

RURAL AND URBAN HEALTH CARE NEEDS

HEARING

BEFORE THE

SUBCOMMITTEE ON IMMIGRATION

OF THE

COMMITTEE ON THE JUDICIARY

UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

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MAY 22, 2001
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Serial No. J-107-20

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Printed for the use of the Committee on the Judiciary



U.S. GOVERNMENT PRINTING OFFICE

78-402 DTP

WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
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CONTENTS

STATEMENT OF COMMITTEE MEMBER

Brownback, Hon. Sam, a U.S. Senator from the State of Kansas	1
--	---

WITNESSES

Hegerty, Martha, President, Country Care Nursing Facility, Easton, Kansas ..	7
LeBaron, Bradley D., President and Chief Executive Officer, Uintah Basin Medical Center, Roosevelt, Utah	20
Levine, Ruth E., Senior Health Economist, World Bank, Washington, D.C.	23
Page, Susan, President and Chief Executive Officer, Pratt Regional Medical Center, Pratt, Kansas	3
Shusterman, Carl, Attorney, Los Angeles, California	11
Sosne, Diane, Co-Chair, Service Employees International Union Nurse Alli- ance, Seattle, Washington	16
Wear, Douglas M., Chair, Committee on Rural Health, American Psycho- logical Association, Seattle, Washington	26

SUBMISSIONS FOR THE RECORD

Akin, Gump, Strauss, Hauer & Feld, L.L.P., Washington, DC, memorandum ..	30
American Bar Association, Governmental Affairs Office, Washington, DC, statement	33
Commission on Graduates of Foreign Nursing Schools, Philadelphia, PA, statement	37
Lutheran Immigration and Refugee Service, Philadelphia, PA, statement and attachments	39
Keller, Allen S., M.D., Division of Primary Care Medicine, New York Univer- sity School of Medicine, New York, NY	51

RURAL AND URBAN HEALTH CARE NEEDS

TUESDAY, MAY 22, 2001

U.S. SENATE,
SUBCOMMITTEE ON IMMIGRATION,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:11 p.m., in room SD-226, Dirksen Senate Office Building, Hon. Sam Brownback, Chairman of the Subcommittee, presiding.

Present: Senator Brownback.

OPENING STATEMENT OF HON. SAM BROWNBACK, A U.S. SENATOR FROM THE STATE OF KANSAS

Chairman BROWNBACK. I will call the hearing to order. Thank you all for joining us today.

We are in what is affectionately referred to as a vote-arama on the Senate floor. For any of you who are unschooled here, although I think most of you are familiar with this, it where the Senate basically has a continuous vote going on.

So I ran over here from the last vote. I will stay here as long as I can and I will run back for the vote, and we are going to try to catch a couple of these vignettes, if you will, and recesses in between.

I apologize in particular to the people who traveled a long distance to be here to testify. It is an important subject and an important topic, but this is a big tax bill and we are trying to get this through. Unfortunately, that is where we are.

So if you will bear with me, what I would like to do is put forward an abbreviated opening statement, open it up for very concise comments from the panelists of 2 minutes or so in length. Then we will go to each individual.

I will probably have to take a break fairly quickly. We may only get to one or two of you and then I will have to break to run over and vote. I will come right back and then we will continue it from that point. So this is going to be very herky-jerky, I guess is the term. I don't know how technically to put it, but we are going to have to stop and start on this to be able to get this done. I didn't want to cancel the hearing because a number of you had traveled long distances and I think this is an important topic.

Let me start out by saying again that I am pleased that everybody is here. This is a topic we need to review over some extended period of time. For a while now I have come across the topic of needs in rural health care during my travels across the State of Kansas. As I would visit particularly rural hospitals, but also

urban hospitals in my State, I saw a shortage and great need for health care personnel—physicians, nurses, medical technologists, and others as well. I would hear from hospital administrators—such as Don Wilson who is here from the Kansas Hospital Association—who would comment about the critical shortages that we were experiencing.

The charts here show the decline in percentage of registered nurses under the age of 30 and under the age of 35. We have another chart that I would like to show up here as well. It shows the projection of supply and demand for full-time equivalent registered nurses, 2000 to 2020. This was done in 1996 and doesn't even accurately reflect the data we have today.

Today it looks like we have a convergence of supply and demand, yet as I think you will hear in testimony, that is not the case of what is occurring. This projection was made in 1996 and you can see what happens in the outyears.

Nothing can traumatize a family more than a medical emergency, particularly one that may have been prevented by timely access to needed medical professionals. In Kansas, I know that many communities, would be without a doctor if it were not for an immigrant physician. I know that many communities, both in Kansas and around the country, would benefit from a greater number of not only doctors but nurses, nurses aides, radiologists, medical technicians and other health care professionals.

In the area of nursing, it has become apparent that the problem has developed into one of national significance. According to the American Organization of Nurse Executives, a nursing shortage is emerging nationwide that is fueled by age-related career retirements, small to moderate increases in job creation, and reduced nursing school enrollments.

According to the American Organization of Nurse Executives, "Job replacement-related demands due to registered nurses age-related retirements are expected to increase rapidly over the next 5 to 15 years."

Data from the Department of Health and Human Services indicates that 18.3 percent of registered nurses today are under the age of 35, compared to over 40 percent in 1980. And only 9 percent of registered nurses are under the age of 30, compared to 25 percent in 1980. Projections by several economists show that by the year 2020, the number of registered nurses working in America will actually be 20 percent below the projected need.

The purpose of today's hearing is to learn about the scope of current personnel needs in health care around the country and learn what role this Committee can play in addressing those needs.

Larger or more in-depth solutions to today's pressing needs may emerge from the HELP Committee or the Finance Committee, and we must keep in mind the limited jurisdiction of the Judiciary Committee in its ability to address all outstanding financial or labor issues present in today's hospitals and nursing homes. Indeed, many of these issues will have to be addressed at the State level.

However, simply because we cannot solve all of today's health care problems does not mean that we abdicate our responsibility to

find practical solutions to help real people. So I look forward to the testimony that will be presented here today by the witnesses.

I call on our people to make their presentations. We are going to start here from my left, Susan, and the reason we are doing this is that the two Kansans are to my left, not to be prejudiced against the rest of you, but I have a bias for Kansas.

Susan Page is with the Kansas Hospital Association. She will be making a presentation on behalf of the Kansas Hospital Association.

Susan, why don't you go ahead? I will introduce each of you as we go along, and if you could keep that to a couple of minutes in summary form, we will take the full testimony and have that in the record.

STATEMENT OF SUSAN PAGE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PRATT REGIONAL MEDICAL CENTER, PRATT, KANSAS, ON BEHALF OF THE KANSAS HOSPITAL ASSOCIATION

Ms. PAGE. Thank you, Chairman Brownback. As you said, my name is Susan Page, and I am the CEO of Pratt Regional Medical Center in Pratt, Kansas.

Attached to my testimony for the record is a copy of "Critical Condition," a research monograph prepared for our Committee on Workforce Strategies. It examines the status, causes and suggested solutions of our workforce shortages. While it doesn't address immigration specifically, it details the need for immediate action. Easing immigration restrictions to allow qualified health care professionals to practice in places like Pratt would provide some immediate relief, allowing for other more long-term strategies to come to fruition.

Like most industries, our health care field has undergone tremendous changes over the past decade. One of the manifestations of these changes is an increasing shortage of health care professionals, particularly nurses, as the slides project.

During this past winter, it was common for hospitals to divert patients to other hospitals, not because of a lack of beds but rather a lack of nurses and other health care professionals to take care of our patients.

