured regular venue for medical, mental health, detention, and other staff to collaborate to support the care of detainees experiencing mental health challenges. Communication between medical and psychiatric staff appears to be informal, with multiple providers reporting reaching out to other facility providers to request follow-up visits or rule out evaluations for detainees. This practice does not satisfy the need for ongoing collaboration that ensures all treating providers are pursuing the same aims based on a consensus understanding of the detainee's health care needs.

Psychiatric Care

Cal DOJ reviewed the facility's provision of psychiatric care and related prescription protocols for individuals with mental health conditions. Cal DOJ noted issues with the availability of non-formulary medications, consistent implementation of medication distribution protocols, lack of laboratory and AIMS testing, and missed opportunities to provide medications or increased dosage levels that may have helped the patient.

Medication Distribution

A variety of medications are available to detainees at Imperial, but certain medications are functionally unavailable due to prescribing practices or wait times for non-formulary medication. Facilities generally have a list of medications that they keep in stock on site as well as a formulary, a list of medications that ICE has pre-approved.[219] The psychiatrist reported that he "never" orders non-formulary medications, which is of concern for cases in which a non-formulary medications would be the most effective treatment. The pharmacy technician denied keeping a list of stock medications even though the list was available on Sapphire, the facility's records management program. Imperial does not offer long-acting injectable antipsychotic medications, and one detainee interviewed by Cal DOJ's experts reported injectable antipsychotic medications they received prior to detention that were not continued at Imperial. It is concerning that the facility rejects injectable medications as a matter of policy, especially because they are generally prescribed in cases where the patient has resistance or other inability to consistently comply with a daily treatment regimen. In another case, Cal DOJ's medical expert found that a patient's ears were allowed to remain inflamed for a week because the original prescription was non-formulary. These treatment deficiencies occur despite ICE being generally responsive to non-formulary requests when made, according to medical staff.

In interviews with Cal DOJ staff, all detainees (four in total) who answered a question about medication distribution reported no difficulties receiving their prescribed medications. However, Cal DOJ's experts found that pill pass procedures were deficient due to staff inconsistently administering mouth checks and allowing unusual detainee behaviors. During pill pass, the nurse providing medication should distribute medication in an orderly manner, including administering mouth checks to confirm the detainee has ingested the medication. Experts observed pill pass in two units and noted that mouth checks occurred regularly in one unit and not the other. In one unit, a detainee squatted outside of the view of the nurse while taking medication, and neither the nurse nor the detention officer made any effort to redirect the detainee to the proper medication procedures. The lack of mouth checks and abnormal detainee behavior increases the risk of medication non-adherence and diversion of medication for detainees to hoard and use as contraband or for overdose (accidentally or as a suicide attempt).

219 *Id.* § G, pp. 265-266.

Psychotropic Prescribing and Medication Management

Prescribing practices for psychotropic medications, i.e. medications intended to treat mental health conditions, were at times appropriate but at other times fell short of patient needs. This deficiency is concerning in any facility, but is of greater concern at Imperial where there are no available psychotherapy services and psychiatric care carries the facility's full burden to provide treatment to detainees with mental health disabilities and symptoms. Of those detainees listed in mental health logs who were interviewed, 80% (eight of 10 detainees) were prescribed medication to treat their mental health conditions.

Cal DOJ's mental health expert found that, in general, the medications prescribed corresponded well to the symptoms documented in the reviewed detainee charts. However, chart review also revealed that some detainees were not offered psychotropic medications for symptoms or diagnoses that were treatable with available medications. The detainees described in the *Continuity of Care* section whose medication was reduced after returning from the hospital, in addition to being examples of failure to offer needed testing, are also examples of cases in which providing additional medications could have been helpful. In another case, a patient was prescribed a low starting dose of Abilify. The psychiatrist reduced the dose and did not follow up for two weeks, despite the patient experiencing manic symptoms and banging his head on hard objects. This patient was high risk due to a recent release from suicide watch.

While the psychiatrist did take note of detainees' trauma symptoms to a greater degree than is often seen in detention settings, review of multiple charts revealed that trauma symptoms in particular tended not to result in a medication prescription that could have been helpful. One detainee who presented with severe PTSD with some psychotic features was prescribed an antipsychotic but no medication to assist with trauma symptoms, such as a selective serotonin reuptake inhibitor (SSRI). Another detainee seeking treatment for medical insomnia was only given melatonin, an over-the-counter treatment that helps with a specific subset of sleep-interfering conditions, rather than any prescription medication or treatment for related trauma symptoms.

Laboratory and AIMS Testing

Psychiatry practice at Imperial does not include systematic monitoring for metabolic or clinical side effects of prescribed mental health medications, which presents health risks to detainees. It was apparent from both chart review and detainee and medical staff interviews with Cal DOJ's mental health expert that the psychiatrist does not usually order laboratory studies, except for Depakote (a mood stabilizer psychotropic medication used to treat bipolar disorder and epilepsy), and does not administer Abnormal Involuntary Movement Scale (AIMS) testing. In one case, a patient was prescribed Depakote without being diagnosed with one of the mental health conditions for which Depakote is usually offered and without labs to check that Depakote levels remained in the safe and effective range. In at least two additional cases, the detainee was sent to a hospital in mental health crisis and prescribed new medications and stabilized there. On return to Imperial, the new medications were discontinued despite the treatment success, with no labs or AIMS testing ordered. In at least one of these cases the detainee gained weight quickly after being prescribed Zyprexa, which is one of the expected side effects and reasons to order laboratory testing.

Documentation

Overall, mental health documentation by facility staff met the standard of care. Cal DOJ's medical and mental health experts reviewed patient files to assess provided care and generally were able to do so based on the information provided in the client record. Documentation of informed consent was consistently found in detainee charts; Imperial has prioritized such documentation by making it one of their chronic care quality metrics. Medication refusals were also appropriately documented with

requisite forms signed by either the nurse or the detainee, or a detention officer if the detainee refused to sign.

Cal DOJ experts noted some concerns related to documentation that arose from detainee interviews. First, of the ten detainees interviewed by Cal DOJ who reported that they had been prescribed mental health medication, four were listed in the medication roster that Imperial provided to Cal DOJ at the start of the site visit, and eight total appeared in at least one of the other mental health logs provided, but two were not present in any mental health log that Cal DOJ received. It is not clear whether this reflects inaccuracy in the information provided by the detainee or documentation errors by Imperial.

Second, while informed consent documentation was consistent, information from detainee interviews indicates that the core purpose of the consent forms – that the patient understands the purpose and likely effect of the prescribed medication – was not always successfully achieved. Of the ten detainees who reported in interviews that they were prescribed medication for mental health, four reported that a mental health professional explained the medication to them, but another four reported that medications were not explained (two of the ten were not asked this question). Cal DOJ's medical expert interviewed one additional detainee who denied understanding the expected side effects of his medication. This lack of consistent patient understanding indicates that while the facility is meeting the basic requirements of informed consent documentation, that further work is needed addressing language, cultural, or other barriers to ensure that consent is truly informed. Additionally, Imperial's pharmacy technician stated that the facility does not provide side effects package inserts to detainees, as standard medical and pharmacy practice requires,[220] which may increase detainee comprehension of expected medication effects.

Finally, Imperial's method of documenting serious mental illness (SMI) in order to ensure appropriate treatment and accommodations for impacted detainees was lacking. Imperial maintains a mental health watchlist, but it was not clear what principles guided placement on the list. There were no established criteria for who is placed on the list and the psychiatrist reported a limited definition of SMI, stating that it meant "a diagnosis that precludes [detainees] from working with their attorney." This statement may be true for a subset of detainees diagnosed with SMI, but excludes many conditions included in the definition of serious mental illness listed in the PBNDS section 4.3.[221]

Therapy and Other Non-Medication Interventions

Availability and Quality of Psychotherapy

Neither individual nor group psychotherapy are available at Imperial due to staffing vacancies described in the *Mental Health Staffing* section above, which represents a crucial deficiency in the facility's ability to meet the basic needs and requirements for mental health services as required by PBNDS.[222] The high incidence of trauma-related symptoms and diagnoses in the detained population make this absence particularly harmful. While medications may address some common symptoms of trauma diagnoses, treating the trauma itself requires psychotherapy.[223] The psychiatrist stated he provides psychotherapy "sometimes," but in interviews with Cal DOJ's mental health expert, detainees reported that the psychiatrist does not provide psychotherapy.

Some detainees listed individual and group counseling or therapy among treatments that they were receiving before being detained, with some of these reporting receiving ongoing individual and group

220 21 C.F.R. § 209.11 (requires each authorized dispenser or pharmacy to distribute the side effects statement with each prescription drug product disbursed).
221 ICE, PBNDS 2011, Section 4.3 Medical Care, Part X, pp. 274-275.
222 *Id.* Part V, § N, p. 269.
223 See, e.g., Dept. of Veterans Affairs et al., *VA/DoD Clinical Practice Guideline for Management of Posttraumatic Stress Disorder and Acute Stress Disorder* (2023) <https://www.healthquality.va.gov/guidelines/MH/ptsd/VA-DoD-CPG-PTSD-Full-CPG-Edited-11162024.pdf> (as of April 23, 2025).

psychotherapy while incarcerated in CDCR facilities. At least one detainee reported to Cal DOJ's mental health expert that they received services from the psychiatrist but were not satisfied with this arrangement because they sought therapy, not medication services. One detainee reported that he had arranged to be seen remotely by a provider from Counselors Without Borders, but that the facility would not allow him to take advantage of this service.

Rapport and Cultural Competence

Detainees provided inconsistent reports of the quality of their rapport with Imperial's psychiatrist. Some detainees described the psychiatrist as "okay," while one described a more actively positive impression that the psychiatrist was "kind and friendly," "uplifting," "talks nice," and "gives [the patient] confidence." On the other hand, another detainee reported experiencing the psychiatrist's statements as at times inappropriate, such as an instance in which the psychiatrist asked him if he planned on transporting drugs after being released from the facility. Of detainee responses that discussed quality of their interactions with mental health staff, half (three out of six; 50%) described the quality as adequate, and half as inadequate. The three detainees who discussed staff attitudes described them in positive terms, using descriptors such as "good people" and "kind" and that "[staff] joke with us and have fun with us."

Detainee experience of the helpfulness of mental health services in general was also mixed. Of the seven participants who reported receiving mental health treatment at the facility, three participants reported that the treatment was helpful and three participants reported that it was not helpful; one participant was not asked the question.

The cultural awareness of mental health providers and their skill at tailoring treatment to a diverse population is crucial for building therapeutic rapport and providing effective treatment. Training materials for health care and other facility staff at Imperial include information about considering culture when providing care or otherwise interacting with detainees. A training PowerPoint provided by the facility included lists of common causes of cultural misunderstanding and of professional behaviors to improve interactions, although Cal DOJ was not able to observe the training as given and so was not able to evaluate it in full. The psychiatrist reported cultural issues being relevant to decision making but did not elaborate on how this awareness was put into practice. It was not common during chart review to observe significant focus in case notes related to cultural explanations for or contributions to detainees' mental health symptoms. In one case reviewed by Cal DOJ's experts, inattention to cultural difference may have contributed to the psychiatrist minimizing suicide risk for a patient who displayed suicidal behaviors but often denied being suicidal. The patient came from a culture that typically does not use mental health language to describe distress. Case review suggested that the psychiatrist had not been successful in talking about depression in a culturally intelligible way with this patient.

Detainees reported other instances where more robust cultural understanding may have been helpful, although sufficient detail and corroboration for Cal DOJ to evaluate facility response were not available. One detainee described suicidal ideation due to racism and reported that he had been connected with mental health services, but did not indicate whether the allegations of racism were addressed.

Availability and Quality of Other Non-Medication Interventions

Detainees additionally reported limited or no access to other non-psychiatric services that previously supported their mental health. Such services included recreational group activities, neurology services, group counseling through a religious institution, individual and group therapy, and online mental health classes. Some enriching activities are theoretically accessible by tablets available on the units, but there are barriers to access including low numbers of tablets (nine per unit), staff unfamiliarity with tablet features, and the requirement to pay for access to such content when not all detainees have access

to funds.[224] However, Cal DOJ's mental health expert rated Imperial's physical areas and recreation opportunities positively, noting among other things the availability of a garden area and the option to work tending it.

Figure 26: Garden

Suicide Prevention and Response

Suicide Risk Assessments, Intervention, and Prevention

Since Cal DOJ's last inspection, Imperial has had no successful suicides occur.[225] However, Cal DOJ's experts had concerns about the facility's readiness to identify individuals at risk of suicide or other self-harm and to intervene in a manner that is timely, effective, and meets medical care expectations.

The physical facility itself was overall appropriate. Cal DOJ's mental health expert noted the presence of suicide resistant shower heads. However, the expert also observed concerning tie off points and other features that may facilitate suicide attempts. The Facility Administrator reported that preparation drills are conducted quarterly, but he was unable to offer in his interview more details about how many staff participated, and during which shifts.

Mental health expert case review revealed more concerning practices related to suicide prevention and intervention care. File review showed no evidence of formal suicide risk assessments being regularly administered. There was evidence that, when the facility had more mental health staff, a licensed

224 Note "standard content" (games, music, books, sports) costs $0.05 per minute or $3 per hour, and "promotional content" (movies) costs $0.03 per minute or $1.80 per hour, while the voluntary work program pays $1 per 8 hour day.

225 In Dec. 2020, DHS OIG issued a report specific to Imperial regarding prolonged detention in administrative and/or disciplinary segregation. See DHS Off. of the Inspector General, *ICE Needs to Address Prolonged Administrative Segregation and Other Violations at the Imperial Regional Detention Facility* (Dec. 18, 2020) at <https://www.oig.dhs.gov/sites/default/files/assets/2020-12/OIG-21-12-Dec20.pdf>; In 2022 February and August Compliance reports, ODO found that Imperial staff did not maintain continuous monitoring of detainees on suicide watch as required by PBNDS. DHS Off. of Detention Oversight Division Compliance Inspection, Enforcement and Removal Operations ERO San Diego Field Office, *Imperial Regional Detention Facility, Calexico*, *California* (Feb. 14-18, 2022) at p. 12 < https://www.ice.gov/doclib/foia/odo-compliance-inspections/ImperialRegionalDF-CalexicoCA-Feb2022.pdf>; DHS Off. of Detention Oversight Division Compliance Inspection, Enforcement and Removal Operations ERO San Diego Field office, Imperial Regional Detention Facility Calexico, California (August 16-18, 2022) p. 7 at <https://www.ice.gov/doclib/foia/odo-compliance-inspections/imperialRegDetFacCalexicoCA_Aug16-18_2022.pdf> (as of Apr. 23, 2025).

professional counselor (LPC) administered the Columbia Suicide Severity Rating Scale (C-SSRS) at times, but that this service was offered inconsistently and was not always accurately scored.

In one case, the psychiatrist misjudged suicide risk repeatedly, resulting in multiple hospitalizations and re-entries to suicide watch. On hospitalization, the external providers consistently assessed the patient's diagnosis as more severe and increased the patient's medication dosage accordingly. On the patient's return, Imperial's psychiatrist reduced the severity of the diagnosis and/or the medication dose more than once.

When reviewing this case, Cal DOJ's mental health expert expressed concern about the psychiatrist minimizing risk in the progress notes. Although the patient repeatedly denied suicidal intent, they at times engaged in significant self-harm, including an intentional fall from the second tier of the unit. Additionally, several risk factors that were apparent from the record were omitted from the psychiatrist's calculations when he administered the C-SSRS.

Suicide Watch

At Imperial, 19 detainees were placed on suicide watch between January 2021 and March 2023. There is one suicide watch cell in the medical unit, and any medical professional at the facility can place a detainee on suicide watch. When more than one detainee requires suicide watch any additional detainees are sent to the hospital. Patients in suicide watch receive a physical assessment several times a day, usually every eight hours, by a registered nurse. The psychiatrist reported seeing detainees in suicide watch daily, as the PBNDS section 4.6 requires.[226] However, Cal DOJ's chart review indicated that a mental health provider only saw detainees in suicide watch every two to four days, which does not meet the standard of daily mental health care on suicide watch. The psychiatrist generally sees detainees on suicide watch via telepsychiatry, or in person in the medical area when the psychiatrist is onsite. Telepsychiatry is more common post-COVID, but requires clear documentation regarding how the provider is assessing the types of signs or symptoms that are hard to observe virtually, e.g. body language or hygiene problems. Such documentation was not present in the records at Imperial.