For the first 4 months, at Pratt Regional the cost for our use of temporary agency nurses would have funded two full-time nurses for an entire year if they were available, and our policy of paying extra bonus shift premiums to fill uncovered shifts has cost us over the past 4 months \$31,000, enough for another full-time RN. This is despite the fact that over the past 4 years we have increased nursing salaries 23 percent.

The chart on page 2 of my written testimony illustrates how rapidly our workforce shortages are increasing. Between 1999 and 2000, 80 percent of the categories of clinical employee job vacancies increased significantly. This resulted from both an increase in demand based on volume and a decrease in the number of available workers.

The table on page 3 of my testimony illustrates the projected percent change in necessary health employment in Kansas and the U.S. from 1996 to 2006. Within the next 6 years, Kansas will re-

quire from 20 to 70 percent more clinical workers like RN, LPNs and respiratory therapists than it did in 1996.

Chairman BROWNBACK. Susan, I am going to have to leave in a minute.

Ms. PAGE. I will get to my recommendations, what we can do perhaps.

We have identified a monograph on a number of short, intermediate and long-term strategies. We would ask you to consider reinstating the H-1A visa program, modify and streamline the H-1C visa program to allow more hospitals to qualify, and ensure that NAFTA is not altered to restrict the flow of health professionals from Canada and Mexico into the U.S.

Thank you, Chairman.

[The prepared statement of Ms. Page follows:]

[An attachment is being retained in the Committee files.]

STATEMENT OF SUSAN PAGE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PRATT REGIONAL MEDICAL CENTER, PRATT, KANSAS

Chairman Brownback, members of the subcommittee, my name is Susan Page. I am the chief executive officer of Pratt Regional Medical Center in Pratt, Kansas. Pratt Regional Medical Center is located in rural south central Kansas. The hospital has 69 acute care beds, 15 skilled nursing beds, and 55 intermediate beds. In addition to my duties at Pratt Regional, I am the chair-elect of the Kansas Hospital Association's Board of Directors and chair the association's Committee on Workforce Strategies.

Attached to my testimony for the record is a copy of Critical Condition, a research monograph prepared under the direction of the Kansas Hospital Association's Council on Health Delivery and the Committee on Workforce Strategies. The monograph examines the status, causes and suggested solutions, both short-term and long-term, of the critical nature of our workforce shortages. While it does not address immigration specifically, it details the need for immediate action. This impending workforce crisis must be addressed immediately in order to assure access to health care services in the years to come. Easing immigration restrictions to allow qualified health care professionals to practice in appropriate health care settings would provide some immediate relief allowing other, more long-term strategies to come to fruition.

Like most industries and professions, health care has undergone tremendous changes over the past decade. Unimagined advances in medical technology, drugs and pharmaceuticals, and diagnostic capabilities, combined with severe reductions in payments caused by the increase in managed care and the passage of the Balanced Budget Act, have totally altered the face of health care today. One of the manifestations of these changes is an increasing shortage of health care professionals, particularly nurses. During this past winter it was common for hospitals to divert patients away to other hospitals, not because of a lack of available beds but rather because of a lack of nurses and other health care professionals to care for them.

For the first four months of this year at Pratt Regional, the cost for our use of temporary agency nurses would have funded two full-time nurses for an entire year, if they were available. And our policy of paying extra "bonus" shift premiums to fill uncovered shifts has cost us over \$31,000, enough for another full-time RN. This despite the fact that over the last four years we have raised nurse's salaries 23 percent just to keep those we have.

Unlike other industries, it is difficult for health care to respond to traditional supply and demand theories when it comes to workforce shortages. Health professional shortages in the past, though painful, were transient, responding to the conventional wisdom of labor economics. Economists argue that shortages are short-term phenomena, disappearing when employers increase their wages and benefits to attract more workers. This may be true in properly functioning labor markets, but health care does not fit the traditional labor model. Employers, particularly in rural areas, do not have the complete freedom to increase salaries to attract new employees. As a hospital's proportion of Medicare, Medicaid and managed care patients increase, the depressed revenues in the form of prospective payment systems and discounts increase, leaving little room for salary and benefit increases.

Furthermore, entry into and retention within health professions are not controlled by wages alone. Other social variables are at work in the decision to enter and/or remain in the health profession work force. The current shortage is not caused simply by the inability of the new worker supply pipeline to offset normal workforce attrition; rather, it is complex and projected to be long term and chronic. Higher salaries alone—even if the money to increase salaries were available—will not solve the problem. Population growth, social changes and public and private health insurance payment policies, and an anticipated explosion of demand caused by the aging of the “baby boomer” generation are all underlying causes of the current shortage. Therefore, a sustained, multi-faceted approach, including easing of current and ineffective immigration restrictions, will be required to overcome the problem.

CURRENT SHORTAGES

The following table describes the change in vacant health care position rates in Kansas hospitals between 1999 and 2000. As you can see, in 80% of the categories of critical clinical employees the job vacancy rate has increased significantly. This resulted from both increases in demand for workers due to increases in volume and decreases in the number of available workers.

Selected Health Professions Job Vacancy Rates in Kansas Hospital 1999–2000

Position	1999	2000
O. R. Technicians	9.2	15.8
Nuclear Medicine Technologists	10.9	14.3
Certified Nurse Assistants (LTC)	8.1	11.2
Certified Nurse Assistants (Acute Care)	8.4	10.2
Ultrasound Technologists	10.1	9.9
Respiratory Therapists	8.9	9.2
Emergency Medical Technicians	5.0	8.6
Radiologic Technologists	6.0	7.6
Staff Nurses (RN)	4.3	6.1
Licensed Practical Nurses	9.7	5.3

PROJECTED CHANGE IN HEALTH CARE WORKFORCE

The projected percentage change in necessary health employment in Kansas and the United States for the period 1996–2006 is shown in the table below. The projected rate of increase in Kansas exceeds the national rate in 10 of 17 health professions. Within the next six years, Kansas will require half again as many or more EMTs, respiratory therapists, physical therapists, PT assistants, OT assistants and medical records technicians as it employed in 1996. The rate of increase for RNs, nurse aides and orderlies, pharmacy assistants, speech pathologists and audiologists and dieticians and nutritionists will increase by approximately 25 percent.

Projected Percentage Increase in Needed Positions

Selected Health Professions 1996–2006

Health Profession	Kansas	U. S.
Registered Nurses	25.3	20.9
Licensed Practical Nurses	15.9	18.5
Nurse Aides and Orderlies	26.6	23.3
Physician Assistants	36.8	46.7
Pharmacists	20.3	12.6
Pharmacy Aides and Technicians	26.1	11.0
Physical Therapists	47.7	70.8
Physical Therapy Assistants	50.0	78.5
Occupational Therapists	42.9	66.1
Occupational Therapy Assistants	60.0	68.7
Speech Pathologists and Audiologists	26.3	50.6
Respiratory Therapists	72.0	45.8
Emergency Medical Technicians	55.6	45.1
Radiologic Technologists	35.5	28.9
Laboratory Technologists	21.7	14.9
Medical Records Technicians	61.5	50.9
Dieticians and Nutritionists	22.2	18.2

Source: Bureau of Labor Statistics

SUPPLY PIPELINE AND TRAINING PROGRAMS

The American Association of Colleges of Nursing reported that enrollment of nursing students in entry-level baccalaureate nursing programs declined by 19.3 percent in the five years from 1995 through 1999. The decline is attributed to fewer applicants and the availability of fewer training slots. In Kansas, enrollment in registered nurse education programs declined by 17.4 percent in only four years. The declining trend is also reflected in graduation rates. In 1999, there were almost 300 fewer RN graduates than in 1996, a reduction of 22.5 percent. Further, expanding the number of training slots for health care professional training is limited by the availability of faculty and clinical practicum sites. Students must be closely supervised to benefit from their clinical experience. Staff shortages in hospitals and clinics affect the ability of health professionals to teach students in clinical settings. And, even if every currently available slot in Kansas were filled by qualified students they still would not meet the projected need for workers today.

AGING WORKFORCE

The primary cause of workforce attrition today and in the immediate future is the aging of workers that is felt most acutely in nursing. In Kansas, 64 percent of the registered nurses employed are older than 40 years of age. The percentage of employed LPNs over age 40 is 57.7. Twenty-eight percent of employed RNs in Kansas are over 50 years of age and 26.4 percent of employed LPNs are over age 50.

The aging of the workforce has three immediate consequences. First, according to a 1996 report from the Institute of Medicine, older workers have a reduced capacity to perform certain strengthrequired tasks, such as lifting and turning patients. Second, older workers are less dependent on fulltime employment than younger workers and often reduce their productive work hours. And third, as older workers retire from the workforce equally qualified workers must replace them.

POTENTIAL SOLUTIONS

The Kansas Hospital Association Council on Health Delivery and the Committee on Workforce Strategies have identified a number of short, intermediate and long term strategies and goals to address the workforce crisis. While most of these goals are locally achievable, federal assistance is critical. Several good pieces of legislation have recently been introduced in both the House and Senate addressing the nursing shortage using educational incentives, however I would recommend this committee consider the following recommendations to ease immigration restrictions which would provide immediate relief:

- Reinststate the H-1A visa program. In the past, this program was used specifically to allow RNs licensed in their own countries to enter the U.S. temporarily.
- Modify and streamline the H-1C visa program to enable more hospitals to qualify. The program should also provide for expedited entry of qualified foreign nurses into the U.S.
- Ensure that the North American Free Trade Agreement (NAFTA) is not altered to restrict the flow of health professionals from Canada and Mexico into the U.S.

Mr. Chairman, thank you for the opportunity to address the subcommittee. I would be happy to answer any questions from the members.

Chairman BROWBACK. Thank you. That was very well done, and I apologize for rushing you and my rudeness in so doing.

I am going to run to the floor and I will run back and we will go on from there. We will call a recess and it will be about 15 minutes. I will be right back.

[The Subcommittee stood in recess from 2:20 p.m. to 3:02 p.m.]

Chairman BROWBACK. I will call the hearing back to order. My apologies for that long break. The votes took much more time in between than what I thought they would.

Our next person to present is Martha Hegerty. She is President of Country Care, Incorporated, in Easton, Kansas, and is here on behalf of the American Health Care Association.

Ms. Hegerty, the floor is yours.

STATEMENT OF MARTHA HEGERTY, PRESIDENT, COUNTRY CARE NURSING FACILITY, EASTON, KANSAS, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Ms. HEGERTY. Good afternoon, Chairman Brownback. I am honored to appear before you. As you said, I do own a small skilled nursing facility in Easton, Kansas. Easton is a town of 200 located 12 miles from the Federal prison in Leavenworth. We have 63 employees who take care of 56 residents 24 hours a day, 7 days a week.

There are a couple of points that I would like to make out of my written testimony. One is that nursing homes and sometimes hospitals are starting the practice of offering computers, giving computers away if somebody will leave one facility and go to work for another facility. They are offering a \$5,000 sign-on bonus if you leave the employment of one nursing home and go to work for another one. What this is causing is just a shift of your nursing personnel. One facility is robbing another for the same people, so they make a round of the nursing homes or the hospitals.

The other point that I would like to make is that I have petitioned for two Filipino nurses. I did this back in 1996 and it took me until March 2, 2001, to receive these nurses from the Philippines. So something needs to be done with the shortage that we have and the length of time that it does take for us to get the nurses.

In summary, I feel like we have a train wreck on the horizon. The baby-boomers are retiring; they are needing care and long-term care. We have a shortage of people wanting to enter the nursing field to take care of these people. It is stressful; it is physically and emotionally taxing to be in the nursing facility. You have all these frail elderly and you don't have enough people who want to join the nursing workforce.

Something needs to be done to help the nursing facilities have CNAs, LPNs, as well as RNs. Right now, the immigration laws don't cover the certified nurses aides at all. So I feel like that we need to count on you to enact some new immigration programs that would cover all of the health care workers that we need.

Thank you for listening to my problem, and I hope I did that in my time span.

[The prepared statement of Ms. Hegerty follows:]

STATEMENT OF MARTHA HEGERTY, PRESIDENT, COUNTRY CARE NURSING FACILITY, EASTON, KS, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Good afternoon Chairman Brownback, Ranking Member Kennedy and members of the Subcommittee. My name is Martha Hegerty, my friends call me Marty, and I hope you will too. I am extremely honored to appear before you to discuss the critical shortage of caregivers in long term care, and the important role reforming our nation's immigration must play in beginning to solve the problem.

Let me tell you about myself and the people in my care in Easton, KS. I own and operate a skilled nursing facility—called Country Care—and my patients are very much like a family to me. My daughter is the administrator, and we have 63 dedicated caregivers with us. We care for 56 patients 24 hours a day, 365 days a year.

Easton, Kansas is what you would probably call a small rural town. We have a total population of 200 people. In fact, with 63 employees, I am the largest employer in town employing about one-third of the population of Easton.

This is the kind of town where everyone cares for each other, and its the kind of town where having skilled providers is critical to access to care, quality of care, and ultimately, quality of life.

As you are well aware, there is a nationwide shortage of caregivers. You have heard about the RN shortage, but I am here to be certain that you do not forget about the nursing paraprofessionals—those on the front line of caregiving.

These dedicated women and men are the unsung heroes of caregiving. The Certified Nurse Aide, the Licensed Practical Nurse, and the resident assistants that together provide over 80% of the hands-on care in nursing homes, assisted living, and other long term care settings are the backbone of our senior's health care system.

Without these people, who work in anonymity for relatively low wages, our elderly and disabled would not get the care they need. To ignore this shortage is to ignore the fact that we need to strengthen our skilled nursing infrastructure at a time when demand for care is expanding rapidly.

In rural Kansas, this problem is made worse by the trend called depopulation. I know Senator Brownback is all too aware of the critical problem compounding the caregiver shortage. While the number of elderly in KS is exploding, the people who would provide that care are leaving in droves.

Since the riverboat gambling opened up 30 miles from Easton, the flight has become even worse. Now, young people can work in the casinos for \$15–\$25 per hour. When Medicaid pays me \$3.20 per hour to care for each patient, I simply can not compete for workers by paying casino wages. That would take funds away from patient care something I cannot do.

At Country Care, we manage to provide excellent care despite the difficulty competing in the labor market. I pay as high wages as I can afford, and I care for the people who work with me. But many of my colleagues in caregiving around Kansas are struggling. I read an ad in the paper last week where nursing homes are offering free computers to people who come to work for them. In fact just a few days ago several of my LPNs received postcards from a nursing home in Leavenworth offering \$5,000 signing bonuses for leaving me and going to work for them. We are now at a place where we are stealing caregivers from one another, bidding up costs, with no increase in numbers of staff or quality of care. I'm here to ask you to help stop this destructive cycle.

Amid this shortage of caregivers that all experts agree will only escalate, the option of relying on the current legal immigration programs is really not an option at all. My experience in attempting to bring nurses from the Philippines is a good example of how the system does not work for caregivers or patients.