File review also revealed some cases of delay in care after self-harm behaviors and providers working outside the scope of their practice to cover said delays. Cal DOJ's medical expert noted one instance in which the medical Advanced Practitioner saw a detainee returning from a six-day self-harm hospital stay and ordered housing conditions and wellness checks, while the psychiatrist who should have ordered these conditions did not see the patient until the next day. The expert reported that this incident appeared to be isolated and not the common practice, yet is notable due to the elevated risk present just after inpatient hospitalization. For one detainee who experienced multiple hospitalizations, his medical chart noted several occasions in which appointments with the psychiatrist were delayed or did not occur, and the patient was eventually released from the facility while under active mental health care with no evidence of discharge planning.

At Imperial, only the psychiatrist is authorized to downgrade or discontinue suicide watch. Record review indicated the psychiatrist did not engage in standard practices to reduce risk during the critical period of transitioning from suicide watch back to the general population. Charts did not include a safety plan, and the provider did not schedule more frequent follow-up visits as is common practice in corrections settings.

226 ICE, PBNDS 2011 Section 4.3 Medical Care, Part V, p. 334.

Medical Care

In addition to the areas of review discussed in the *Access to Medical and Mental Health Care* section above, which implicated both medical and mental health care, Cal DOJ reviewed medical staffing and the quality of medical care, focusing on how this care impacts mental health concerns at Imperial.

Figure 27: Medical space with 3 beds

Medical Staffing

As was the case with mental health care staffing, medical staffing at Imperial also was insufficient to cover the needs of the detainee population. The onsite physician departed the facility in December 2022, which left a gap in services that impacted both medical and mental health care.

Existing medical staff at Imperial are dedicated but understaffing impacts health care service provision. PBNDS 2011 4.3.B requires that the Health Service Administrator, who manages health care staff and services at the facility, be a "physician or health care professional." The HSA at Imperial does not have a clinical background, but rather began as a medical secretary who reported working as the "right hand" of the previous Health Service Administrator and later took on the role. A Registered Nurse assists the Health Service Administrator with clinical issues. At the time of our site visit, this same nurse was covering many of the responsibilities that a Director of Nursing would while that position remained vacant pending the outcome of the required ICE background check.[227]

Imperial also lacked a Medical Director at the time of the visit, as the prior director who served from 2016 to 2022 had resigned but continued as an on-call backup physician. This vacancy means Imperial does not have a physician consistently available to treat physical disorders. Three RN positions are also vacant, resulting in shift coverage difficulties. However, nurses described the workload as being manageable within shifts, with the current population size.

A full-time dentist, dental assistant, pharmacy technician, and two medical records technicians were on staff. There was no dental hygienist position, though the dentist himself performed scaling and cleaning as verified in medical records.

227 ICE, *Personnel Vetting at Determinations at ICE* (Mar. 2025) <https://www.ice.gov/careers/vetting> (as of Apr. 16, 2025)

Chart review by Cal DOJ's medical expert suggested that the in-person chart review and supervision that the onsite physician had previously been performing was beneficial for appropriate evaluation, diagnosis, and treatment, particularly for patients with mixed medical and mental health conditions. One detainee who was showing some cognitive irregularity was in observation for two months, but the detainee was not referred to the ER for imaging and labs until 18 days after admission to medical housing when the onsite physician performed an in-person evaluation. Another patient began seeing one of the facility's Advanced Practitioners (AP) in November 2022, whose notes were limited in detail and did not include notes on differential diagnoses, which generally helps avoid treatment errors. The AP referred the patient to the on-call backup doctor for pain management in March 2023, at which time the doctor referred the patient to the ER that same day due to weakness, gait and balance impairment, and neurological abnormality; he required an emergency surgical procedure. In another instance, an AP ordered baseline labs for a detainee on hunger strike and set a plan to repeat labs in three months, despite receiving abnormal results in the context of an ongoing hunger strike. This oversight may have been identified by the supervising onsite physician if they were still working at Imperial.

Health care staff receive 40 hours of annual in-person training that includes topics related to mental health conditions that may be comorbid with other medical conditions. Covered topics include signs and symptoms of multiple mental health diagnoses, substance abuse and withdrawal, side effects of psychotropic medications, suicide prevention and intervention, impacts of isolation on mental health, and mental health first aid techniques. The training also included an audio representation of auditory hallucinations, which is a valuable training tool for building empathy for detainees experiencing symptoms of some severe mental illnesses. However, Imperial does not provide funding for continuing medical education or subscribe to clinical decision support tools, which would help ensure that providers stay current in their medical knowledge and would support staff licensing needs.

Quality of Medical Care

Quality of medical care was evaluated by Cal DOJ through review of in-facility treatment, including medical and mental health observation, availability of out-of-facility treatment, medications, and care for chronic conditions as observed in medical files and policies related to these issues.

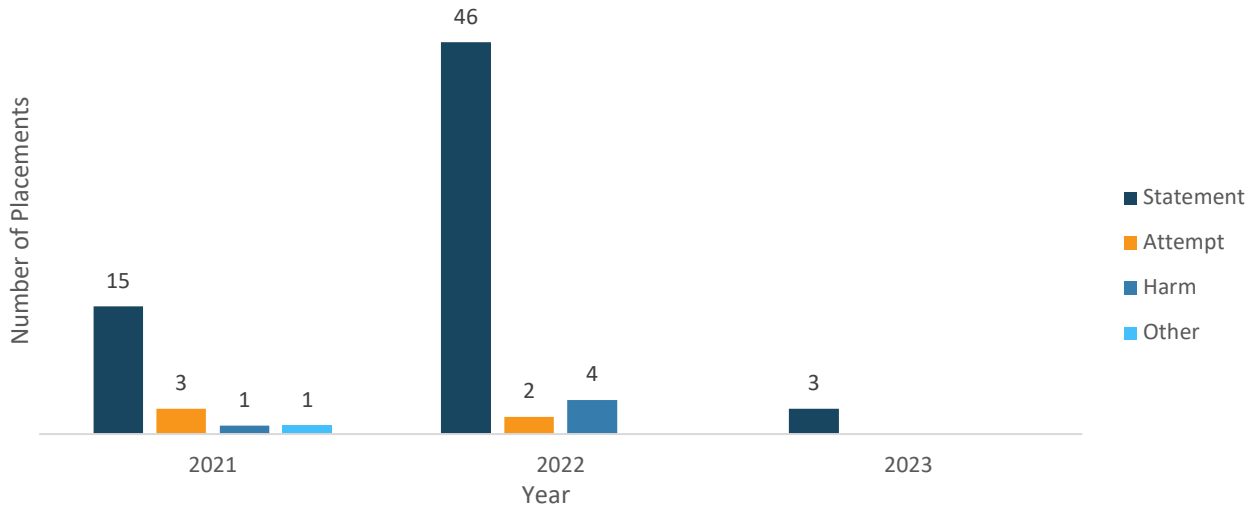
When a medical or mental health condition does not warrant transfer outside the facility, detainees can be placed in an observation bed for prolonged medical or mental health observation. Some detainees spent extended periods in the medical observation unit. At the time of Cal DOJ's visit, one detainee in the unit had been on hunger strike for about three weeks and had spent this entire period in medical observation. In contrast, record review indicated another detainee on hunger strike received much less health care attention. This individual was not monitored by health care staff until after the period in which they were most at risk of poor health outcomes. Another detainee's health records reflected that they had been in medical observation due to presenting with altered mental status and remained there for two months until they were deported.

Based on Cal DOJ's review of medical housing logs, during the January 2021 through March 2023 period, Imperial recorded 546 medical observation placements. In 2021, the top two reasons for placement in medical observation were COVID-19 (68%; 292 out of 431) and scabies (19%; 82 out of 431). In 2022, most medical observation cases concerned scabies (57%; 56 out of 99). As of March 2023, most cases involved scabies infection (five cases), retreatment (three cases), and tuberculosis testing (three cases). MTC has set aside housing at Imperial to be used in the event of a COVID recurrence. Cal DOJ's corrections expert noted this as a facility strength that exceeded the unclear requirements of the PBNDS.[228]

228 This may have been in response to findings in the 2021 report, in which Cal DOJ observed a failure to adequately prepare for communicable disease outbreaks at Imperial led to delays in court proceedings due to quarantine practices. *Immigration Detention in California* (Jan. 2021), *supra*, p. 87.

Within the same medical housing log, the facility recorded 104 occasions on which a detained person was placed in medical housing for mental health reasons, with some individuals experiencing multiple placements. The most common reason for placement in medical housing for mental health reasons was described as mental health observation (72%; 75 out of 104) followed by suicide watch (18%; 19 out of 104). A large majority (85%) of detainees who were placed on mental health observation were placed for a reason described as "statement," suggesting the detainees had likely shared a statement regarding thoughts of self-harm or the intent to harm themselves. The average length of stay in the mental health observation unit was one day.

Figure 28. Number of Placements by Year and Reason for Placement in Observation (One-on-One) Cell Watch, Imperial, 2021 to 2023 (February).[229]



Barriers to Health Care

Cal DOJ reviewed possible barriers that may affect the successful provision of health care or may otherwise exacerbate issues that prevent the successful provision of health care at Imperial. Specifically, Cal DOJ assessed: (a) detainees' knowledge of how to access care; (b) language access; (c) cultural competency; (d) privacy; and (e) facility culture as it relates to both mental health and medical services.

Language Access

The quality of language access at Imperial is mixed. Generally, the facility has policies and tools to provide language access and these appear to be provided in most cases. However, there are points of weakness around language/technological interface and housing barriers.

Language services appeared to be provided during standard medical and mental health appointments. According to the senior nurse, all but one of the nurses employed at the time of Cal DOJ's site visit were bilingual but the nurse did not specify in which languages. Chart review reflected documented use of language line services during intake screening encounters and psychiatry visits. Medical grievances were sometimes answered in Spanish. In interviews, all detainees who reported that they received teletherapy and answered a question about whether they could access interpretation services indicated that they could. However, one detainee reported that they were unable to communicate effectively with their mental health provider due to the poor quality of interpretation services.

229 Note: The numbers displayed in the chart do not represent unique individuals, but rather unique placements to One-on-One Watch. Detainees could be placed on One-on-One Watch multiple times for different reasons.

The growing use of tablets to provide detainees access to various facility functions, including enrichment opportunities, contact with families, and grievance and health care appointment requests, introduces additional language barriers. The tablets are by default loaded with only three languages: English, French, and Spanish. The tablet can support other languages, but the instructions to access them are provided only in English and Spanish. Detainees appear to rely on each other for help accessing the tablet functions when they do not know English, Spanish, or French or have poor literacy skills. Instructions for the phones in the residential units are also only posted in English and Spanish.

Cal DOJ encountered evidence during site observations and detainee interviews that interpretation services are used inconsistently. For example, it appears that it is possible for staff to use cell phones to access an interpreter line for communication with detainees who are placed in segregation, but uncertainty in detainee and staff responses suggest that this practice is not always followed. In interviews with Cal DOJ staff, multiple detainees reported instances in which detention officers did not make use of available interpretation services. Instead, detainees reported that officers used English or Spanish to give detainees instructions or orders, even when the detainee did not understand those languages, or they relied on other detainees to translate. Using detainees as translators is problematic because a detainee may not have the requisite language skills for this task, and the translation process may impact or be impacted by relationship dynamics among detainees.

Confidentiality and Privacy Concerns

Mental health clinical space at Imperial is located in the medical area and appeared sufficient during Cal DOJ's facility tour. Both the psychiatrist and detainees speaking to Cal DOJ reported that mental health visits are confidential. However, due to the lack of an on-site mental health provider, detainees in suicide watch are evaluated via telepsychiatry at the cell door, which compromises confidentiality in these particularly sensitive cases. The three attorneys representing clients at Imperial who responded to Cal DOJ's survey expressed concerns that mental health treatment locations were not fully private.

Facility Culture on Medical and Mental Health Services

Detainees as a group did not report ongoing problems related to the professionalism of medical staff or a broad practice of disrespect or neglect of mental health needs. During interviews with medical experts, detainees did not report any problems with the facility culture on health care services. Grievances reviewed by Cal DOJ's experts included one grievance reporting feeling generally shamed by mental health staff, and another reporting feeling shamed specifically related to sexual identity. Other grievances noted general instances of disrespect, and one grievance regarding medical staff professionalism was adjudicated to be founded.

During interviews, Cal DOJ staff asked seven detainees whether they felt staff treated them differently because of their mental health condition and received mixed responses. A majority (five detainees) reported that they did not feel that staff treated them differently. However, two detainees did report that they believed staff treat them differently because of their mental health condition.

Medical and Mental Health Quality Assurance Process

Cal DOJ's medical and mental health experts assessed the comprehensiveness and effectiveness of Imperial's quality assurance processes. The PBNDS state that the facility's Health Services Administrator is required to implement: a quarterly at minimum meeting at which the facility accounts for effectiveness of its health care program; a system of internal review and quality assurance; and an intra-organizational external peer review program for all independently licensed medical professionals, conducted annually.[230]

230 ICE, 2011 PBNDS, Part 4.3 Medical Care, Part V, § EE, pp. 279-280.

The lead nurse at Imperial regularly conducted chart reviews for quality improvement on specific care targets, which Cal DOJ's medical expert noted as one of the facility's areas of strength. Cal DOJ's medical expert reviewed files indicating that quality improvement meetings were happening. However, interviews with staff responsible for quality improvement did not indicate attempts made to develop corrective actions related to reducing risk of recurrence of overdose, medication hoarding for the purpose of overdose, and repeated suicide attempts.

Conditions of Confinement

Cal DOJ's review also looked at conditions of confinement at Imperial generally and assessed the extent to which they affect mental health and medical health care, including the following: security classifications and housing, discipline, use of restricted housing, use of force, programming/recreation and staff/detainee relations. Cal DOJ found issues with administrative segregation and disciplinary segregation practices and access to counsel, which persisted from the 2021 report.[231]

Classification and Housing

Security classifications are one major factor in determining a detainee's housing assignment and can impact access to other programs and services. Detainees typically are classified as low, medium-low, medium-high, or high security levels and will be held in a unit with similarly classified detainees.

Imperial's classification procedures had some areas of concern. One area of concern was the degree to which ICE custody classification levels and risk designations did not correspond. At the time of Cal DOJ's site visit, MTC reported approximately 500 detainees in custody of which 83% were classified high custody. However, census data provided by MTC on June 13, 2023 indicated a large majority of detainees had neither criminal arrest nor conviction history, and were determined to represent no threat by Cal DOJ's corrections expert. This discrepancy suggests a large number of detainees are held in conditions of detention that are more restrictive than warranted for their characteristics, such as in dorms with a lower degree of freedom of movement, which can negatively impact detainee mental health.

Insufficient staff training may be partially responsible for this outcome. The PBNDS Custody Classification System requires a formal classification system for managing and separating detainees based on verifiable and documented data.[232] Imperial applies an ICE scoring sheet that meets this requirement in some ways, but detention staff responsible for implementing the classification scheme do not receive special training. The lack of training may result in a corresponding lack of consistency and objectivity in the system as applied.[233]

Alleged Security Threat Group involvement (e.g. gang membership) may be over-assessed at Imperial. In turn, this overassessment may additionally drive classification to higher than warranted security levels. The PBNDS require that a facility consider only objective, verifiable proof of affiliation and a similarly objective, verifiable assessment that the affiliation is current and active.[234] At Imperial, detention officers rely on less formal sources of information, such as prior California Department of Corrections information, without a corresponding assessment of recency or accuracy. Detention officers also appear to assume that any tattoo indicates gang activity without sufficient substantiating information. Cal DOJ's corrections expert evaluated MTC's "Classification Security Threat Group Determination Guide" and found it insufficient to ascertain current, active gang involvement to a reasonable degree of certainty. Security Threat Group affiliation elevates classification scores, thereby increasing classifications levels, e.g. from Low to High. Therefore, any lack of accuracy in determining

231 *Immigration Detention in California* (Jan. 2021), *supra*, p. 64.
232 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part I, p. 60. Dora p. 9.
233 Intentionally omitted
234 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, § C, pp. 62-63.

such affiliation has profound consequences for a detainee. Detainees who receive an erroneous Security Threat Group identification may also experience negative impacts in their immigration proceedings related to subsequent bond hearings, eligibility for release on an alternative to detention, and even the outcome of their immigration proceedings.