A few years ago, I found myself unable to recruit the Nurses I need to meet the needs of some more acutely ill patients, and to comply with new paperwork burdens added on by the Health Care Financing Administration (HCFA). I tried everything to find caring and dedicated Kansans to come work in Country Care, but they just were not available. I should tell you that I have no mandatory overtime at Country Care, and never have. But when someone calls in sick or doesn't show up, the patients still need care, so I often must pay double-time to get the residents the care they need. But this shortfall of staff was not possible to fill domestically at any price, so I had to turn to immigration.

In 1996, I petitioned the INS for two Registered Nurses to help meet the needs of my patients. I knew it would be a struggle to make it through another month without more help. I needed Certified Nurse Aides (CNAs) too, but there is no immigration program that makes getting them possible. I was told it would take about 6–12 months to bring the two RNs here from the Philippines and get them processed by the INS.

Little did I know, that 6 to 12 months would turn into 24 months, 36 months, and then nearly 5 years. The fact is that the two nurses that I so desperately needed in 1996 came two months ago in March 2001.

Don't get me wrong, I still need them. In fact, I need several additional nursing staff, but I'm not sure if my residents or I can wait another five years for INS to process the required paperwork.

I'm here to tell the Committee, the INS needs reform so that the process works for employers and the many patients whose care can not wait. Yet more than that, there must be a special system set up for the critical health care needs our nation faces.

This will be the only way to meet the needs of caregivers as the baby boomers are increasingly in need of care, and the supply of domestic caregivers dwindles. Everyone can see this train wreck in the making, but it is only you who can take the necessary steps to avert it.

The American Health Care Association and I propose is a system by which the caregiver shortage is measured annually by the Department of Health and Human Services, and the INS makes the necessary visas available in an expedited manner.

This would be a system under which, if the shortage were abated with an enhanced domestic workforce, no visas would be needed, and hence none granted. But

in times of severe shortage, such as now and in the foreseeable future, there should be a flexible mechanism to help facilitate the supply of care providers our seniors need and deserve.

BACKGROUND

SHORTAGE

According to Cornell University's Applied Gerontology Research Institute, the US will need 600,000 additional CNAs over the next five years. According to the Health Care Financing Administration, nursing homes are 250,000 CNAs and 60,000 RNs short of the minimum needed to provide quality care right now. How many seniors will not get the attention and care they need today and tomorrow due to this shortage?

The GAO report released last week entitled "Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern." The analysis found that nurse and nurse aide shortages can severely impact the quality of care and that the shortage is expected to worsen as the aging population increases and fewer people enter the nursing workforce.

DEMOGRAPHICS

The Congressional Research Service, the population requiring long term care will explode by 75% over the next 40 years. The fastest growing age group in our country is those 85 and older, and Kansas has 5 of the oldest populated counties per capita in the country.

Over the next several years, as the baby boomers begin retiring, the nurse aide jobs are expected to be among the fastest growing in the workforce. But who will fill those jobs? There is no "H-1" category for the nurse aides or Licensed Practical Nurses. In fact, even RNs for nursing homes are largely excluded from the H-1B visa category. This just doesn't make sense in the current shortage environment.

Both the House and Senate Budget Committees included language in this year's budget requesting that relevant committees address this critical shortage. Additionally, as Senator Kennedy knows, the HELP Committee held a hearing last week on this very topic. However, this hearing focused on hospitals and RNs rather than the front-line caregivers in long term care—where the most severe crisis exists.

According to the GAO report from that hearing, the number of nurse aide jobs will grow an additional 36% by 2008—from 2.1 million to 2.9 million jobs needed—compared to a 14% increase in all jobs. 93% of our nurse aides are women, and as you know women have many other attractive employment options today that often are less demanding physically and emotionally.

Many will point to low wages and poor benefits as the reason the domestic supply of nurses and nurse aides is diminishing. It is important to remember that when Medicaid in Kansas pays about \$3.50 per hour to meet all needs of the patients, nursing homes are limited in the amount they can spend on labor. Nevertheless, last week's GAO report compiled statistics that show that nursing homes are doing all they can to be competitive in the service sector labor marketplace. According to the report:

- Average individual earnings of nurse aides in nursing homes is \$14,723, compared to \$13,412 among service sector workers generally.
- 67.4% of nurse aides have health insurance compared to 58.6% in the service sector jobs and 64.5% among all workers.
- 25.2% have pension coverage compared to 21.3% in the service sector generally.

This level of pay and benefits is impressive when you consider the fact that Medicaid pays less than cost for most nursing home patients, and that in many states, such as Massachusetts, profit margins are actually in the negative.

FINANCING

As I have stated, nursing facilities are unlike any other business, or even any other health care provider. We are dependent on the government to pay for nearly 80% of our patients' care needs. If these payment levels fall short of the cost of care, we cannot discharge patients, we will not reduce the quality of care, and we cannot lay-off staff. This explains why nearly 200,000 nursing home patients are being cared for in bankrupt facilities, and why—for example- 56 facilities have closed in the past 2 years in Massachusetts alone, displacing over 3,000 patients.

70% of nursing home costs are labor costs. But with more than two out of three of our residents paid by Medicaid, when labor costs go up, the state-set payment

rate often does not follow. That's why in 1998, Kansas enacted a wage pass-through for nurse aides to combat the shortages. We found that turnover decreased slightly, by 4%, but there has been little significant dent made in the shortage. In 2000, the state could not find the money to continue the program and any salary increases given must now be shouldered by the facilities alone.

COMPETITION/BUILDING THE DOMESTIC WORKFORCE

In Kansas and throughout the nation, skilled nursing facilities serve as the training ground for nurse aides. We recruit unskilled people and put them through the mandatory training program, both classroom and clinical education, and then help them take the certification exam to become Certified Nurse Aides. Once they are CNAs, many people leave our facilities, to work in hospitals, which can afford to pay higher wages, or in home health, assisted living, or other health care settings.

Additionally, you should know that caring for the elderly and disabled is very difficult work. Feeding dressing, bathing, and toileting are physically demanding; and treatment of Alzheimer's patients and losing others who become like family to you is emotionally demanding as well. It is much easier to say "Welcome to Walmart" for \$9 per hour than to care for seniors for \$8.

Providers and many policymakers are doing everything they can to develop domestic sources for these caregivers. The Nurse Reinvestment ACT, the NEED Act, and other bills have been introduced to build domestic supply of Nurses. Again these bills do not yet address the CNAs, LPNs, and other front-line caregivers. We feel strongly that the traditional nurse-targeted education programs in Titles 7 & 8 should be expanded to include these critical paraprofessionals.

AHCA is also proposing a system of grants for recruitment, retention, and training of nurse aides, in addition to wage pass-throughs and better Medicaid rates to develop American caregivers. But even if we are wildly successful, we will not reach the 600,000 additional CNAs that the studies say we must have within five years. We have met with the Department of Labor and the Department of HHS to discuss the shortage and immigration. But the solution is really in your hands.

IMMIGRATION

The Immigration programs of the past have been unresponsive, disjointed, inflexible, and politicized. We must find a better way that takes a common sense approach to solving this national problem. And we must put politics aside to meet the growing needs of our nation's senior citizens. The H1-A program was repealed in 1994 due to political opposition. The H-1B program is targeted toward the technology sector and even excludes many RNs—it does not apply at all for LPNs or CNAs. And the H1-C program was so limited as to be unusable to nursing homes. We need to rethink this patchwork system of Band-Aids, and replace it with a system that responds when there is a real shortage, and goes away when there is not.

As I have said, we need a flexible program that is targeted specifically to meet the critical health care needs of our seniors before the coming demographic wave washes over the system of care delivery. We need a program that allots the right amount of visas during shortages and none when the shortage is gone.