Imperial's classification procedures had some well-functioning aspects, despite these concerns. Imperial appears to offer more opportunities to adjust to a lower classification, as compared to other facilities Cal DOJ reviewed. While ICE's scoring sheet only considered detainee's deficits, including immigration, criminal, and purported gang activity, Imperial staff reported conferring with ICE to request lower scores based on a detainee's good or improved conduct or participation in facility programming. In some instances, Imperial staff reported that reduction of score also triggered reclassification to a lower custody level consistent with the new score. However, MTC did not provide Cal DOJ with all the information needed to verify how frequently downward classification shifts occurred.

Discipline

Cal DOJ reviewed administrative segregation and other discipline-related protocols, reviewed disciplinary files, and interviewed detainees about their experiences with discipline. Imperial's processes appeared to function in general but demonstrated weaknesses that negatively impacted detainees with mental health conditions.

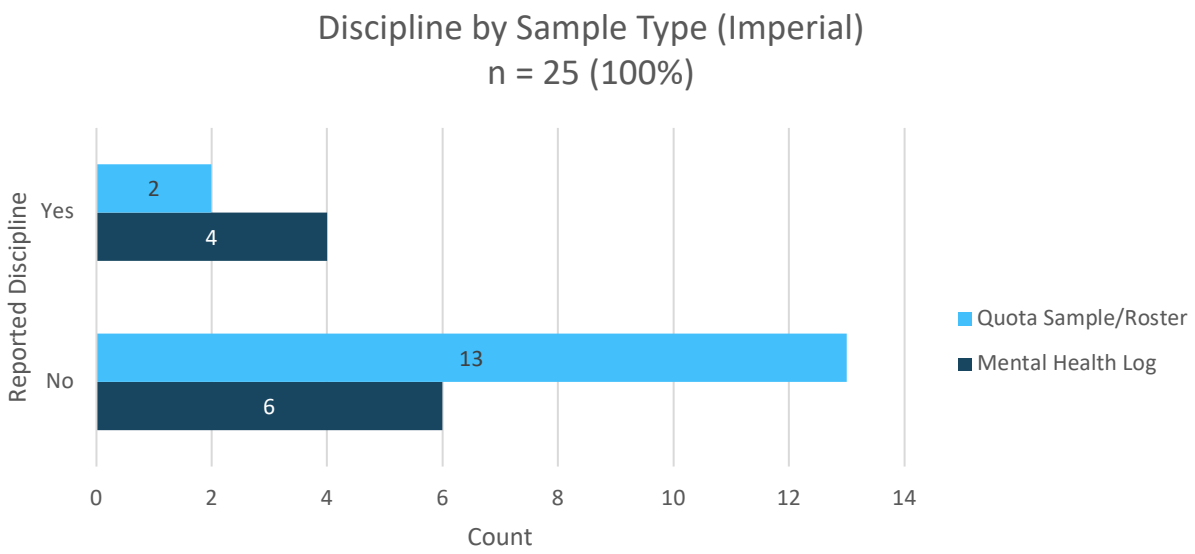
Mental health disciplinary reviews do not occur at Imperial which does not conform to PBNDS.[235] Prior to reviewing an alleged infraction and applying discipline, a mental health professional must be consulted to determine (a) whether the detainee is competent to participate in a disciplinary hearing, (b) whether mental health contributed to the alleged behavior, (c) whether there were any mitigating factors in regard to the behavior, and (d) whether certain types of sanctions may be inappropriate because they would interfere with supports that are part of the detainee's treatment or recovery plan.[236] Cal DOJ did not see evidence that these required mental health reviews were happening at Imperial.

Cal DOJ's review of facility logs and interviews with detainees who had been disciplined suggests that mental health impacted discipline. In a review of disciplinary logs cross referenced with mental health logs for cases between January 2023 and March 2023, Cal DOJ found that of the 97 recorded disciplinary incidents, 44 (45%) involved at least one detainee that the facility identified as receiving mental health care services, while 64 (66%) incidents involved detainees who were not receiving such services.[237] Notably, the 43 incidents linked to detainees receiving mental health care involved 18 individuals, whereas the 64 incidents involving detainees who were not, were associated with 58 individuals. When comparing these proportions, the findings suggest that detainees receiving mental health care faced disciplinary action at a higher rate, averaging 2.44 incidents per person, compared to 1.10 incidents per person for those not receiving such services.

When comparing the rates of reported discipline among detainees that Cal DOJ interviewed from the mental health roster and detainees that Cal DOJ recruited from the quota sample, a greater proportion of detainees from the mental health roster group reported receiving discipline. Four of ten detainees (40%) recruited from the mental health roster reported discipline, whereas only two of 15 detainees (13%) recruited from the quota sample reported discipline.

235 ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part II, p. 214.
236 *Id*. at Part II, §A, p. 216.
237 The total percentage of incidents exceeds 100% because some incidents involved multiple detainees, including both those identified as receiving mental health care and those who were not.

Figure 29. Discipline by Sample Type, Imperial



Two detainees who reported discipline to Cal DOJ staff elaborated on the relationship between the discipline and their mental health. The first detainee reported that they believed the allegations were the result of behaviors related to their mental health condition. The other detainee reported that discipline was the cause of their mental health concerns, stating "[b]eing disciplined led to my mental health problems, stressing, exchanging words with other detainees. I've been here too long. Some of the detainees know my condition more than the psychologist and they tell me to calm down."

Additionally, two detainees reported incidents in which religious disagreements with staff or detainee attempts to engage in a religious practice resulted in a disciplinary response, which is of concern, although some details in these reports made the core reason for the discipline unclear.

One well-functioning aspect of Imperial's discipline processes is the facility's general practice of evaluating the truth of allegations. Cal DOJ's corrections expert assessed that in five of the 12 months prior to the site visit, half or more of disciplinary write-ups resulted in a finding of not guilty. This finding bears contrary interpretations: on one hand, it is good that the facility shows some evenhandedness in evaluating whether an allegation justifying discipline is accurate. On the other hand, a high rate of not guilty findings suggests that facility personnel err on the side of over-discipline, which may negatively impact detainees' daily experience at Imperial even when the errors are ultimately corrected.

Restrictive Housing: Disciplinary and Administrative Segregation and Protective Custody

Placement in Restrictive Housing

Disciplinary segregation is a form of isolation used when a detainee violates detention rules or regulations. Administrative segregation separates detainees who may pose a threat to others. Protective custody provides for a vulnerable detainee to be housed separately for their safety.

Figure 30: Rows of closed cells in two story housing unit

Figure 31: Caged enclosure with a computer

As is true for the disciplinary process, the system of placing detainees in segregation at Imperial also benefits from a strong policy of regular internal reviews. Nonetheless, Imperial's segregation practices have elements that result in overly restrictive conditions for detainees. Imperial has an interdisciplinary Special Management Unit team that includes the Facility Administrator, Chief of Security, health care staff, and an assigned ICE staff member who meet weekly to track detainees placed in restrictive housing. This group considers the number of days the detainee has spent in the unit, their progress, and whether a less restrictive environment is feasible when evaluating segregation placements. Imperial has held these weekly meetings in each of the years that Cal DOJ has conducted its inspections. The meetings are a worthwhile endeavor, worthy of replication by ICE's other providers.

However, Imperial's segregation practices are not without problems. The same unit is used for detainees placed in administrative segregation, disciplinary segregation, and protective custody. All three categories have the same limited access to out-of-cell time, phones, outdoor recreation, and other services or opportunities, which is problematic because detainees in administrative segregation or protective custody are owed the same conditions as those in the general population.

Another issue is that Imperial fails to provide pre-segregation placement review by mental health staff when detainees are placed in restricted housing due to discipline, administrative segregation, or protective custody. This absence falls short of the PBNDS, which require such review to avoid negative health outcomes for detainees with mental health conditions who do not fare well in isolation.[238] Nurses do, however, assess detainees prior to placement, including some attention to mental health. They also provide wellness checks while the detainee remains in restricted housing. The psychiatrist performs an evaluation after placement, which may occur within three days but sometimes takes up to a week. The intention of this evaluation appears to be that the psychiatrist monitor any mental health issues, rather than to approve or deny the placement or make recommendations for accommodations. The psychiatrist may at that point say the placement is inappropriate, but the detainee may have spent up to a week in restricted housing already. This process defeats the purpose of PBNDS 2.12, which is intended to stop harm before it happens rather than mitigate the effects afterward.

In addition, Cal DOJ's analysis of data from mental health and restricted housing logs showed that segregation stays were longer for individuals present in Imperial's mental health logs compared to those who were not included in the logs. The average stay for a detainee present on the mental health logs was 23.55 days, while the average for others not on the mental health logs was 10.30 days. The size of the discrepancy between the two groups differed by type of restrictive housing and was particularly large for protective custody or for administrative segregation/security risk. Detainees on the mental health logs experienced four of the five longest stays in protective custody recorded by Imperial (141, 151, 175, and 401 days, with one stay of 161 days experienced by a detainee who was not on the mental health log). For stays due to administrative segregation/security risk, the longest stay (153 days) was by a detainee not on the mental health logs, but the two next longest stays (both 132 days) were by detainees present in the logs. Notably, the lengths of stay listed on the logs ranged from four months to over a year, which risks mental health complications for all detainees and poses increased risks for detainees who enter segregation with existing mental health conditions.

Mental Health Conditions and Treatment During Isolation

Through detainees' own reports, most individuals who were placed in segregation were seen by care providers and able to have existing treatments continue, with some exceptions. Chart review reflects weekly follow up by the psychiatrist and monthly re-evaluations. Of the six aforementioned detainees who reported placement in segregation, four reported that they were checked on by a health care professional, one reported that this check did not happen, and one was not asked. Two of these detainees reported that they continued to receive treatment in restricted housing, one reported they did not receive treatment; the others were not asked or the question was not applicable. Three of these detained persons reported that they continued to receive medication; the other three were not asked or the question was not applicable. Review of corrections records indicated that Imperial does conduct safety checks of detainees placed in segregation, but Cal DOJ could not ascertain whether checks occurred at the frequencies required by applicable standards.[239] Per PBNDS, medical personnel shall conduct at a minimum daily checks on detainees in special management units.[240]

In interviews with Cal DOJ staff, detainees shared negative perceptions of the impact of restricted housing on their mental health. All three detainees who were asked whether segregation impacted

238 ICE, PBNDS 2011, Part 2.12 Special Management Units, Part V, § P, pp. 182-183.
239 Id. at § M, p. 182.
240 *Id*. at § P, pp. 182-183.

their mental health said that it did. One detainee described the placement as "worse than prison" and stated it worsened the severity of their PTSD.

A DHS-OIG report following an unannounced inspection conducted in February 2020 described poor segregation conditions consistent with these negative detainee perceptions.[241] The OIG found that detainees placed in administrative segregation were kept in their cells 22-23 hours daily and that one detainee had been held in isolation for over 300 days. The report also noted that medical checks were insufficient to ensure proper medical care, and that medical grievances and responses were not properly documented. A lawsuit with similar allegations was filed at about the same time.[242]

Release from Restrictive Housing

Substantive reviews and reassessments occur weekly. As a result, some detainees serve less time for infractions than was imposed. Cal DOJ was unable to review data to establish how many detainees saw benefits from this approach, and to what degree. Nonetheless, the reviews and reassessments are a model practice that other facilities should emulate.

Some detainees had difficulty obtaining release from restricted housing, even when they struggled with mental health issues in segregated placement. Cal DOJ's mental health expert reviewed one case in which a detainee with PTSD and psychotic symptoms remained in restricted housing for eight months.

The expert was unable to assess the cause of the detainee being placed for that length of time and whether there was any relationship between placement in segregation and the detainee's mental health condition. Regardless, the expert believed it unlikely that an eight month placement would be appropriate given the mental health diagnosis. In another case reported by an attorney who responded to Cal DOJ's attorney survey, a detainee with a mental health diagnosis was placed in protective custody on facility advice upon arrival and was not able to obtain release from protective custody for over a year despite deteriorating mental health.

Use of Force

Cal DOJ reviewed records of 18 use of force incidents that involved 16 detainees between January 2021 and March 2023. The majority (83%; 15 out of 18) of these incidents were spontaneous uses of force while 17% were calculated, or pre-planned. Of the 18 incidents, eight (44%) involved a detainee present on the mental health roster.

As with discipline in general, mental health providers should review proposed planned uses of force when feasible. The review should assess whether mental health is a partial cause of the behavior in question and whether there are any indications that a use of force technique is not appropriate for a given detainee's mental health presentation. The Acting Director of Nursing shared that before a planned use of force, nursing staff are asked about any known prior injuries that the involved detainee has and to provide any other helpful guidance related to the use of force. Nursing staff do not provide opinions on mental health issues, and the Director of Nursing is not sure whether the former mental health staff were involved in this process from a mental health perspective at the time of their employment. The psychiatrist reported that he is called prior to a planned use of force and that he may be included to assist with de-escalation. However, this practice seems impractical and unlikely given that the psychiatrist works remotely.

241 Office of the Inspector General, Dept. of Homeland Security, *ICE Needs to Address Prolonged Administrative Segregation and Other Violations at the Imperial Regional Detention Facility* (Dec. 18, 2020), pp. 3-6 <https://www.oig.dhs.gov/sites/default/files/assets/2020-12/OIG-21-12-Dec20.pdf> (as of Apr. 16, 2025).

242 See *Vega v. Mgmt. & Training Corp.* (S.D.Cal. Apr. 19, 2023, No. 3:21-cv-1770-GPC-LR) ECF No. 76.

Prison Rape Elimination Act

The Prison Rape Elimination Act aims to reduce sexual abuse and assault in prisons and also applies to detention facilities. The law establishes a zero-tolerance policy for sexual misconduct in custodial environments and establishes various procedures to respond to allegations and support victim survivors.

At the time of Cal DOJ's visit, Imperial employed a dedicated PREA coordinator who reported being on call 24 hours a day, seven days a week. The coordinator was male and stated that a female backup investigator was in the process of being trained, after two to three months had passed without backup support. The coordinator's duties include investigations of PREA allegations, responding to any grievances related to sexual assault, conducting an annual staff training, and orienting new detainees. There was evidence of the coordinator taking initiative to perform job duties beyond minimum requirements; for example, he reported creating PREA materials in languages in which the materials were not initially available at the facility. The coordinator also appears to have created his own PREA screening instrument. This effort shows dedication to the role, but also raises concerns. The coordinator's custom tool has not been validated and is not evidence-based. It may both over- and under-identify individuals at risk of victimization or abusiveness. Cal DOJ's corrections expert recommended that Imperial discontinue use of this instrument and shift to using a screening method with a more established evidence base.

During detainee interviews and health care file review, Cal DOJ noted two instances in which sexual abuse allegations may not have been appropriately addressed. In one case, a patient with pre-existing post-traumatic stress disorder (PTSD) reported to the mental health provider that a sergeant had touched him while he was sleeping, and the provider did not initiate a PREA complaint. It also does not appear that the provider took steps to address the incident as a potential trigger for the patient's PTSD although the patient's symptoms were consistent with this possibility. Another detainee reported a negative experience with the ICE interviewer after making a PREA complaint, in which he experienced the ICE interviewer as aggressive. It is not clear from the information available whether any Imperial personnel were able to improve the detainee's interactions with representatives of ICE.

Staff and Detainee Relations

Imperial's pay rate for detention officers is unusually high, resulting in a greater pool of more qualified candidates, as well as higher retention, which over time creates a more experienced workforce. Cal DOJ's corrections expert also noted that detention staff at Imperial receive more frequent and higher quality training with more reinforcement than other facilities on average. However, it is unclear that the benefits of this stability accrue to detainees. Measures and evidence of the impact of this greater experience on staff detainee relations are mixed.

Cal DOJ's experts also reviewed staff training materials and found them generally appropriate but with some omissions. Cal DOJ's medical expert described the mental health training materials as including multiple slides of information on suicide risk factors and prevention, good empathy building techniques, "thorough and relevant" information regarding the impacts of isolation and segregation, communications guidance, and review of facility procedures and materials (e.g. cut down tools). However, the facility's Director of Nursing reported that there was no trauma-informed care training offered at Imperial.

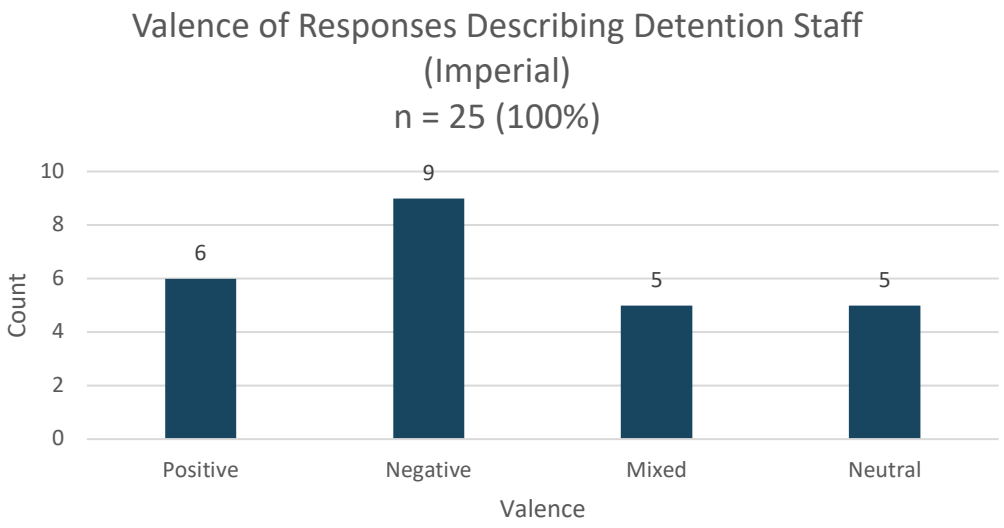
Detainees at Imperial can submit grievances related to conditions of confinement including health care by using a tablet or a paper grievance form. In December 2022, DHS CRCL began investigating of Imperial and four other facilities for allegations of retaliation for grievances.[243] A group of detainees had filed a CRCL complaint in September 2022 alleging, among other things, that multiple detainees

243 Information about the December 2022 investigation has been removed from the federal government's website.

received increased discipline including extended periods of placement in solitary confinement as retaliation for protected First Amendment activities such as filing grievances or otherwise advocating for improved conditions.[244] In an interview with Cal DOJ, the Facility Administrator stated he was unaware of an increase in grievances about retaliation, or of the investigation. Cal DOJ's corrections expert also raised concerns about the accessibility of tablets in order to file grievances, citing concerns about the small number of tablets available (only nine per unit), the language barriers to use as discussed in the *Language Access* section, and the cost to use certain functions (although detainees can submit grievances by tablet at no cost). During interviews with Cal DOJ staff, two detainees reported that they filed grievances against detention officers. One of these two detainees reported that they were told by officers to "forget about it."

Detainees expressed mixed impressions of their relationships with detention officers when discussing this topic with Cal DOJ interviewers. Among the 25 detainees who spoke with Cal DOJ, six (24%) described their interactions with staff as positive, and nine (36% as negative). Five of the 25 detainees (20%) described their interactions as mixed, involving some positive and some negative elements, and another five (20%) described their interactions in a neutral way.

Figure 32. Valence of interviewees' descriptions of interactions with facility staff, Imperial



Six detainees (24%) highlighted how their experiences vary between staff members. One detainee voiced this variety of experience, stating that "Like all people, there are good people who are doing their job and others who are abusing their power." Detainees who made statements relating to detention staff attitude were evenly split between those who provided positive descriptions and those who provided negative descriptions (three each of six detainees).

Detainees who discussed whether detention staff were respectful tended to have positive impressions. Of the eight detainees who talked about respect, five (63%) described staff as respectful, two (25%) described staff as disrespectful, and one (12%) reported mixed experiences.

244 Letter from Deyci Carrillo Lopez et al. to CRCL et al. (Sept. 12, 2022) Re: First Amendment Retaliation, Medical Negligence, Violations of Civil Rights, and Other Abuses Against Individuals in Immigration Detention at the Imperial Regional Detention Facility <https://www.ccijustice.org/laf-09-13> (as of Apr. 23, 2025); see also Morrissey, *Complaint Alleges Calexico Immigration Detention Officials Use Solitary Confinement as Retaliation* (Sept. 14, 2022) San Diego Union-Tribune <https://www.sandiegouniontribune.com/2022/09/14/complaint-alleges-calexico-immigration-detention-officials-use-solitary-confinement-as-retaliation> (as of Apr. 18, 2025) (See also tabs 3 and 16 in Imperial background portfolio.)

Detainees also shared clearly negative experiences and interactions with staff. A majority of detainees (75%, six of eight detainees) who discussed staff attentiveness described staff as dismissive, and a similarly large majority of detainees (80%, four of five detainees) discussing fairness described staff or their behavior as unfair. One detainee expressed frustration because he felt the staff were putting on a performance for Cal DOJ during the site visit and that staff generally did not interact positively with detainees or keep the facility clean to the degree that was happening while Cal DOJ was present.

Detainees also reported concerning aggressive or discriminatory behavior from detention officers. Seven detainees described instances of verbal bullying in the form of yelling, making overly harsh comments, or insulting detainees in a language they could not understand. Three detainees reported officers make fun of them for speaking their native language, or demand that the detainee speak English even though they could not. Two detainees expressed that Black or African detainees received mistreatment because of their race or national origin. Another two detainees independently described an instance when an officer made a gesture indicating that the African detainees smelled bad. Other instances of discrimination reported by detainees included being called a racist name, being told to go back to their country, and receiving hostile responses to practicing religion.

Due Process

Cal DOJ reviewed whether conditions at Imperial impacted due process, focusing on whether information regarding the *Franco-Gonzalez* settlement agreement was accessible. Although facilities are not responsible for detainees' immigration cases, Imperial must give detainees access to legal services and representation, as well as legal materials, legal calls, and mail. The facility must also provide detainees access to personal property related to their case.

While detainees at Imperial appeared able to receive a general level of access to counsel and court appearances, there remained obstacles to due process for detainees with language, mental health, or other barriers. Most detainees who participated in interviews with Cal DOJ reported having attended an immigration court hearing while detained at Imperial (20 of 25, 80%). However, the language access barriers described in the *Language Access* section have due process impacts in addition to the negative impact on daily experience at Imperial. Tablet usage requires some knowledge of English, French, or Spanish to understand instructions, and tablets are a source of case research and communication access with attorneys or family. Translations of key materials such as facility handbooks, orientation materials, signs, forms, and instructions were limited.

Most concerningly for purposes of Cal DOJ's mental health-focused review, a large majority of detainees (84%; 21 of 25) who spoke to Cal DOJ staff were not familiar with the *Franco-Gonzalez v. Holder* case, by which detainees diagnosed with certain serious mental illnesses have a right to be represented by counsel. The terms of the *Franco-Gonzalez* settlement agreement requires that the agreement be posted in public areas of the facility so that detainees can access the materials and understand whether they qualify as class members, and, if so, the scope of their rights under the agreement. During a facility tour, Cal DOJ did not observe *Franco-Gonzalez* materials consistently posted as required to ensure detainee awareness of potential eligibility. The psychiatrist indicated that he conducted referral appointments for detainees identified as possibly eligible and stated that detainees he determined to qualify would be "added to the list" but was somewhat vague about what happens to ensure detainees are informed of the determination and receive access to counsel.

Facility Focus: Otay Mesa Detention Center

Background and Summary of Key Findings

The Otay Mesa Detention Center (Otay Mesa) is a medium-maximum security facility operated by CoreCivic, a private prison company, in San Diego, California.[245] Otay Mesa contracts with Immigration and Customs Enforcement (ICE) to hold ICE detainees and inmates of the U.S. Marshals Service (USMS). ICE detainees and inmates of the USMS are held separately.

Otay Mesa was built in 2015 and expanded in 2021.[246] ICE granted a contract extension to CoreCivic in 2019, which provided up to $2.1 billion through December 2024 with two five-year option extensions through 2034.[247] Currently, Otay Mesa has a capacity for 1,142 ICE detainees, not including the medical and restricted housing units. ICE pays a guaranteed minimum of 750 detainee beds.[248] At the time of Cal DOJ's site visit, the population was above 750, so ICE was not paying for unused beds at that time. ICE detainees exclusively occupy a majority of housing units, which are separated by sex. CoreCivic's contract designates 1,142 beds for ICE detainees and 512 for individuals detained by the USMS.

At the time of Cal DOJ's site visit, people detained at the facility represented 61 different countries. The top ten countries represented were Uzbekistan (272), Mexico (162), Russia (128), El Salvador (66), Georgia (62), Guatemala (54), Tajikistan (50), Honduras (46), Colombia (36), and Brazil (27). This distribution marks a change from Cal DOJ's 2021 report, which identified the top three countries as Mexico, Cameroon, and China.[249] Detainees at Otay Mesa as of September 2023 ranged in age from 18 years old to 67 years old, with the highest percentage of detainees present being within 30-39 years of age. The majority of detainees present at the facility were newer to Otay Mesa with lengths of stay that fell within the one to 30 day category (52%; 622 of 1,187 detainees). However the average length of detention was 61 days and at least one detainee had been held at the facility for 1,693 days.

Table 10. Key Data Points, Otay Mesa

Facility:	Otay Mesa
Operator:	CoreCivic, Inc.
Housing Detainees Since:	2015
Bed Capacity:	1142
Type(s) of Detainees Facility Can Hold:	Female and Male Adults
Snapshot of Detainees Housed at Otay Mesa on September 19, 2023	
No. of Countries of Origin:	61
No. of Detainees by Sex[250]:	Female: 169 Male: 1018
Average Age:	35
Average Length of Detention:	61 days
Longest Length of Detention:	1693 days

245 Intentionally omitted
246 *Immigration Detention in California* (Jan. 2021), *supra*, p. 97.
247 Spagat, *US Awards Immigration Detention Contracts in California* (Dec. 23, 2019) Associated Press <https://apnews.com/article/immigration-us-news-ap-top-news-laws-gavin-newsom-93eac7079a98796451266dd805451539> (as of Apr. 18, 2025).
248 ICE, DHS, Budget Overview Fiscal Year 2022 Congressional Justification, p. 118 <https://www.dhs.gov/sites/default/files/publications/u.s._immigration_and_customs_enforcement.pdf> (as of Apr. 18, 2025).
249 *Immigration Detention in California* (Jan. 2021), *supra*, p. 14.
250 Facility logs do not report transgender status.

Cal DOJ conducted a three-day site visit at Otay Mesa in September 2023. Cal DOJ was not able to view all housing units due to time constraints, but CoreCivic was generally cooperative with Cal DOJ's review of the facility. Cal DOJ's review focused on: (1) mental health care; (2) medical care; (3) barriers to accessing these services; and (4) conditions of confinement more generally, including security classifications, discipline, restrictive housing, use of force, staff and detainee relations and the impact of these conditions on detainee wellbeing.

Cal DOJ's review resulted in the following key findings regarding Otay Mesa:

- Inadequate staffing impacted the quality of services available for both mental health and medical care which in turn resulted in detainees feeling care was ineffective. Mental health services were particularly limited due to insufficient staffing.

- Both mental health and medical records were not properly updated and maintained to ensure that providers were offering appropriate referrals or providing treatment to address detainee needs and to resolve ongoing health concerns.

- Mental health and medical providers did not engage in necessary multidisciplinary treatment planning to ensure coordinated care.

- Suicide prevention and intervention practices were insufficient to address suicide risks and did not offer adequate protections to detainees experiencing mental health crises.

- Quality assurance measures were not fully implemented for medical providers, and mental health staff were not a part of quality assurance review processes.

- Security classification protocol was not applied consistently, which impacted detainee experience and overall conditions of confinement.

Otay Mesa improved upon some of the issues identified by Cal DOJ in the 2021 report, including the 1) facility layout, which no longer prevented timely and adequate delivery of health care and other services, 2) PREA prevention practices, which did not appear to compromise access to health care, and 3) language access measures that improved across the facility.[251]

Methodology and Limitations

Cal DOJ arrived at its findings after observing conditions at a site visit, interviewing detainees and facility staff, reviewing documents provided by CoreCivic, and analyzing survey responses from attorneys and legal services providers who had worked with detainees held at Otay Mesa. In preparation for the site visit, Cal DOJ submitted a request to CoreCivic for pertinent records and documents from the facility and held a pre-site visit meeting with CoreCivic counsel and Otay Mesa staff on September 7, 2023.

Cal DOJ staff and experts visited the facility from September 19-21, 2023. During the site visit, Cal DOJ toured the facility, observed shift briefings and other routine operations, and interviewed executive staff, operational managers and department heads, medical and mental health care providers, detention staff and supervisors, and detainees. Cal DOJ's medical expert, mental health expert, and Cal DOJ staff reviewed health care records, and Cal DOJ's corrections expert and Cal DOJ staff reviewed custody and use of force files.

251 *Immigration Detention in California* (Jan. 2021), *supra*, pp. 98-99.

Cal DOJ interviewed 33 detainees through standard interviews by Cal DOJ staff and nine additional detainees participated in targeted interviews by Cal DOJ experts related to their areas of expertise. Detainees who spoke with Cal DOJ staff and experts came from 20 different countries and spoke eight different languages: Arabic, Armenian, Dari, English, French, Georgian, Ixil, Pashto, Jamaican Patois, Russian, Somali, Spanish, Tigrinya, and Uzbek. All interviews were conducted in the detainee's preferred language by fluent interviewers and/or with the assistance of a language line.

To support the mental health focus of this review, Cal DOJ selected detainees to be interviewed using two methods: (1) based on the detainee's appearance in mental health logs provided by Otay Mesa; and (2) a quota from the general facility roster excluding detainees who appeared on mental health logs and by subregion of origin to ensure participation of a broad range of detainees. Four attorneys who represented 16 clients with mental health conditions or reported symptoms at Otay Mesa between January 1, 2021 and March 3, 2023, and a combined 282 clients at Otay Mesa throughout their careers, also responded to Cal DOJ's attorney survey.

Access to Medical and Mental Health Care

Cal DOJ evaluated Otay Mesa's systems of providing health care for ease of access to medical and mental health care services, both at intake and during detention generally. Review also focused on continuity of care between facility providers, external providers of any health care the detainee received before or after detention, and providers of any offsite care that was required during detention. Cal DOJ also considered reports from detainees or other evidence of detainee understanding of the facility's system of accessing care.

Intake and Mental Health Screenings

Upon arrival at Otay Mesa, detainees receive a comprehensive medical and mental health screening by an Advanced Practitioner (nurse practitioner or physician assistant) within the first 12 hours of detention, as required by PBNDS.[252] The screening intake form included explanations to facilitate detainee understanding because the wording was sometimes difficult to understand. The mental health portion of the intake screening document included questions on prior mental health care, hallucinations, substance abuse, sexual offenses, victimization, and/or "serious problems" the detainee would like to discuss with mental health staff.[253] Most detainees that Cal DOJ staff interviewed (64%; 21 out of 33), reported that they had been asked questions about their mental health upon arrival to Otay Mesa, while eight (24%; eight out of 33) reported they were not asked, two (6%; two out of 33) were unsure, and two were not asked this question. Cal DOJ's review of health records also showed at least one case in which a detainee's serious mental health condition was missed at intake. One detainee who had been diagnosed with a serious mental illness documented in prior records did not report their diagnosis at intake. The diagnosis was not identified until the records were reviewed by medical staff and reported to the Health Services Administrator (HSA) for referral to the psychiatrist.

Cal DOJ observed that in cases when a mental health concern was identified during intake, medical staff referred detainees to the mental health nurse for a mental health evaluation and the mental health nurse scheduled the detainee for assessment by the psychiatrist. Staff also described that individuals identified at risk for self-harm or more immediate safety concerns were placed in a safety cell, pending a consultation with the psychiatrist. The mental health nurse reported a practice of identifying and confirming existing prescription medications with the psychiatrist or other providers. This practice was intended to ensure there were no lapses in medication prior to the psychiatric evaluation. However, through chart review, Cal DOJ's medical expert identified one detainee who reported use of psychotropic medication upon arrival but did not see the psychiatrist for 16 days.

252 ICE, PBNDS 2011, Part 4.3 Medical Care, Part II, p. 258.
253 *Id.* at Part V, § J, pp. 266-268.

Access to Mental Health Care During Detention

Figure 33: Medical clinic entrance

During detention, detainees or staff may initiate medical or mental health care requests and any health care provider may refer detainees to receive additional types of care. Detainees receive orientation materials during intake that provide information about how to access health care. For illiterate detainees, CoreCivic policy provides that staff read orientation materials aloud to them or show a video as an aid. Detainees primarily make requests for medical or mental health care on paper. They can access both medical and mental health forms in their housing unit, prepare the request, and drop it into a lockbox in the housing unit to ensure confidentiality. Staff reported that forms are collected and reviewed in the individual housing units by a registered nurse each night at midnight. Mental health requests may also be scheduled with the mental health nurse during the weekdays.