An expanded H-1.C program that serves rural as well as urban shortages would be helpful. But the requirement for a baccalaureate degree should be removed, since many RNs in long term care come through diploma programs or associate degree programs. This makes it extremely difficult to require a BS degree to qualify for H-1B or C programs for RNs.

This will not however, in any way alleviate the shortage of LPN and CNA caregivers in long term care or any other setting. This crisis must be addressed with new solutions such as that which we have proposed.

But most importantly, I would like members of this subcommittee to look at immigration for health care personnel as separate and distinct from other occupations that do not hold our citizens' lives in their caring hands. Our dependence on the government for revenue, and the work that we do caring for frail elderly and disabled populations make us unique as employers, and access to our services and the quality of our care must not be compromised.

CONCLUSION

In summary, we have a train wreck on the horizon. The baby boomers retiring and needing care will collide with the shortage of people to care for them.

The crisis is far more deep than just a lack of RNs. Nursing facilities need CNAs and LPNs to provide the hands-on care. Our dependence on government rates that are often below the cost of care prevents us from competing in the labor market-

place, and the difficulty of the job physically and emotionally prevents caregivers from entering the field.

The current immigration patchwork takes too long for patients to wait, and is not targeted to where the real need is. Care providers are counting on you, the Congress, to enact a new immigration program that is responsive to the care needs of our frail elderly and disabled citizens.

Thank you for the opportunity to give you my personal story and my views on the best ways to meet the needs of our seniors and disabled. Your attention and action in addressing this crisis will ensure an adequate and stable workforce to serve our seniors as they enter their "golden years" in increasing number.

I'd be happy to answer any questions you may have.

Chairman BROWNBACK. You did a very good job, and I am deeply apologetic that we aren't having the quantity of time that I would like to have to go through this. Unfortunately, it is just simply a function of voting on the floor.

Mr. Shusterman is an attorney in Los Angeles, California. Welcome to the Committee and you are welcome to testify.

STATEMENT OF CARL SHUSTERMAN, ATTORNEY, LOS ANGELES, CALIFORNIA

Mr. SHUSTERMAN. Thank you for inviting me, Senator Brownback.

To summarize my testimony, right now we have three different immigration programs, none of which work satisfactorily. We have the H-1B program which covers almost every other health care profession, from physician to med tech to therapist. But because nurses don't generally require a 4-year degree in order to work at a hospital in the United States, they are not allowed to get H-1B visas.

They are allowed to get H-1C visas, which was a program that was sponsored back in 1999, but to date not one single nurse has been able to qualify. The reason for that is this: Congress passed the law and it was signed by the President in November 1999. The Labor Department, in September of 2000, came out with regulations. In the regulations, they specified that only 14 hospitals in the entire United States could possibly qualify.

Some of those hospitals, I might point out, the Labor Department now admits it made a mistake and is in the process of trying to deny their qualifications. They are not in an underserved area back in 1997, which is what the law required, and the Labor Department says you just don't qualify.

The Immigration Service 19 months later has not even come out with regulations. So even the 14 hospitals which the Labor Department has now certified, no matter how many nurses they petition, cannot get a visa to come to the United States.

Those are the only two temporary visa programs. The permanent visa program, as the witness to the right of me just pointed out, can take up to 5 years. I was going to be conservative and say 18 to 24 months. We represent hospitals all over the country and that is the usual waiting time. That is a very long time to wait, and the administrative hoops that the hospitals have to jump through are just incredible.

I talked to various people during the break and I can see that the real crux of this is that there are all sorts of labor-management issues, but I don't think that is the function of this committee. I think the function of this Committee would be to sponsor a tem-

porary nurse program that is streamlined and that worked very well from 1952 up until when it expired, despite the Labor Department committee's recommendation that it be continued, back in 1995. I commend you to consider introducing legislation along that order.

I thank you and I would be happy to answer any questions.
[The prepared statement of Mr. Shusterman follows:]

STATEMENT OF CARL SHUSTERMAN, LAW OFFICES OF CARL SHUSTERMAN

Mr. Chairman and Distinguished Members of the Subcommittee:

My name is Carl Shusterman, and I am the principal attorney in the Law Offices of Carl Shusterman in Los Angeles, California. I formerly served as a Trial Attorney with the Immigration and Naturalization Service and have practiced immigration law for over 25 years. I have written many articles regarding the immigration of nurses, physicians and other allied health care professionals to the United States. Some of my articles appear on the Internet at <http://shusterman.com>. Our law firm represents both health care professionals and providers across the country.

I appreciate this opportunity to present my views on how our current immigration policy can be modified to result in improved health care for patients in both urban and rural areas.

REGISTERED NURSES

1. TEMPORARY "H-1C" VISAS

In the past, our country has experienced periodic shortages of health care personnel, particularly registered nurses. And, one of the strategies that has helped us respond to these cyclical shortages was through immigration. However, by all accounts, our nation is now experiencing a severe shortage of registered nurses that is different from any we have ever before faced. Fewer men and women are choosing nursing as their career. The average age of an RN is rising. Many are approaching retirement and will leave the nursing workforce within the next ten years. Couple this with the fact that 78 million "baby boomers" will be eligible for Medicare within the next ten years, and many of us will be in need of more health care.

There are many complex reasons behind the nursing shortage and I commend you, Mr. Chairman, for focusing attention on this issue as it relates to the health care needs of our rural and urban regions.

While our nation must look to long-term approaches to address the shortages, there are short-term strategies that we can take now to help alleviate the problem. One short-term approach is to revise this nation's policies on nursing immigration.

Current U.S. immigration policy severely constrains our ability to recruit qualified RNs to respond to the immediate shortages many of our hospitals are experiencing.

This was not always true. From 1952 to 1990, U.S. health care providers could quickly and easily obtain temporary "H-1" professional visas for foreign-born nurses. The employer filed a petition with the local INS office which approved it, and forwarded the approved petition to the U.S. Embassy in the nurse's home country which issued the working visa.

However, following the effective date of the Immigration Nursing Relief Act of 1989 (INRA), only hospitals with "attestations" certified by the Labor Department were permitted to petition for temporary "H-1A" status for nurses. Despite the stringent paperwork requirements imposed upon employers by the Labor Department, between 1990 and 1995, approximately 7,000-8,000 nurses entered the U.S. annually using temporary visas.

When INRA expired in 1995, a governmental commission recommended that the law be continued with certain modifications. Instead, the law was permitted to expire.

By 1997, the nurse shortage had begun to reappear, and many hospitals were unable to fill vacant nursing positions, even after extensive recruitment and retention efforts geared towards U.S. nurses. Representative Bobby Rush introduced legislation to allow 500 nurses to be sponsored by selected hospitals in medically underserved areas on temporary "H-1C" visas. Similar legislation was introduced by Senator Durbin. This legislation was not enacted into law until November 12, 1999, when the President signed the Nursing Relief for Disadvantaged Areas Act of 1999 (NRDAA). By that time, due to a growing national shortage of nurses, the addition of 500 nurses per year to a workforce which exceeded one million nurses had become a woefully inadequate response to the problem.

Because of a long delay in the issuance of regulations by the Department of Labor, hospitals were unable to submit H-1C "attestations" until September 21, 2000. The regulations took the unusual step of listing 14 hospitals across the country that the Labor Department determined would be eligible to apply for attestations.

On March 27, 2001, the Labor Department indicated that nine hospitals had submitted attestations. The Department approved four of these attestations, denied one, and four were under review.