The process at Otay Mesa during this site visit marked an improvement from Cal DOJ's 2021 report. Cal DOJ previously found that detainees had difficulty submitting requests during the limited hours of 5:00 a.m. and 6:00 am and that some detention officers deferred requests for care to the following day if the request was made after 6:00 a.m.[254]

While staff reported that the mental health nurse reviews detainee mental health requests, detainees shared that a mental health specialist also responded to requests with a face-to face visit. Cal DOJ's mental health expert was particularly concerned about this practice because triaging mental health requests requires clinical decision making, but the mental health specialist was not a licensed health care provider who is qualified to do so. When asked, the mental health specialist stated their role in requests was limited to providing information to detainees.

Similar to Cal DOJ's 2021 report findings, Cal DOJ again observed that detainees with mental health needs were not always referred for appropriate treatment or follow up care, even after documenting

254 *Immigration Detention in California* (Jan. 2021), *supra*, p. 123.

relevant issues.[255] During file review, Cal DOJ found that when the mental health nurse did not regularly make mental health referrals after documenting serious mental health histories in patient notes, such as past suicidal thoughts, suicidal plans, or acts of harm. When there was a referral, Cal DOJ's file review showed that a former psychologist, who provided services at Otay Mesa for about two years, repeatedly attributed mental health symptoms to malingering to influence the immigration process and did not address the patient's needs. These limited mental health visits also created gaps in identifying history of trauma or sexual abuse. Detainees were not asked follow-up questions related to trauma or sexual abuse, which resulted in deficient screening and identification of post-traumatic stress disorder.

Cal DOJ reviewed Otay Mesa mental health referrals for detainees with existing psychiatric medication prescriptions, a history of mental health hospitalizations, a history of hallucinations, or sexual victimization. Cal DOJ's medical and mental health experts found that generally detainees were set for routine follow-up from between two to 14 days after intake was completed.[256]

Access to Medical Care During Detention

Detainees access medical care services using the same methods they use to access mental health care. Detainees may also submit requests through electronic tablets in the housing units, which allows for immediate review by the night shift nurse who schedules appointments in the clinic or medical rooms located in the housing units. Nursing staff shared that medical requests were most frequently made with the paper forms, which are dropped in a locked box and reviewed by the evening nursing staff. Two detainees who identified as illiterate shared that they request medical attention through the paper forms, which Cal DOJ presumed were completed with the help of other detainees or staff. The charge nurse reported that medical requests are typically addressed within 72 hours, although the Health Services Administrator noted that the staff aimed to see detainees within 24 hours.

The medical unit is equipped to provide chronic primary care service, emergency evaluations, dentistry and dental hygiene, and X-ray services. Otay Mesa's medical unit includes housing, which consists of two dorms with nine beds each and 14 single cells for medical observation.

Otay Mesa's medical unit is not staffed to provide more acute care to individuals on intravenous medications or those requiring individual assistance with activities of daily living. Detainees with serious medical needs are transported to local hospitals for appropriate care. Specialty care such as gastroenterology, neurology, physical therapy, optometry, and ophthalmology requires referrals to off-site community providers. Health staff also reported that medication assisted treatment for opioid addiction (e.g., suboxone) is not allowed to be prescribed at Otay Mesa. Medical providers are certified to offer this treatment but care is limited to overseeing a process of tapering medications and supporting withdrawal symptoms for patients who have already been prescribed medication-assisted treatment when they arrive at the facility.

The medical director reported that the medical team met monthly to review patients on the medical watch list, which includes patients deemed "medically complex" such as individuals with chronic conditions. These patients were referred to community specialists outside of Otay Mesa as needed.

255 *Id.* at p. 126.
256 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § J, pp. 266-267.

Figure 34: Medical exam room

Detainee Knowledge of How to Access Medical and Mental Health Services

Cal DOJ found that detainees were mostly familiar with the process for accessing mental health and medical care and interpretation services. Most detainees interviewed by Cal DOJ (21 out of the 26 who were asked, 81%) indicated that they were familiar with how to request mental health care at Otay Mesa. However, detainees expressed concerns about requests for care made using the tablets. Due to issues with the software for the tablets, requests did not connect with the electronic health system. Thus, medical records did not reflect the details of a request or frequency of requests if detainees used tablets to request health care assistance.

Continuity of Care

Continuity of care describes the 1) consistency of follow up care for detainees after entering Otay Mesa, arriving from other facilities, returning to the facility from the hospital or other specialty care, and upon departures from the facility, 2) access and use of information from medical records, and 3) discharge planning as detainees prepare to transfer or be released from Otay Mesa. Cal DOJ used medical records and interviews with staff and detainees to assess practices and protocols impacting continuity of care.

When applicable, mental health evaluations include a referral to the psychiatrist to approve bridge medication or a temporary prescription to permit existing medication to continue pending further assessment by a medical provider. This practice addresses existing mental health needs by continuing prescription medication plans for newly arrived detained persons.

When a detainee returns from offsite treatment or hospitalization, nursing staff conduct an assessment of vital signs and contact the medical records technicians to obtain records, if not yet available. Detainees are then admitted to the Medical Housing Unit for follow up.

Cal DOJ was concerned by inconsistencies in continuity of care for some detainees with mental health conditions at Otay Mesa. Cal DOJ found that discharge summaries related to mental health hospitalizations were relayed verbally to the psychiatrist rather than formally recorded for the medical chart. Cal DOJ observed in one detainee's file that, after referral to a local hospital, the psychiatrist had minimal communication with the psychiatric hospital providers, to the extent that the hospital providers did not understand the goals for hospitalization. As a result, the detainee was rehospitalized due to lack of appropriate follow-up care. Notes from the Otay Mesa referring provider should have included concerns or other issues to inform the hospital staff of the patient's status. This example highlights why mental health providers must accurately document and communicate observations, diagnoses, treatment plans, and objectives to ensure consistent and effective care.

Further, detainees' complete health records did not appear to be accessible or maintained by mental health or medical staff. Despite holding detainees for over three years in some cases, prior health records for detainees held before September 2020 were not accessible to Otay Mesa staff in violation of PBNDS, which requires that all health records be maintained by the Health Services Administrator and organized uniformly in accordance with accreditation standards.[257] This deficiency was in part attributed to CoreCivic taking over medical services from ICE Health Services Corps (IHSC) in 2020. It was not made clear to Cal DOJ or its experts why CoreCivic was unable to access or maintain these records established under IHSC operations, which should have been addressed at the time of transition.

While CoreCivic's policies detailed how forms should be prepared for detainees upon discharge from Otay Mesa, Cal DOJ found that appropriate discharge planning was not happening, despite PBNDS requirements and related policies. PBNDS requires that all detainees who have received medical care, including mental health care, be provided a discharge plan, which includes a summary of medical records and medically necessary documentation, a set supply of essential medication, and referrals to community-based providers, if appropriate.[258] It was also not clear whether family or counsel were notified of any discharge plans in the case of either removal or release.

Mental Health Care

Cal DOJ conducted a comprehensive review of mental health population characteristics and quality of services offered at Otay Mesa through review of facility data and selected medical files for mental health diagnoses and psychotropic medication use, logs related to placement in the medical unit for mental health and suicide watch, and logs related to use of force and placement in restrictive housing. This section of the report details mental health care provided to the detainees and discusses practices with respect to (1) staffing, (2) assessment of mental health needs, (3) treatment planning, (4) psychiatric care, (5) therapy and non-medication interventions, and (6) suicide prevention and response.

As noted in the 2021 report, CoreCivic has been responsible for mental health services at Otay Mesa since September 2020.[259] During the site visit for the 2021 report, Otay Mesa staff reported that the facility received detainees with serious mental illness who cannot be treated at other local detention facilities.[260] However, this statement did not appear to be the case at the time of Cal DOJ's site visit in 2023. In the 2021 report, Cal DOJ identified issues with Otay Mesa's provision of mental health care, including: failure to refer for mental health concerns, underdiagnosis of detainee mental health conditions, substandard treatment for medication monitoring, inadequate treatment plans, and isolation of detainees with mental illness. Cal DOJ continued to monitor and observe these issues during the current review, and many persisted. Some areas of concern from the 2021 report appear to have improved, such as availability of prescription medication to treat mental health conditions,

257 ICE, PBNDS 2011, Part 4.3 Medical Care, Part BB, § 1, p. 277.
258 *Id.* at Part II, § 5, p. 258.
259 *Immigration Detention in California* (Jan. 2021), *supra*, p. 121.
260 *Ibid*.

confidentiality, and language access. These issues will be covered in detail in the following sections.

Mental Health Staffing

At the time of Cal DOJ's 2023 visit, Otay Mesa's mental health unit was staffed by one full-time psychiatrist, one part-time psychiatrist, one mental health specialist, and one mental health registered nurse. A new psychiatrist had been hired at the time of Cal DOJ's visit to fill a full-time position and staff noted this position would provide care on the weekends. A former full-time psychologist resigned in July of 2023 and the position remained vacant as of September 2023.

Otay Mesa's full-time psychiatrist and part-time psychiatrist only saw patients through telehealth appointments. The part-time psychiatrist covered one eight-hour shift. The newly hired psychiatrist was expected to take over for the part-time psychiatrist, who would be phased out of the mental health team.

Two mental health professional positions, which could be filled by licensed social workers or marriage and family therapists, had been vacant for approximately two years at the time of Cal DOJ's 2023 visit. Health care administrative staff reported that the lengthy background check process required by ICE posed an obstacle to hiring, as promising candidates who received offers of employment accepted positions elsewhere while waiting for approval to begin work.

Otay Mesa is the only facility whose mental health staffing includes a mental health specialist with administrative duties tailored to improving mental health care operations. Responsibilities include tracking detainee mental health requests and facilitating appointments, coordinating interpretation services, attending committee segregation reviews, and tracking whether a detainee attends appointments and takes prescribed medications. This role is not intended to be a health care service provider and is currently filled by an individual who had previously served as an officer at the facility. Cal DOJ observed the person in this role to have enthusiasm for the job, to appear to have good rapport with other staff and detainees, and to overall improve service delivery at Otay Mesa especially in the context of existing clinical staff shortages. However, Cal DOJ had concerns that, likely due to staffing shortages, some of the functions assumed by this role involved clinical determinations that should be performed by a licensed mental health provider. Cal DOJ observed that the role's responsibilities included reviewing and responding to confidential detainee requests for care including making triage decisions when required, conducting medical treatment rounds, and participating in decision-making that occurred during weekly mental health segregation review meetings.

Figure 35: Medical Unit Hallway

Mental Health Assessment

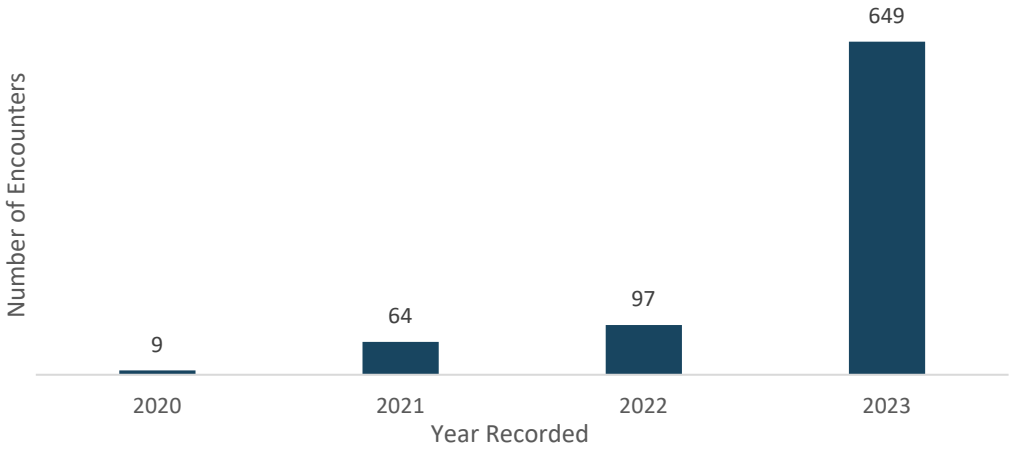
Cal DOJ reviewed records for the prevalence of mental health concerns and mental health evaluations and diagnoses.

Prevalence of Mental Health Concerns

Cal DOJ reviewed detainee population information to ascertain the type and frequency of mental health concerns that detainees experience while in custody at Otay Mesa. Data from CoreCivic showed that between January 2021 and August 2023, there were at least 612 mental health related diagnoses, although the records did not identify the number of detainees with a mental health diagnosis at the time of Cal DOJ's visit. The most common mental health conditions identified included voluntary starvation, anxiety, depression, post-traumatic stress disorder, adjustment disorder, and psychosis.[261] More specifically, the top three mental health-related diagnoses appearing in the facility log of mental health disorders were voluntary starvation (255 of 612 diagnoses), anxiety (139 out of 612 diagnoses), and depression (91 out of 612). Two hundred forty-four detainees who were held at the facility at any point between January 2022 and August 2023 had received mental health services, as documented in the number of encounters, which included detainees engaged in repeated visits, as shown in **Figure 36**.[262] Based on data provided by CoreCivic, 33 detainees were receiving psychotropic medication at the time of Cal DOJ's site visit.

261 The mental health diagnoses records did not account for detainees with multiple diagnoses, so Cal DOJ was unable to identify the number of detainees with a diagnosis.
262 Information regarding the specific mental health condition or symptom that led to the mental health services encounters was not included in the log.

Figure 36. Number of Encounters by Recorded Year of Mental Health Encounter, Otay Mesa, Active Detainees January 2022-August 2023.



Mental Health Evaluations and Diagnosis

When a detainee is identified for a mental health evaluation at intake or during detention, they are scheduled for an evaluation with the psychiatrist. Cal DOJ staff and experts observed that follow-up with mental health staff occurred between two to fourteen days after the referral, which was beyond the time limits set by PBNDS standards.[263] The psychiatrist conducted all evaluations via telehealth appointments, which were facilitated in-person by the mental health nurse and the mental health specialist. The Clinical Director shared that there is no separate process for periodic screenings by mental health staff after a mental health issue was identified or diagnosed.

File review showed that diagnoses were set and documented in medical records by the psychiatrist. However, in some cases the documentation suggests inattention to the diagnostic process. For example, in some charts, criteria for some diagnoses were not established in the documentation, and in others the symptoms listed did not support the diagnosis on record. Medical records showed that one detainee engaged in over a dozen mental health visits before being diagnosed by the psychiatrist, despite having disclosed traumatic life events and psychological symptoms during several of those visits. At least one detainee reported that, during their mental health evaluation visit, the psychiatrist focused only on medications to the exclusion of other types of care that may have been more appropriate.

Treatment Planning

Effective mental health care requires that the provider engage in treatment planning that corresponds to the patient's diagnosis and includes evidence-based interventions that are expected to alleviate the patient's symptoms or provide coping strategies for symptoms that remain. It also requires quality multidisciplinary treatment planning or coordination of treatment between mental health and medical providers and other staff interacting regularly with the detainee, to ensure existing diagnoses and plans are shared and consistently addressed by all practitioners.

At Otay Mesa, mental health treatment plans are created by the psychiatrist and generally include details on medication, education, and follow-up care. However, record review showed that providers did not consistently create written treatment plans, and that the psychiatrist did not always include treatment goals in the plans even though these goals were written in patient charts, particularly those involving psychotropic medications.

263 ICE, PBNDS 211, Part 4.3 Medical Care, Part V, § O, pp. 269-270.

Cal DOJ's 2021 report highlighted that medical files did not include patient signatures to confirm their awareness and approval of treatment plans, which should be created collaboratively with the patient and provide direction in addressing and improving mental health conditions.[264] This documentation continued to be absent during the 2023 visit.

Cal DOJ observed that collaboration between mental health and medical staff at Otay Mesa was limited. Although medical and mental health staff conducted virtual case conferences weekly, no written treatment plans resulted from these meetings. Due to this lack of collaboration, Cal DOJ observed multiple individuals who remained isolated in the medical housing unit for months without adequate psychological care while demonstrating mental health symptoms. The PBNDS requires that any detainee needing close or chronic medical supervision shall be treated in accordance with a written treatment plan.[265]

Psychiatric Care

Cal DOJ reviewed the facility's provision of psychiatric care and related prescription protocols for individuals with mental health conditions. Consistent with the 2021 report, Cal DOJ remained concerned by the limited treatment options for individuals with diagnosed mental health conditions and deficiencies in medication monitoring but noted improvements in medication formulary and management of detainee consents.