In fact, of the four hospitals whose attestations were under review, the Labor Department is currently attempting to deny the attestations of at least three of these hospitals. Even though these hospitals were on the Labor Department's list of 14 qualified hospitals, the Department later determined that the hospitals were—not located in medically underserved areas on the required date, March 30, 1997. Finally, no nurses can be approved until the INS issues regulations to implement the program.

It is tragic that today, over 19 months after the passage of the law, not a single nurse has obtained H1C status. And, even if this program were in full operation today, 500 nurses per year would hardly fill the need.

Clearly, the present H-1C nurse program is not a viable option to help us address the current nursing shortage.

2. TEMPORARY "H-1B" VISAS

Current immigration laws permit a total of 195,000 visas annually for persons in "a specialty occupation" and "fashion models. . .of distinguished merit and ability".

The law defines a "specialty occupation" as an occupation that requires the "attainment of a bachelor's or higher degree in the specific specialty . . .as a minimum for entry into the occupation. . ."

Although many foreign-born registered nurses have attained a Bachelor of Science in Nursing (BSN) degrees, most health care providers will hire staff nurses with a minimum of a 2-year degree.

Therefore, most staff nurses do not qualify for H-1B visas.

3. PERMANENT RESIDENCE

Even though nurses remain ineligible for temporary visas, there is another way for health care providers to employ foreign-born registered nurses. Employers may petition for registered nurses to obtain permanent residence in the United States. Unfortunately, this too has become a long and tedious process.

In order for a foreign-born registered nurse to have a petition submitted on her behalf, she must possess either a nursing license in the state of intended employment or have passed a test administered by a private organization, the Commission on Graduates of Foreign Nursing Schools (CGFNS). To obtain a state license, a nurse must pass the NCLEX examination that is administered by the National Council of State Boards of Nursing. Since this examination may only be taken in the United States, it is necessary for foreign nurses to obtain visitor visas to enter the U.S. in order to take the examination. Since it is difficult for nurses in most third-world countries to obtain visitor visas from U.S. Embassies abroad to enter the U.S., few of them are able to take the NCLEX.

Instead, they must register with the CGFNS, months in advance, to take their examinations abroad. The CGFNS examination is not offered in all countries, and often nurses must travel considerable distances and incur significant expenses in order to take the examination.

Once a nurse passes either of these two examinations, the prospective employer may then submit a petition to the INS. The employer must submit proof that the nurse has completed her nursing education and has passed either the NCLEX or CGFNS examinations. Depending on the location of the INS Service Center where the petition is submitted, it may take anywhere from three to eight months for the immigrant petition to be approved.

If the registered nurse is residing abroad, generally the approved petition is forwarded to the State Department's National Visa Center (NVC). The NVC mails the nurse, or her attorney, a biographic form and a list of documents that must be presented to the U.S. Embassy or Consulate in her country at her immigrant visa interview. These documents include her birth certificate, police clearance(s), marriage certificate, medical examination, and various other documents. The NVC screens the forms for completeness and accuracy, and forwards them to the appropriate U.S. Embassy or Consulate abroad. This process may take several months.

In addition, there is the "VisaScreen" requirement. The VisaScreen certificate requirement was mandated by Congress as part of the Illegal Immigrant Reform and

Immigrant Responsibility Act of 1996. Section 343 of that law requires that certain foreign-born health care workers obtain certification that their education, training, license and experience are equivalent to that of American workers, and that they take examinations to demonstrate their proficiency in the English language. Although this requirement is well-intentioned, for registered nurses, it duplicates requirements already imposed by state licensing authorities.

The VisaScreen requirement became effective on the day that the law was enacted, on September 30, 1996. This had the effect of preventing nurses from obtaining permanent residence in the U.S. until the INS issued regulations implementing this section of law, and the nurses were able to comply with these regulations.

For over two years after the passage of the law, the INS failed to issue VisaScreen regulations until, on October 14, 1998, confronted with several federal lawsuits, the agency issued regulations that became effective on December 14, 1998. Regulations for physical and occupational therapists were not issued until April 1999 while regulations for other health care workers were finally issued, pursuant to a settlement agreement reached under a federal lawsuit, earlier this year, four and one-half years after the 1996 law.

Many nurses and other health care workers have complained about the difficulties in communicating with the International Commission on Healthcare Professions (ICHP), the private agency designated by the INS to issue VisaScreen certificates. Furthermore, the INS takes the unreasonable position that even foreign-born nurses who are educated and trained in the United States must obtain VisaScreen certificates to demonstrate that their education and training are equivalent to nurses educated and trained in the U.S.

Most foreign-born nurses immigrating to the U.S. are from the Philippines where there is an abundance of nursing schools, and where the language of instruction is English. There is a substantial backlog in obtaining permanent visas for registered nurses at the U.S. Embassy in Manila, Philippines. U.S. health care providers must often wait over 18 months to immigrate a nurse from the Philippines.

The present system specifies that a nurse cannot be admitted to practice in the U.S. until she has cleared a multitude of bureaucratic hurdles. The result of the present system is long and unnecessary delays in processing visas for nurses. Something is clearly wrong when, despite the severe nationwide shortage of nurses, it is far easier to obtain a working visa for a fashion model than for a registered nurse.

RECOMMENDATIONS

If nurses trained abroad are to be part of the solution to the national shortage of registered nurses in the U.S., it is essential that Congress restore a temporary visa program to allow U.S. health care providers to bring nurses to the U.S. within a one to two-month period, rather than requiring them to wait up to 18 months to secure the services of these nurses.

To be effective, such a program should be available not only to a handful of hospitals, but to all health care providers in need. It should be streamlined to enable qualified nurses to obtain visas to enter the U.S. in one to two months, and should only require health care providers and nurses to produce a minimum of documentation sufficient to insure that the health care needs of U.S. patients are being met, and that foreign-born nurses are being paid at a wage rate comparable to U.S. nurses working at the same facilities.

PHYSICIANS

The American public suffers not from a shortage of physicians, but from a maldistribution of existing physicians. Also, our system is suffering from a severe undersupply of primary care physicians.

Every year, the Secretary of Health and Human Services (HHS) publishes a list of Health Professional Shortage Areas (HPSAs) located across the U.S. where the ratio of primary care physicians to patients is less than one physician per 3,500 patients. Virtually all states contain areas that are medically underserved. HHS has designated over 80%–90% of some states as HPSAs. The list of HPSAs designated by HHS fills over 90 pages of the Federal Register in small print.

Since 1996, states have been permitted, under federal immigration laws, to sponsor up to 20 foreignborn, U.S.-trained physicians annually to work in HPSAs and other medically underserved areas. They work in these areas for three years. In exchange, they are granted the opportunity to apply for permanent residence in the U.S. once they have completed their work assignments. In the five years that the law has been in existence, at least 43 states have established such programs, thousands of physicians have participated, and hundreds of thousands of Americans have benefited. The number of HPSAs has been reduced, but only slightly. Allowing

states the option of sponsoring 50 to 100 physicians annually would benefit many more Americans living in medically underserved areas, and the extra cost of administering the program would be minimal.

In 1999, Congress provided that certain foreign-born physicians who work in medically underserved areas or for the Veterans Administration for five years are eligible to apply for permanent residence through a National Interest Waiver of the usual Labor Department requirements. However, INS regulations, issued in September 2000, substantially reduced the scope of the law. For example, while the law provides that "any alien physician" is eligible for such a waiver, the regulations restrict the benefits of the law solely to physicians engaged in primary care. Also, while the law allows county and municipal health departments to write a letter certifying that the physician's work is in the "public interest", the regulations require that the letter may be written only by a state department of public health. The regulations impose so many burdensome requirements upon employers of physicians as to lead one to conclude that the INS is actively trying to restrict the number of physicians who will be able to qualify for benefits under the law. Before the regulations become final, INS should be informed of something that every person that the agency naturalizes is required to know: The function of the executive branch is to enforce the laws written by Congress, not to amend those portions of the law with which the executive branch disagrees.