Medication Distribution

Otay Mesa receives formulary medications pre-approved by Immigration Health Services Corporation (IHSC) by mail from the facility's pharmacy supplier and stores them in the on-site pharmacy. The Health Services Administrator reported that facility personnel may readily access additional supplies by same-day pick up from other local pharmacies. The Clinical Director explained that external pharmacy pick up is allowed for continued dosing of non-formulary or unapproved medication while staff wait for non-formulary approval. This practice was an improvement from the 2021 report, wherein Cal DOJ found inadequate formulary and stock medications.[266]

For detainees with prescriptions to address mental health conditions, pill pass appeared to be routinely conducted four times daily. Cal DOJ staff observed that nursing staff administered prescription doses and engaged courteously with detainees, addressing medication refusal by detainees with a brief discussion. Nursing staff completed mouth checks to ensure medications were swallowed and not pocketed for use as contraband or for a possible suicide attempt.[267]

Psychotropic Prescribing and Medication Management

Cal DOJ's review of prescribing practices at Otay Mesa as reflected in detainee medical charts revealed several issues. The psychiatrists did not consistently monitor, at appropriate intervals, whether the prescribed dosage had the desired treatment response or, conversely, excessive side effects. The CoreCivic Mental Health Services Policy included reference to the PBNDS requirement that detainees who are prescribed psychotropic medications be "regularly evaluated by a duly licensed and appropriate medical professional at least once a month to ensure proper treatment and dosage."[268] However, file review showed that evaluations were not happening at that frequency, and it appears the facility policy was to hold such evaluations approximately every 90 days. One detainee experienced substantial weight gain on an antipsychotic medication, as noted by the Assistant Physician, but this side effect was not addressed by the psychiatrist for eight months. In another case, mental health staff

264 *Immigration Detention in California* (Jan. 2021), *supra*, p. 128.
265 ICE, PBNDS 2011, Part 4.3 Medical Care, Part IV, § W, p. 273.
266 *Immigration Detention in California* (Jan. 2021), *supra*, p. 128.
267 ICE, PBNDS 2011, Part 4.3 Medical Care, Part II, p. 259.
268 Intentionally omitted

did not follow up with a detainee who started antipsychotic medication over a month before their release.

Cal DOJ found that psychotropic prescriptions were sometimes prescribed over or under the Food and Drug Administration's (FDA) recommended doses without an adequate clinical explanation in the patient's medical file. As a result of over prescribing, detainees experienced predictable side effects including dizziness and weight gain, which should have been monitored in the individual's medical file notes. One example of overprescription is the aforementioned detainee who experienced significant weight gain after starting antipsychotic medication, which was not addressed until eight months after starting the medication. Other detainees were prescribed unusually low doses of antidepressants or other medications to address symptoms of depression, anxiety, and trauma. Typically, when starting with a low dosage, a psychiatrist monitors whether the low dose is effective, maintains notes reflecting evaluation of the treatment response, and increases the dose for patients not showing improvement. In patient records, levels started low and were left at those levels without explanation.

Laboratory and AIMS Testing

When prescribing antipsychotics and mood stabilizers, laboratory tests are typically required to establish a patient's baseline, rule out medical causes of the patient's symptoms, and identify developing adverse medication effects. Abnormal Involuntary Movement Scale (AIMS) testing is also necessary to monitor whether a patient is developing tardive dyskinesia, a severe physiological side effect of some antipsychotic medications that can be addressed if caught early but that is rarely reversible once it progresses. Providers at Otay Mesa did not appear to order such labs or conduct AIMS testing to establish whether detainees demonstrated improvements or harmful side effects after beginning psychotropic medications, which would indicate a need to discontinue the prescription. In one patient file, upon starting antipsychotic medication there were records of baseline AIMS screening, but no initial labs were ordered for monitoring as part of medication management.

Documentation

Cal DOJ identified several aspects of mental health documentation that required improvement, including the quality of mental health records, the watchlist used to monitor detainees with mental health conditions, and documentation of detainee consent to prescription treatment.

Through review of detainee medical files, Cal DOJ's experts observed that providers cut and paste language from prior visits or another provider's progress notes rather than document the relevant detainee evaluation and care that occurred during the visit being documented. Treatment goals also appeared identical across detainee files, raising concerns about the quality of evaluation and care that occurred during visits.

Additionally, Cal DOJ found that while diagnoses were documented, providers did not always describe the criteria supporting the diagnosis, which is important information for future providers when considering alternative diagnoses as needed and to monitor improvement or lack thereof as treatment progresses.

Although the psychiatrist created a mental health watchlist to track detainee conditions, the list was often not documented or used effectively. The psychiatrist was unable to explain who qualified for the list and Cal DOJ encountered no discernable standards that clarified how or why individuals were added to the list. Additionally, the mental health watchlist was not incorporated into individual detainee electronic health records or medical files as required under PBNDS, although the Clinical Director shared an intention to remedy this absence in the near future.[269]

269 ICE, PBNDS 2011, Part 4.3 Medical Care, Part V, § X, p. 274.

In the files reviewed, Cal DOJ observed that psychotropic medication consent forms signed by detainees were included in detainee medical records as required. However, file review uncovered a few exceptions in which consent forms for antipsychotic medications were missing. Additionally, when asked during interviews with Cal DOJ staff, only one of four detainees (25%) who confirmed they were prescribed medication for a mental health condition reported that a mental health professional explained the medication to them. Two detainees reported that no mental health professional explained the medication and the fourth detainee was not asked the question.

Therapy and Other Non-Medication Interventions

Availability and Quality of Psychotherapy Services

Otay Mesa was not offering psychotherapy services at the time of Cal DOJ's 2023 visit as the psychologist had retired a few months prior. Similarly, the availability of group therapy at Otay Mesa had been disrupted during the COVID-19 pandemic and mental health staff had not been able to resume the service by the time Cal DOJ conducted its 2023 visit. The lack of individual and group psychotherapy services offered limited non-medication interventions available to detainees.

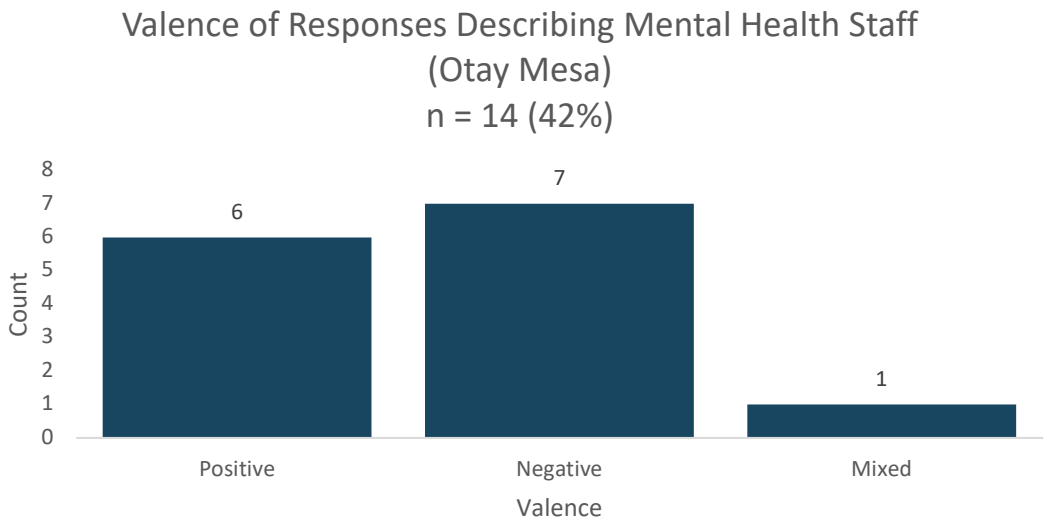
During interviews with mental health staff, Cal DOJ learned that, in lieu of psychotherapy, the mental health nurse visited detainees to offer alternative ways to address mental health conditions, including education on coping skills. The mental health nurse used an identical coping skills intervention with many detainees without adjusting for differences between patients and diagnoses. Some detainees reported that the coping skills sessions were helpful, while others found alternative outlets. Nevertheless, these sessions are not an adequate replacement for ongoing psychotherapy.

Rapport between Mental Health Providers and Detainees

Interviews with mental health staff and detainees offered some insight into the dynamic between staff and detainees at Otay Mesa. The mental health specialist shared that because of their background as an officer for 16 years prior to shifting roles, they believed they had a better rapport with detainees and has been able to better serve as a voice for detainees' concerns. Staff also reported that they had received cultural competency and trauma informed care training to assist in treating a diverse population. One nurse shared that cultural sensitivity training was redundant, as she had previously worked at a multicultural clinic. However, evidence that providers use identical treatment notes and interventions, as described above, suggests additional regular training on culturally informed mental health treatment is needed. Ensuring a match between the treatment offered and the patient's culture and other personal characteristics is a core element of culturally competent care.

Detainee interviews and grievance records demonstrated a less congenial relationship with mental health staff. Detainee responses regarding interactions with mental health staff was mixed, as shown in **Figure 37**. A little less than half of detainees reported positive interactions and slightly more than half reported negative or mixed (i.e., both positive and negative) interactions.

Figure 37. Valence of interviewees' descriptions of interactions with mental health providers, Otay Mesa



Detainees who had participated in therapy with the former psychologist shared in interviews that they felt some of the comments made by the psychologist were inappropriate. During its review, Cal DOJ identified several grievances regarding that psychologist. Cal DOJ also reviewed mental health files which documented a discriminatory attitude towards detainees who shared mental health symptoms. These files were primarily attributable to the psychologist who had left Otay Mesa earlier in the year. Cal DOJ observed in medical records that the psychologist did not acknowledge detainees' distress or offer appropriate treatment. One detainee who was referred by an Advanced Practitioner due to symptoms that appeared related to a mental health condition was seen by the former psychologist who concluded the detainee was feigning illness to benefit their legal case. This psychologist's notes did not acknowledge the stress, trauma, and fear shared during detainee encounters and how they could influence a detainee's motive to seek asylum relief. And concerningly, one detainee who participated in a standard interview with Cal DOJ staff and reported using translation services when receiving care reported that "the mental health nurse and interpreter were making fun of him and laughing during the appointment."

Availability of Other Non-medication Interventions

Non-medication interventions for detainees included treatment accessed outside the facility as well as spiritual resources, community programs, and recreation options.

Most of the detainees interviewed by Cal DOJ who were asked (26 out of 29, 90%) reported that they had access to programming, including religious services or classes. Additional programming included a library from which detainees may access two books at a time. The librarian reported that this service is available to most housing units in shifts and that the librarian also makes accommodations for individual access or books by request for detainees who are in restricted housing or in safety cells when appropriate. Library resources include books on self-help topics and meditation. Some detainees noted that they found the coping mechanisms available from the facility's library to be more effective than meeting with the mental health nurse.

The few offerings for therapy and non-medication interventions appeared to continue from Cal DOJ's 2021 report which identified limited modalities of treatment as an area of concern.[270]

270 *Immigration Detention in California* (Jan. 2021), *supra*, p. 128.

Suicide Prevention and Response

Suicide Risk Assessments, Intervention, and Prevention

Cal DOJ staff and experts reviewed Otay Mesa's suicide prevention practices, specifically as related to 1) prevention measures, suicide risk assessments and safety planning, 2) suicide watch protocol, and 3) review of suicides and other fatalities. Concerns from Cal DOJ's 2021 report continued as detainees placed on suicide watch remained isolated with few measures for sufficient evaluation and interventions for detainees whose mental health symptoms were worsening due to isolation.

Physical suicide prevention measures at Otay Mesa included cut down tools in the command center and in emergency boxes in the main corridor. There are two suicide watch cells — both in the intake area — which are dry cells with floor grates instead of a toilet. There was also a safety cell in the medical center.

Figure 38: Medical Observation Cell

Cal DOJ noted potential suicide risk areas while touring Otay Mesa. Review of the restrictive housing units and cells revealed that the cells had handrails that could be used as tie-off points. Other cells had bunk beds with a ladder and rung, all of which could be used to hang oneself. These hazards could be remedied by simple changes to the restrictive housing cells, such as handrails designed to prevent use as a tie-off point.

Cal DOJ also reviewed Otay Mesa's policies and practices related to suicide prevention. The CoreCivic intake screening procedure directly referenced the section of the PBNDS on suicide prevention.[271] Suicide risk assessments are initiated when detainees are found to be at risk for self-harm or other safety concerns during intake or medical or mental health encounters. However, based on medical

271 Intentionally omitted

file review and interviews with mental health staff, Cal DOJ found that suicide risk assessments were not structured, which raised concerns as to the consistency and efficacy of such assessments. In an interview with the psychiatrist, he shared that mental health staff do not always use the facility's suicide risk assessment form. Interviews and record review did show that the psychiatrist was involved in evaluating every suicide risk assessment.

The suicide prevention training for staff, which was previously facilitated by mental health staff, was not being provided at the time of Cal DOJ's site visit.

Suicide Watch

Detainees are placed on suicide watch when either medical or mental health providers identify risks of self-harm or safety concerns. Detainees on suicide watch are placed in safety cells, which have no plumbing and require detainees to relieve themselves through the grates on the floor. Detainees are monitored by staff in 15-minute intervals and nursing wellness checks are required to take place every eight hours. The Health Services Administrator shared that the nursing staff wanted to improve the consistency of these eight hour checks during suicide watch. In April 2023, ICE Office of Detention Oversight (ODO) inspectors found lapses in the 15 minute checks on individuals under suicide watch, which was identified as a priority deficiency.[272]

Figure 39: Empty Suicide Watch Cell

After two days of suicide watch, escalation to the hospital should be considered. File review showed that escalation was not always considered within that time. In one instance, a detainee was placed on suicide watch on a Friday, had no mental health visits over the weekend, and started decompensating and eating his own waste on Monday, but was not hospitalized until Tuesday.

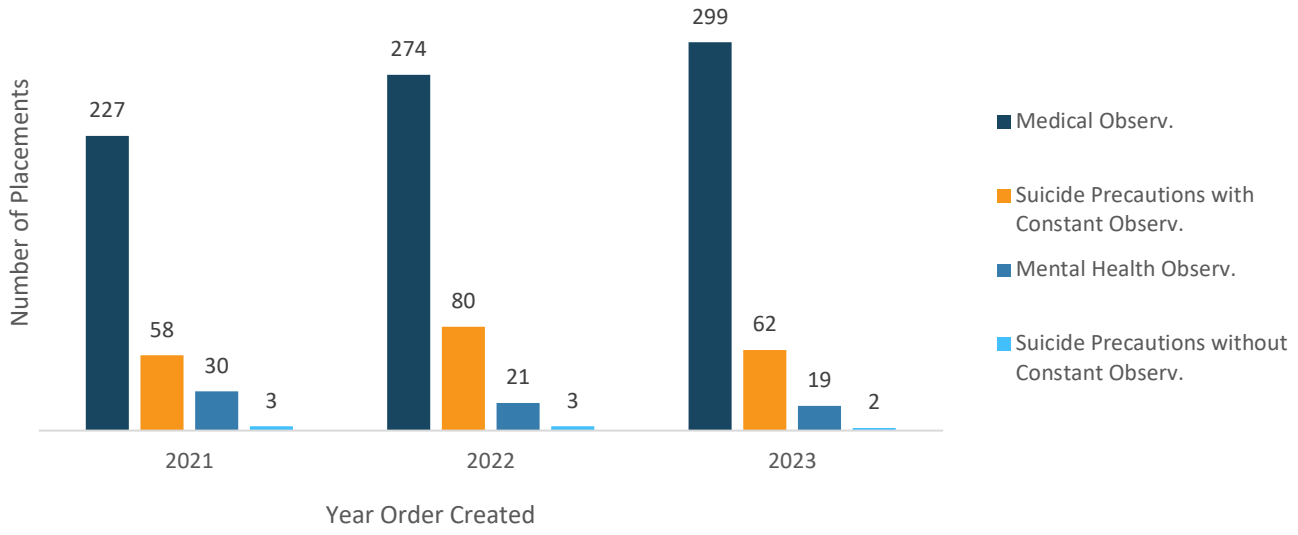
272 ICE, DHS: Office of Detention Oversight, Follow-Up Compliance Inspection of the Otay Mesa Detention Center (Apr. 25-27, 2023) p. 8 <https://www.ice.gov/doclib/foia/odo-compliance-inspections/otayMesaDetCntrSanDiegoCA_Apr25-27_2023.pdf> (as of Apr. 11, 2025).