The immigration laws do not classify all physicians who wish to immigrate to the United States as "foreign medical graduates". Persons who graduate from medical schools in Canada are not considered to be foreign medical graduates. While foreign medical graduates need to complete a medical residency in the U.S. and pass all three parts of the U.S. Medical Licensing Examination (USMLE) prior to obtaining permanent residence as a physician in the United States, Canadian graduates are not subject to either of these requirements. Almost 50% of Canadian medical graduates are primary care physicians, while in the U.S. there is a critical shortage of primary care physicians.

Canadian physicians are entitled to obtain medical licenses through reciprocity in 90% of U.S. states. However, an HHS regulation issued in the early 1990s requires Canadian physicians to pass all three parts of the USMLE examination as a condition of obtaining H-1B temporary working status. It takes most persons 12 to 18 months to study and pass all three parts of the USMLE examination. This regulation is outdated and sets the federal immigration laws at loggerheads with state licensing laws and with federal immigration laws which exempt Canadian physicians seeking permanent residence in the U.S. from taking the USMLE.

CONCLUSION

The United States is in the midst of a severe nationwide nursing shortage, and our country's supply of physicians is distributed in such a way that large areas of the U.S. are medically underserved. We also suffer from an undersupply of primary care physicians.

While changes in immigration laws will not, in themselves, solve the nursing crisis, the present immigration laws contribute to the crisis by creating protectionist walls that make it difficult for U.S. employers to hire foreign-born nurses. To help ease the nurse shortage, Congress should restore the system of temporary visas for registered nurses that worked so well between 1952 and 1995.

While there is no shortage of physicians comparable to the nursing shortage, much of the United States is classified as medically underserved by the Department of Health and Human Services. Also, the U.S. suffers from a severe shortage of physicians who practice primary care. Medical residency programs in the U.S. train thousands of international medical graduates. Congress has wisely decided to allow a portion of these physicians to remain in the U.S. if they work in medically underserved areas for a certain number of years. Such programs should be expanded, and states, counties and municipalities should all play a role in sponsoring physicians under federal immigration laws. Also, our laws should encourage the immigration of primary care physicians to the United States.

Thank you for permitting me to testify on such a critically important subject.

Chairman BROWNBACK. That is a very good and specific recommendation to look at something we have done in the past, Mr. Shusterman. Hopefully, we will have time for some questions so I can ask you further about that.

Diana Sosne is the President of Local 1199 Northwest, and Co-Chair of the SEIU Nurses Alliance, out of Seattle, Washington. Thank you very much for joining us and for being here today.

STATEMENT OF DIANE SOSNE, CO-CHAIR, SERVICE EMPLOYEES INTERNATIONAL UNION NURSE ALLIANCE, AFL-CIO, SEATTLE, WASHINGTON

Ms. SOSNE. Thank you, Senator Brownback, and I am one of those older nurse statistics on your chart.

I am speaking on behalf of over 1.4 million members of SEIU, many of whom are immigrant health care workers, including physicians. So I am going to speak to this from a slightly different angle, but I think it is important to put all the pieces together.

The nursing shortage is a complex problem and the solutions are complex. It is important to note that there are available nurses and other health care workers in this country who have left hospitals and nursing homes because of the conditions currently in hospitals and nursing homes. It is the short staffing and things like mandatory overtime. People have left.

The proportion of registered nurses working in hospitals declined from 68 percent in 1988 to 59 percent in 2000. It is in a report and we will submit this to the committee. We just did a national survey of nurses working in acute care hospitals. Only 55 percent said they planned to stay in hospitals until they retire.

So these are alarming statistics and I think we have to look at what is underlying it because there are nurses and health care workers who could be doing these jobs, but they are leaving these institutions. And to just bring in immigrant nurses on visas, they would face the same unsafe and poor work environments and would not stay, we believe.

So we are interested in working with this Committee in crafting a solution to this issue with the noted caution that changes in immigration policy for nurses and other health care workers not exacerbate the shortage by diverting attention away from solving the root causes.

We are going to submit in testimony some specifics on principles related to immigration policy. Where established labor-management relationships exist, for example, we would want a direct role in the labor certification process, and we would want to ensure that immigrant workers be guaranteed all labor protections, including whistleblower protections for both quality patient care and labor rights.

I think that is just a very brief summary of what we wanted to call your attention to today.

[The prepared statement and an attachment of Ms. Sosne follow:]

STATEMENT OF DIANE SOSNE, RN, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CO-CHAIR, SEIU NURSE ALLIANCE

Thank you Senator Brownback and Senator Kennedy for allowing me to testify at this hearing on behalf of the Service Employees International Union.

My name is Diane Sosne, and I am registered nurse (RN) and co-chair of SEIU's Nurse Alliance. Today I am speaking on behalf of the over 1.4 million members of the SEIU, 110,000 who are nurses and 120,000 nursing home workers in our health care division. SEIU is committed to achieving access to quality health care for all who live and work in America—and quality jobs for all who dedicate their lives to caring for others.

We are a nation of immigrants that has benefited from the talent and expertise of immigrants in every occupation. Today countless nurses, doctors, and other health care givers who have come from other countries are working in the United States. SEIU has embraced these dedicated workers. They are making our union stronger through their diversity and energy, and they have joined our movement for quality patient care.

We are proud of our SEIU immigrant members working in home healthcare, nursing homes and hospitals. We are very aware of the staffing crisis, because our members are working in health facilities with too few staff, and too many patients with increasingly complex and chronic health conditions. SEIU is uniquely qualified to be a partner in the health care staffing dialog as the largest health care union. SEIU's Committee for Interns and Residents (CIR) members are doctors working in inner city hospitals, many of whom are in this country through the H1-B visa program. Other SEIU members are health caregivers in some of the toughest public hospitals in New York, New Jersey, Washington D.C. and Los Angeles.

Hospitals today are expecting too few nurses to care for far too many patients. That reality was confirmed by a recent national poll of acute care RNs commissioned by the SEIU Nurse Alliance. In that survey, more than one third of all nurses surveyed said that patients on their units experience missed or delayed medication or treatments at least once a week—Usually as a result of inadequate staffing.

If the problem were just too few nurses in this country, easing immigration might make sense. But, since the root cause of the nursing shortage isn't lack of nurses. Working conditions such as short staffing are driving existing staff away from the profession. Immigration is a bandaid to cover the real problem. Unsafe working conditions diminish quality care for patients and make it unsafe for nurses to practice. The risk of making fatal mistakes and putting licenses on the line is causing nurses to better than leave the profession in record numbers. In fact, nurses who come to this country on visas will be facing the same unsafe, poor work environments that are driving tens of thousands of American nurses out of hospitals.

The proportion of the nation's registered nurses working in hospitals declined from 68 percent in 1988 to 59 percent in 2000, as a result of industry and occupation restructuring.

The same problems exist in nursing homes where nine in 10 homes lack staffing that is needed to provide high quality care, according to the Health Care Financing Administration (HCFA). The problem is not a nurse aide shortage but a retention crisis lifting and bathing patients, and low wages have combined to create 100 percent turnover among nursing home caregivers each year on average. By the year 2020, when the U.S. baby boomer generation will be in greatest need of care, and a shortage of 400,000 nurses in the United States is projected.