Cal DOJ also found that Otay Mesa does not conduct safety planning for detainees who were placed on suicide watch or for those who were recently removed from suicide watch. In an interview with the psychiatrist, he stated he tracks safety plans "in [his] head" and does not check the detainee's medical records, and therefore could not identify whether anyone documents safety planning.

Removal from suicide watch occurs with the approval of the psychiatrist and is decided by a committee consisting of the Health Services Administrator and the mental health nurse. Detainees are not released from suicide watch over the weekend in order to maintain suicide watch precautions until assessment by the psychiatrist.

Cal DOJ received a one-on-one observation log containing 1,078 entries based on 873 detainees who were placed on observation between January 2021 and August 2023. This log showed various reasons for placement, including medical observation, suicide precautions with and without observation, and general mental health observation. There were some variations in reasons for placement across the 2021-2023 review period as displayed in **Figure 40**. While there was a reduction in suicide watch placements with observation, more detainees were identified for medical observation in 2023.

Figure 40. Number of Placements in One-On-One Observation by Year and Reason for Placement, Otay Mesa, 2021-2023 (as of August).



Review of Suicides, Suicide Attempts, and Other Fatalities

Nurse leads and the Health Services Administrator attend quarterly quality review meetings in which they discuss suicide attempts. These meetings previously also included the psychologist who resigned in July 2023. The current psychiatrist had not been involved in any death reviews as of the time of his interview with Cal DOJ.

Otay Mesa had no suicides during the review period, but there was some internal debate about one potential suicide attempt. The incident involved a detainee who had jumped from a second story rail in one of the housing units. The Clinical Director described the incident as merely a "fall and roll," whereas the psychiatrist and former psychologist characterized the incident as self-harm.

Medical Care

This section discusses 1) medical staffing, 2) access to medical care, and 3) quality of medical care, as it may have impacted mental health services and treatment.

Cal DOJ's 2021 report noted lengthy delays in medical care. Otay Mesa added new housing units, and the medical unit was inadequate to accommodate the increased population. The medical unit is overseen by the Clinical Director and the Health Services Administrator (HSA), who reports directly to the Senior Warden. This issue was not observed during the 2023 report as the layout of the medical unit was improved.

Medical Staffing

Cal DOJ assessed staffing and staff resources through document review and interviews with facility medical staff. The PBNDS guidelines require sufficient medical staff to meet care standards. At the time of our review, medical staff at Otay Mesa consisted of a physician serving as Clinical Director of the medical unit, eight Advanced Practitioners (APs) including one certified physician assistant and seven nurse practitioners, 18 registered nurses (RNs), 10 on call RNs working as needed, seven licensed vocational nurses (LVNs), and two on call LVNs working as needed. Evaluation of an April 2023 staffing model review showed that more part-time nursing staff were necessary to cover turnover and existing vacancies. Since Otay Mesa's transition from using ICE Health Services Corps for health care services to CoreCivic directly providing services beginning in 2020, the number of clinicians (APs and full-time physicians) on staff had increased. On the administrative side, there were three full-time medical record technicians tasked with obtaining signed releases for records and to request other documents, including hospitalization records. Staff were unable to provide details about the registered nurse and licensed vocational nurse openings at Otay Mesa at the time of the site visit. Review of weekend and nighttime shifts showed the medical staff were short-staffed to effectively support the needs of the population.

All clinicians are provided a subscription to an evidence-based supportive service to bolster the provision of quality care. Training for medical staff included coverage of general and mental health topics such as de-escalation, communication techniques, management of special needs populations, mental illness, and cultural sensitivity.

Quality of Medical Care

Quality of medical care was evaluated by Cal DOJ through review of in-facility treatment including medical and mental health observation, availability of out of facility treatment, medications, and chronic conditions as observed in medical files and policies related to these issues.

Under CoreCivic policy, detainees are to be scheduled for annual physical exams with screening questions that allow for further mental health assessment. These assessments are intended to assist in identifying emerging mental health conditions or issues not discovered during the intake process.

Cal DOJ's file review also identified some lapses in the quality and timeliness of diagnostic care. In one instance, a detainee with noted abnormalities in two blood tests conducted seven months apart did not have the follow-up lab work as of the time of Cal DOJ's file review. Another patient with a history of elevated blood pressure, impaired kidney function, and high blood sugar had not received diagnostic testing to manage these issues.

Barriers to Health Care

Language Access

In the 2021 report, Cal DOJ identified concerns with confidentiality and language access.[273] During Cal DOJ's current review, some of these issues had been remedied through changes to protocol, but facility culture on medical and mental health services appeared to pose an ongoing barrier to health care.

In the 2021 report, Cal DOJ noted that language access was inadequate at Otay Mesa due to a lack of interpretation services at intake, failure to note detainee's English literacy in records, and limited interpretation availability for wellness checks for isolated detainees. Staff did not have access to handheld interpretation devices to use with isolated detainees in the Restrictive Housing Units or the Medical Housing Unit.

Language access appeared to have improved at the time of Cal DOJ's 2023 site visit. Language access measures were implemented across the Otay Mesa facility, including improvements in language access at intake. For example, the intake orientation presentation included an item on reasonable accommodations in both Spanish and English to inform incoming detainees of their rights and ability to obtain a necessary accommodation. Expansion to include more languages reflecting the linguistic diversity of the population at Otay Mesa would be helpful. Detention and medical staff members were fluent in Spanish, Tagalog, and Urdu and the Health Services Administrator shared that staff without non-English language skills could consistently use the language line to ensure detainees understood staff. Mental health and medical staff reported using the language line with detainees who did not speak English, and Cal DOJ confirmed that the language line is used through review of medical charts. For detainees housed in the Restrictive Housing Units, nurses conducting rounds also reported communicating with any detainees who required interpretation services using the language line.

Detainee interviews confirmed that the above procedures were happening to at least some degree but also suggested that communication with some detainees is not successful. For example, of the 13 detainees reporting using Spanish to speak with staff, seven (54%) reported doing so using an interpreter. However, when discussing interactions with detention staff, at least three detainees discussed a language barrier being an obstacle to relationships with staff, and one of these three stated that the barrier was more difficult for non-Spanish speakers during interactions with both detention and medical staff.

The facility also appeared to be providing language access measures for detainees needing communication assistance due to disability. The formal Receiving policy, a staff-specific intake policy, established that Otay Mesa must provide a telecommunications device and an accessible telephone for deaf or hearing-impaired detainees. The Health Services Administrator confirmed that sign language interpretation was available for detainees who participated in any telehealth appointments or visits.

Confidentiality and Privacy Concerns

Cal DOJ's 2021 report identified confidentiality and privacy concerns with medical and mental health requests. These requests were conducted through publicly posted clipboards, in which detainees signed up by writing their names and noting whether they were seeking medical, dental, or mental health services.[274] Otay Mesa's current medical and mental health request process, as described above in the *Access to Mental Health Care During Detention* section, appeared to be much improved in securing the identity and privacy of detainee's requested health services, for example by shifting to a lockbox for submitting care requests.

273 *Immigration Detention in California* (Jan. 2021), *supra*, pp. 100, 130.
274 *Immigration Detention in California* (Jan. 2021), *supra*, p. 130.

However, some mental health confidentiality concerns persisted. The 2021 report highlighted that during mental health rounds, detainees communicated with medical providers standing outside their cell. In the current review, Cal DOJ found that telepsychiatry visits were occurring at safety cell doors of detainees held in the medical or segregated housing units and that the mental health nurse visits occurred in the unit, which raised concerns about patient confidentiality.

Facility Culture on Medical and Mental Health Services

Cal DOJ observed some issues with the facility culture as related to mental health services, which potentially impacted whether detainees received needed care. Of the 33 detainees interviewed by Cal DOJ staff, 17 reported having mental health concerns, but only three of the 17 shared that they had received any mental health treatment. Additionally, nine detainees reported why they did not request mental health services. Of these nine detainees, six reported that they did not request services because they distrusted the facility specifically. Three reported that they generally distrusted mental health care.

Cal DOJ observed a pattern of grievances against nursing staff. In contrast, the Health Services Administrator shared that her impression of the culture was professional and positive, although she recognized a high burnout rate and turnover among nursing staff.

Medical and Mental Health Quality Assurance Process

The medical and mental health quality assurance process at Otay Mesa was in a transitional period and appeared to be inadequate to address all medical and mental health care deficiencies. CoreCivic had previously set up outside physician peer review of Advanced Practitioners' (nurse practitioners and physician assistants) work. This practice resulted in discussions between staff when areas for improvement were identified. However, the Clinical Director shared that they were not involved in those conversations. During interviews, the Clinical Director also reported that she would assume peer review responsibilities in the coming year through assessment of annual chart review for all nurse practitioners and the physician's assistant, but that was limited to only those Advanced Practitioners and not all staff.

Also, Otay Mesa lacked an effective system of applying a quality assurance process to mental health team functions. Although Continuous Quality Improvement (CQI) meetings were held quarterly and included discussions on suicide and self-harm attempts, none of Otay Mesa's mental health staff attended CQI meetings, preventing identification and implementation of corrective actions within that department. In addition, the psychiatrist reported that mental health staff did not engage in any internal quality improvement practices or a peer review process and that mental health staff were generally reviewed by CoreCivic administrative staff. A qualified mental health professional should be conducting quality improvement review to effectively track issues, analyze data, and identify corrective actions. Cal DOJ did not find any evidence of such reviews.

Conditions of Confinement

Conditions of confinement consist of various factors, policies, and protocols that affect the experiences of detainees held at Otay Mesa, including their mental health. The conditions reviewed below include 1) classification and housing assignments, 2) discipline, 3) restrictive housing: disciplinary and administrative segregation and protective custody, 4) use of force, 5) PREA, 6) staff and detainee relations, and 7) other aspects of confinement.

Classification and Housing

At intake every detainee is subject to a security classification through which staff determine a detainee's custody level (low, medium-low, medium-high, and high) which determines the detainee's housing assignment. During this process a classification officer reviews the detainee's special vulnerabilities, such as serious physical illness, mental or cognitive impairment, or disability. The officer also considers management concerns, including criminal history and prior affiliation with a security threat group (STG) such as a gang. Pursuant to ICE policy, detainees are to be re-classified in 30-, 60-, 90- or 120-day intervals, following their initial classification.[275] CoreCivic's classification protocol appeared to focus on vulnerabilities including mental health diagnoses, developmental challenges, ADA-eligibility, LGBTI identity, or youth. The PBNDS considerations are a bit broader in including limited detainees with limited English proficiency.

At the time of Cal DOJ's site visit, most of the detainees at Otay Mesa (965 out of 1,187) were classified as Level 1, or Low classification. A review of a sampling of detainee files showed that Otay Mesa considered special vulnerabilities (including serious mental illness), security threat group (STG) affiliations, and risks for victimization consistent with PBNDS.[276]

Housing units for detainees classified with a low security level consist of larger dorms housing up to 128 detainees, while medium and high security housing units house fewer detainees, typically in smaller cells. Four high level security and segregation units with cells that house single USMS or ICE detainees were in use during Cal DOJ's site visit.

Figure 41: Housing unit bathrooms and tables

275 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Part V, § H, pp. 65-66.
276 ICE, PBNDS 2011, Part 2.2 Custody Classification System, Appendix 2.2.A: ICE Custody Classification Worksheet, Part 2 Special Vulnerabilities and Management Concerns, p. 67.

In its 2021 report, Cal DOJ highlighted that one of the systemic issues within immigration detention included the detainee security classification system.[277] At Otay Mesa in particular, housing decisions appeared to be based on the availability of beds in a unit, rather than suitability of a detainee for a given housing unit.[278] In addition, the facility staff appeared to not differentiate gang affiliation among those who were active members versus those who had ended their affiliation, nor did staff distinguish whether they were part of neighborhood street gangs or international gangs.[279] Cal DOJ also found that Otay Mesa did not conduct timely re-classifications.[280] These inadequate practices had effects on detainees' access to services, as well as their opportunity for consideration for release from detention, immigration relief, and removal.

During the 2023 review, Cal DOJ reviewed custody files with classification analysis and found that some of these issues continued at Otay Mesa. Known or presumed membership or affiliation with any STG provided a number of points toward a classification of high custody for many detainees, regardless of the nature of the group or whether the detainee remained active with the group. Cal DOJ also found inconsistencies in how staff assessed detainees during re-classification. In one instance, a detainee was classified as high custody because of "criminal history" even though the detainee had no documented convictions in their file. Another detainee's initial low custody classification noted a criminal history, but in subsequent re-classifications, staff increased the detainee to medium-high custody based on that same conviction without noting new information.

Discipline

PBNDS establishes that immigration facilities must implement a fair and equitable disciplinary system to ensure compliance with facility rules and regulations.[281] Disciplinary measures may range from loss of privileges such as commissary, to placement in restrictive housing (isolated housing units). As required, Otay Mesa maintained a graduated severity scale for prohibited acts and disciplinary consequences and maintained a review committee of custody and health care staff to conduct segregation reviews.

The disciplinary review process should typically allow for a health care provider to assess whether mental illness played a role in any detainee involved incident. This assessment may result in a recommendation intended to reduce the detrimental impacts of any disciplinary decision or to reduce the likelihood of punishing detainees with mental health disabilities for the symptoms of their mental health conditions. It was not clear whether this assessment was occurring regularly at Otay Mesa. As it relates to broader health concerns, one detainee reported that they lost commissary privileges for two weeks after missing head count due to a medical issue that prevented them from getting out of bed, despite having reported the health issue to staff.

Restrictive Housing: Disciplinary and Administrative Segregation and Protective Custody

Cal DOJ reviewed the procedures and conditions of segregation at all facilities with particular attention to interactions between mental health status and likelihood of segregation, procedures to ensure reasonable accommodations for individuals with conditions not compatible with segregation, and the impact of segregation on mental health. Segregation is the term used at immigration detention facilities to refer to conditions of solitary confinement. Disciplinary segregation is a form of isolation used to punish a detainee for violation of detention rules or regulations, and administrative segregation provides for separation of detainees who may pose a threat to others. Protective custody provides for a vulnerable detainee to be housed separately for their safety, which may but need not necessarily occur through a placement in segregated housing. Through a review of restricted housing unit logs, Cal DOJ

277 *Immigration Detention in California* (Jan. 2021), *supra*, pp. 17-24.
278 *Id*. at p. 23.
279 *Ibid*.
280 *Ibid*.
281 ICE, PBNDS 2011, Part 3.1 Disciplinary System, Part I, p. 214.

identified 422 placements of detainees in administrative segregation and 196 placements in disciplinary segregation between January 2021 and August 2023 at Otay Mesa.

Figure 42: Restrictive housing unit recreation area

Cal DOJ's 2021 report identified some issues with the imposition of restrictive housing as discipline. Specifically, mental health staff frequently signed off on detainee placement in segregation, despite significant mental health challenges.[282] Additionally, detainees placed in restrictive housing units, administrative segregation, and protective custody were all limited in the time they had outside of their cells, even when those in protective custody were entitled to more liberties and time outside of their cell.[283]

During Cal DOJ's 2023 review, our team observed the disciplinary committee interacted with several detainees who were in disciplinary segregation. Staff appeared respectful towards detainees and offered advice for detainees regarding the process moving forward. However, the concerns identified in Cal DOJ's 2021 report appeared to be ongoing.

The necessity for proper referrals was most apparent through file reviews showing that at least one patient endured a nine month stay in administrative segregation, following which the detainee engaged in self-harm and was placed on suicide watch. During those nine months, the psychologist maintained no documentation of therapy visits, but, following placement on suicide watch, a referral to the psychiatrist was made resulting in a prescription for anti-depressant medication.

While mental health staff reported that a pre-segregation or restrictive housing review is performed prior to placement, the psychiatrist denied conducting any such reviews. Review of patient charts showed that the mental health nurse was conducting these reviews and that the nurse only prevented a detainee from restrictive housing placement when they were suicidal. Several records showed that the medical nurses were performing the pre-segregation reviews rather than the mental health nurse or any other mental health provider. Notes also showed that the mental health specialist (a non-clinician) handled rounds, even though this work is best suited for a mental health nurse or other qualified mental health provider.

282 *Immigration Detention in California* (Jan. 2021), *supra*, p. 27.
283 *Id*. at pp. 26-27.

Medical and mental health staff conducted weekly mental health segregation review meetings attended by the Chief of Security, Unit Management, the STG investigator, an ICE Representative, a USMS representative, the mental health specialist, and the mental health nurse. Decisions to remove or continue restrictive housing placement for detainees with mental health needs were made during these meetings, but were not documented in the detainees' medical records.

Cal DOJ's analysis of data from Otay Mesa reflecting lengths of stay in segregation showed similar average lengths of stay but different patterns when comparing detainees present in mental health logs to detainees not present in such logs. The average length of stay for detainees not in the mental health logs was 9.58 days, and the maximum stay recorded was 414 days. The average for detainees present in mental health logs was only slightly higher, 9.91 days, with a maximum recorded stay of 186 days. Both maximums represent individuals spending months to more than a year in segregation, which is harmful to mental health regardless of whether a detainee enters segregation with an underlying mental health condition.

Among detainees interviewed by Cal DOJ, six indicated they had been disciplined and placed in segregation, and five of these six detainees were present on a mental health log. In file review, Cal DOJ observed that a detainee was placed in administrative segregation and received mental health checks almost daily for the first four days, but that follow up ceased for nine days. One interviewed detainee shared that the isolation from segregation was harmful to their mental health, and that they were only allowed to shower every other day. Another detainee reported that they began to talk to themselves while in segregation and that they were effectively prevented from engaging in outdoor recreation because their access to the recreation yard was set for 5-6 a.m.

Use of Force

Cal DOJ found that between February 2021 and July 2023, there were 34 use of force incidents at Otay Mesa, which included both calculated use of force incidents and reactive use of force incidents. Of the 34 incidents, 21 were reactive, six were calculated, and seven incidents were unspecified in the records.

The use of force log provided to Cal DOJ did not include information indicating whether detainees involved in use of force incidents were known to have mental health conditions or were treated for mental health concerns.

Nonetheless, Cal DOJ found that 27 of the 34 use of force incidents (79%) involved at least one detainee present in the facility's mental health logs. Additionally, Cal DOJ found that 25 of the 47 detainees (53%) involved in these incidents had a mental health condition or had been treated for a mental health concern based on other records.

This rate of involvement in use of force incidents is higher than the general population rate in the facility of detainees having or being treated for a mental health condition. For comparison, 144 detainees (12%) were present in mental health logs out of a total population of 1187 detainees at Otay Mesa during the time period covered by the logs.

PBNDS establishes that for any situation involving a detainee with physical, intellectual, or developmental disabilities, medical or mental health staff shall be consulted prior to any calculated use of force.[284] A mental health use of force review should be performed beforehand to allow for guidance on best approaches for the involved detainee to maintain safety and limit possible injuries to staff or the detainee. File review by Cal DOJ's medical and mental health experts indicated that qualified providers were performing this review regularly. In addition, Otay Mesa's use of force training materials

284 ICE, PBNDS 2011, Part 2.15 Use of Force and Restraints, Part V, § F, p. 205.

did not include any screening process or alert system for individuals in special populations or with mental health illness.

Cal DOJ discovered one use of force report related to a March 7, 2023 incident that appeared significant given the involvement of multiple staff and detainees and reports of injuries to staff. The incident was not captured on video, although closed-circuit television (CCTV) footage should have been maintained according to the PBNDS.[285] Thus, Cal DOJ was unable to review the incident, which facility personnel had deemed compliant with Otay Mesa's use of force policy.

PREA

Cal DOJ reviewed Otay Mesa's Prison Rape Elimination Act (PREA) protocols and policies. PREA provides for establishment and implementation of detention policies to reduce and address instances of sexual abuse, prevention, detection, and response.[286] Otay Mesa employs a PREA Coordinator, who has served in that role for the past three years and had worked as a PREA investigator for 10 years prior.

CoreCivic's 2023 PREA report identified 41 reported incidents in the 2023 calendar year. 31 of these reports involved detainee on detainee violence, 26 of which were related to sexual abuse and five for sexual harassment. Six sexual abuse reports were substantiated and one remained pending at the time of the report, all other reports were determined to be unsubstantiated or unfounded. The remaining 10 complaints were reports of sexual abuse in which staff were alleged perpetrators, of which two were substantiated and one remained pending at the time of the report.

Cal DOJ's 2021 report identified a notable increase in PREA complaints during that reporting period of January 2018 to June 2019, totaling 54 incidents. The 41 incidents reported in 2023 is an increase from 2021 and 2022, when there were 17 and 22 reported incidents, respectively.

Cal DOJ identified at least two instances when Otay Mesa's response to PREA incidents was lacking during the 2023 site visit. One detainee who reported a PREA incident described during an interview that they had received mental health crisis resources from providers at the emergency room but, upon return to Otay Mesa, had no means of accessing any of those resources. This detainee requested psychotherapy, but the only service provided by staff was a single psychoeducation session with the mental health nurse on coping skills, which the detainee found ineffective. In another instance, the mental health nurse spoke with a detainee who submitted a PREA complaint and documented that they were not coping effectively. The nurse never made an appropriate referral to the psychologist or psychiatrist to address any trauma that may have resulted from the initial incident. Failure to provide appropriate services or referrals is noncompliant with PBNDS guidelines regarding sexual abuse and assault prevention and intervention, which require the facility administrator to make victim services available to detainees following any incidents of sexual abuse.[287]

The problems related to PREA identified in Cal DOJ's 2021 report have not yet been adequately addressed. Otay Mesa could do more to respond to PREA allegations through performing more thorough screening, analyzing possible causes, and committing to maintaining a culture of unbiased documentation and investigation of claims.[288] Overall, it is recommended that Otay Mesa prioritize "detainees' vulnerability to sexual abuse and harassment."[289]

285 *Id.* at Part V, § I, p. 207.
286 CoreCivic, 2023 PREA Annual Report, p. 3 <https://www.corecivic.com/hubfs/_files/PREA/2023-PREA%20AnnualReport.pdf> (as of Apr. 18, 2025).
287 ICE, PBNDS 2011, Part 2.11 Sexual Abuse and Assault Prevention and Intervention, Part V, § H, p. 135; Part VIII, § B, pp. 156-158.
288 *Immigration Detention in California* (Jan. 2021), *supra*, p. 111.
289 *Id*. at p. 24.

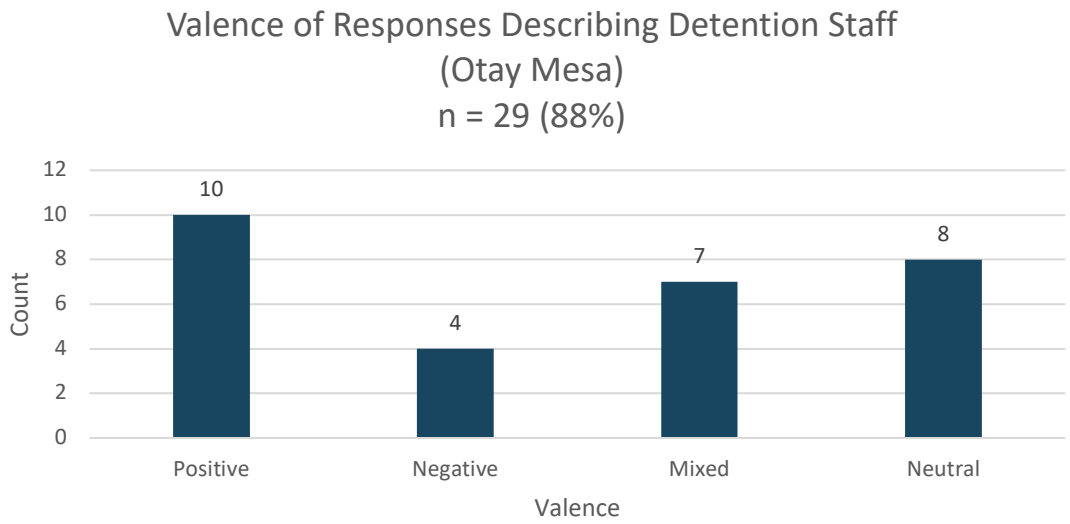
Staff and Detainee Relations

CoreCivic maintains a grievance system and policy to provide detainees with an administrative remedy for any issues they report, which includes one level of appeal. Otay Mesa accepts grievances through paper submissions and through the tablet system. Upon review of detainee files, CoreCivic did not appear to have created, or filed, paper copies of detainee complaints or grievances, or responses, in detainee folders or files. In addition, review of detention files indicated that electronically submitted grievances were not maintained in files with facility responses either. The PBNDS require that facilities create and retain documentation of grievances and their resolutions in both individual detention files and in a grievance log.[290]

A 2021 OIG report similarly found that Otay Mesa did not meet minimum standards for staff-detainee communications. The report indicated that responses to grievances were delayed, and misconduct grievances were not forwarded to ICE officials as required.[291] However, a 2024 OIG report based on findings from unannounced inspections of immigrant detention facilities conducted between 2020 and 2023 indicated that Otay Mesa had implemented OIG-DHS recommendations on grievance procedures.[292] The 2024 report found that Otay Mesa established a grievance tracking system to ensure timely responses to all grievances.[293] The San Diego Enforcement and Removal Field Office ensures all staff misconduct complaints are forwarded to ICE ERO.[294]

Most detained persons at Otay Mesa (29 of 33, 88%) discussed their interactions with detention staff in interviews with Cal DOJ. Ten detainees described their interactions positively, four described them negatively, seven described mixed (i.e. positive and negative) interactions, and eight described them in neutral terms, as shown in **Figure 43**. This evidence suggests that detainee experiences with facility staff vary substantially.

Figure 43. Valence of interviewees' descriptions of interactions with facility staff, Otay Mesa



290 ICE, PBNDS 2011, Part 6.2 Grievance System, Part V, § D, p. 419.
291 Office of Inspector General, DHS, Violations of ICE Detention Standards at Otay Mesa Detention Center (Sept. 14, 2021) pp. 9-11 <https://www.oig.dhs.gov/sites/default/files/assets/2021-09/OIG-21-61-Sep21.pdf> (as of Apr. 10, 2025).
292 Office of Inspector General, DHS, Summary of Unannounced Inspections of ICE Facilities Conducted in Fiscal Years 2020-2023 (Sept. 24, 2024) p. 23 <https://www.oig.dhs.gov/sites/default/files/assets/2024-09/OIG-24-59-Sep24.pdf> (as of Feb. 7, 2025).
293 *Ibid*.
294 *Ibid*.

Programming, Recreation, and Voluntary Work

Cal DOJ observed that detainees had access to programming, recreation, and the Voluntary Work Program, which appeared to positively impact the conditions of confinement, although there were some limitations to access.

Programming and Outdoor Recreation

Otay Mesa employs a Recreation Supervisor who manages leisure activities in the units, such as Bingo and physical education classes, but also handles budgeting, inventory of supplies/equipment, and supervises the recreation provided by Otay Mesa. In an interview, the Recreation Coordinator described programming as "things [detainees] do on the tablets," including classes. However, only a limited number of tablets are available for use in each housing unit and only during set hours, with free use of tablets limited to 30 minutes per day. Otherwise, detainees must pay five cents per minute to access games, messaging, movies, books, and educational programs. Instructions for the tablets are limited to English, Spanish, and French. Tablets were present in the unit Cal DOJ toured, but access is limited due to temporal, financial, and language limitations.

Figure 44: Basketball court

A majority (26 out of 33; 79%) of detainees reported that they had access to programming. Three of the 33 (9%) said that they did not have access, while the four remaining detainees (12%) were not asked the question. During the three-day visit, Cal DOJ staff did not observe staff or any other outside entity facilitating programming but observed the availability of distraction items such as televisions, reading materials, games, and tablets, in the housing units. Cal DOJ's detainee interview responses indicated positive effects of programming on detainee mental health. Eight detainees were asked whether programming affects their mental health. Seven respondents (88%) reported that it has a positive effect and one respondent reported it has no effect.

Cal DOJ also observed multiple instances of individual staff members or detainees taking initiative to create resources for detainees. In one housing unit for example, Cal DOJ learned about a Detention Officer-initiated project – a newsletter and cookbook – which the individual staff member had curated

and printed, with detainee contributions. The newsletter featured art and poetry created by detainees while the cookbook included various recipes shared by detainees. The officer specified that he did not identify authors to protect detainee identities and to allow those detainees who are released to share the publications with their families. One detainee shared that he had initiated and taught an English class, while another detainee in the same unit had started an Alcoholics Anonymous class. The detainees mentioned that staff in their units were helpful in providing a whiteboard.

Otay Mesa appeared to offer consistent access to recreation. A majority of the detainees interviewed by Cal DOJ (26 out of 29, 90%) who were asked reported that they had access to recreation at Otay Mesa. At least two detainees who had been identified as needing special accommodations for mental health conditions were able to participate in one-one-one recreation time after their requests were submitted and approved. In addition, all units observed by Cal DOJ featured an outdoor recreation yard.

Voluntary Work Program

Otay Mesa operates what is called a Voluntary Work Program, for which there are 543 options or slots available for participating detainees. Training for the Voluntary Work Program consists solely of reviewing a two-page set of safety rules created by CoreCivic. Cal DOJ was concerned by the limited information offered to detainees who chose to participate in this program. Some of the assignments appeared to require additional training and safety precautions, such as the chemical/staging assignment for each unit, which involves working closely with industrial-grade cleaning products. Additionally, although PBNDS prohibits high custody detainees from working outside their units or to handle any sharp instruments, Otay Mesa had placed some high custody detainees in assignments as barbers.

Due Process

Cal DOJ reviewed policies and practices that impact detainee due process rights including the ability to access legal counsel and legal materials, and other conditions that impact due process rights.

In the 2021 Cal DOJ report, we found that detainees at Otay Mesa generally had a higher rate of representation than other detained immigrants in the state, in part due to the facility's proximity to an urban center.[295] Despite this benefit, Cal DOJ also found that attorney visit rooms were not equipped with telephones or a means to access interpretation services, there was no mechanism to access packages that may contain legal mail when they were unapproved by staff, and resources in the library were sometimes missing materials or frequently out of service.[296]

During the 2023 review period, CoreCivic reported maintaining a policy to uphold legal rights of detainees by ensuring contact with attorneys and their authorized representatives via in-person contact, phone contact, and through correspondence. During the tours of the facility, Cal DOJ observed that some higher classification units featured law library computers and video visitation space and kiosks. While most detainees who were asked reported not encountering difficulties communicating with their attorneys, some detainees continued to report challenges that included detention staff giving wrong information when relaying messages, language barriers, inability to access in-person attorney appointments, or mistrust of the confidentiality of the phone lines.

295 *Immigration Detention in California* (Jan. 2021), *supra*, p. 118.
296 *Id*. at pp. 1118-1119.

Figure 45: Library

Figures 46: Library computers

The *Franco-Gonzalez v. Holder*[297] settlement, which provides that detainees who are incompetent by reason of mental disabilities should be provided counsel, includes requirements for detention facilities to post information about the case. During Cal DOJ's tour of Otay Mesa, staff observed *Franco-Gonzalez v. Holder* materials in some but not all housing units, and documents for the case were only available in English, Spanish, and Mandarin, despite the varied countries of origin and primary languages of detainees housed at Otay Mesa. Of the 29 detainees interviewed by Cal DOJ and asked about the case, about three quarters (76%; 22 out of 29) responded that they were not familiar with *Franco-Gonzalez v. Holder*.

297 *Franco-Gonzalez v. Holder* (C.D.Cal. Oct. 29, 2014, No. 2:10-cv-02211-DMG) ECF No. 786.

One surveyed attorney noted that they represented two detainees who had been identified as *Franco* class members but, for at least one of their clients, the facility did not believe the client had any mental health condition and treated the client as if they were feigning illness to access a supposed benefit, or malingering. The attorney believed that the facility failed to adequately diagnose their client, which impacted access to resources available under *Franco*. This attorney believed that the facility only performed cursory evaluations of their client, which resulted in an inaccurate diagnosis.

Conclusion

Cal DOJ publishes this report at a time when the nation anticipates a rise in the number of individuals subjected to civil immigration detention and held in facilities operated by private corporations. This report finds significant gaps in such facilities' provisions of adequate mental health care and thus offers key information needed to understand how to support detained individuals going forward. Immigration detention exacerbates mental health conditions and has lasting impacts on the mental well-being of people who experience it. The private detention facilities assessed in this review are not offering the full range of care with the consistency that is needed to mitigate these harms. Through at least the end of the current mandate of July 1, 2027, Cal DOJ will continue to implement AB 103 to ensure that the conditions of detained immigrants in California remain in public view.

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