We do not oppose Immigration as one approach to solving the nursing shortage. But, the priority in our health care system should be to attract and retain health caregivers. Today, only 55 percent of acute care nurses plan to stay in hospitals until they retire. And yet, fully 68 percent say they would be more likely to stay in hospitals if staffing levels in their facilities were adequate.

SEIU believes we can reduce our staffing shortage by increasing funding and financial support for nurse and nurse aide education, recruitment and retention by increasing wages and improving working conditions. These kinds of initiatives should be implemented first before turning to immigration as the solution.

We can attract more American workers to the profession by removing barriers and expanding the pool of potential health caregivers. We need to change the complexion of nursing, we need to recruit more men, and improve the racial and ethnic diversity. Finally, more emphasis should be placed on welfare-to-work programs. Former welfare recipients could be encouraged to choose healthcare as profession if Congress would define post-secondary education programs as a qualified work activity.

However, we acknowledge that new caregiver recruitment and education programs alone won't solve the problem. They will only treat the symptoms, not cure the disease. Unless we address the poor working and quality patient care conditions plaguing our caregivers today, the best we can hope for is a revolving door—with nurses and nurse aides leaving hospitals and nursing homes as fast as they enter.

But I'm certain that all of our members—regardless of where they come from—would agree that trying to solve the current nursing crisis by bringing in more health caregivers from around the world is a short-sighted response. Regardless of nationality, the working conditions are driving health care givers away from these jobs. We should not exploit immigrant workers because conditions in this country may be better than from where they came. Neither American nor foreign-born workers should be subjected to these working conditions.

First of all, the nursing shortage is a worldwide phenomenon. As a member of the global community, our nation should not draw trained nurses away from poor countries that need them even more desperately than we do.

Nor should we selectively adapt our immigration policies to cater to the needs of one particular industry. What we really need is broad reforms of our immigration laws. It's no secret that an estimated 9 million undocumented workers reside in the United States today. But lesser known is the fact that because of the way our current laws work, many of those people are actually working outside of their chosen professions including health care professions. The time has come for our nation to take a hard look at how best to protect the rights and enhance the quality of life for everyone who lives and works in the United States. SEIU as a member of the AFL-CIO is calling on Congress to allow undocumented workers already in this country to be able to legalize, (a copy of AFL-CIO resolution is attached to this testimony).

Rather than seeking stopgap measures to ease the crunch in the short term, we need to fix the system for the long term. Fundamentally, the only real and lasting solution to the growing nursing shortage lies in the establishment of safe staffing standards in our hospitals and nursing homes.

We must make safe staffing a requirement for all hospitals receiving federal taxpayer dollars. We must make sure the federal government is providing adequate oversight of our hospitals. We must protect the rights of patients and the rights of health care workers who blow the whistle on problems with patient care. We must take action immediately to stop the hemorrhaging—by banning mandatory overtime for nurses, just as we do for train engineers, air traffic controllers, truck drivers, and other occupations where public safety is at risk.

Perhaps most of all, we must make sure that workers have a voice in the decisions that affect their professions, their jobs, and their livelihoods. We must involve nurses in the process of designing solutions to the staffing crisis. Any employment based immigration program must involve workers—not just employers.

Understaffing in our nation's hospitals is a serious problem. It's a problem that will only be solved through the joint efforts of public officials, nurses, and hospital administrators. And it's a problem that must be solved if we are to guarantee quality care for patients—and keep skilled nurses in our hospitals.

SEIU, IS COMMITTED TO THE FOLLOWING PRINCIPLES:

- The creation or expansion of temporary or permanent visa programs for health care professionals must be evaluated in light of a comprehensive analysis of the projected needs of the health care industry and the adequacy of measures to train and retain American nurses.
- Immigrant health caregivers should meet existing licensing and certification requirements.
- Immigrant workers should be allowed to stay in this country under any visa program. We should not seek immigrant workers from around the world with the expectation of using them to solve our workforce problem temporarily, and then sending them home. It should be the worker's choice to stay.
- Where established labor/management relationships exist, unions must have a direct role in the labor certification process—such as a joint labor/management visa application process.
- Immigrant workers must be guaranteed all labor protections, including whistleblower protections for both patient quality care and labor rights.
- SEIU is concerned that the health care industry is seeking a quick fix by asking for renewal of the H1-A visa program, which was widely abused by temporary agencies and nursing homes.
- SEIU also opposes efforts by industry to relax the H1-B or expand H1-C requirements so that more RN's and health caregivers workers in general can be made eligible.
- SEIU supports legalization of undocumented workers currently living and working in this county. It is time for undocumented workers already working paying taxes and living in the U.S. to come out of the shadows and work legally without fear. Many are already working in home health care industry, nursing homes and hospitals. Many other undocumented workers could work in these professions because of their foreign training but are not allowed to work because of their undocumented status.

We look forward to working with this committee to crafting a comprehensive solution to the shortage of health care professionals facing this country. Thank you again for allowing me to testify.

I look forward to answering you questions.

AFL-CIO RESOLUTION 2/16/2000

The AFL-CIO proudly stands on the side of immigrant workers. Throughout the history of this country, immigrants have played an important role in building our nation and its democratic institutions. New arrivals from every continent have contributed their energy, talent, and commitment to making the United States richer and stronger. Likewise, the American union movement has been enriched by the contributions and courage of immigrant workers. Newly arriving workers continue to make indispensable contributions to the strength and growth of our unions. These efforts have created new unions and strengthened and revived others, benefiting all workers, immigrant and native-born alike. It is increasingly clear that if the United States is to have an immigration system that really works, it must be simultaneously orderly, responsible and fair. The policies of both the AFL-CIO and our country must reflect those goals. The United States is a nation of laws. This means that the federal government has the sovereign authority and constitutional responsibility to set and enforce limits on immigration. It also means that our government has the obligation to enact and enforce laws in ways that respect due process and civil liberties, safeguard public health and safety, and protect the rights and opportunities of workers. The AFL-CIO believes the current system of immigration enforcement in the United States is broken and needs to be fixed. Our starting points are simple:

- Undocumented workers and their families make enormous contributions to their communities and workplaces and should be provided permanent legal status through a new amnesty program.
- Regulated legal immigration is better than unregulated illegal immigration.
- Immigrant workers should have full workplace rights in order to protect their own interests as well as the labor rights of all American workers.
- Labor and business should work together to design cooperative mechanisms that allow lawabiding employers to satisfy legitimate needs for new workers in a timely manner without compromising the rights and opportunities of workers already here.
- Labor and business should cooperate to undertake expanded efforts to educate and train American workers in order to upgrade their skill levels in ways that enhance our shared economic prosperity.
- Criminal penalties should be established to punish employers who recruit undocumented workers from abroad for the purpose of exploiting workers for economic gain.

Current efforts to improve immigration enforcement, while failing to stop the flow of undocumented people into the United States, have resulted in a system that causes discrimination and leaves unpunished unscrupulous employers who exploit undocumented workers, thus denying labor rights for all workers.

The combination of a poorly constructed and ineffectively enforced system that results in penalties for only a few of the employers who violate immigration laws has had especially detrimental impacts on efforts to organize and adequately represent workers. Unscrupulous employers have systematically used the I-9 process in their efforts to retaliate against workers who seek to join unions, improve their working conditions, and otherwise assert their rights.

Therefore, the AFL-CIO calls for replacing the current I-9 system as a tool of workplace immigration enforcement. We should substitute a system of immigration enforcement strategies that focuses on the criminalization of employer behavior, targeting those employers who recruit undocumented workers from abroad, either directly or indirectly. It should be supplemented with strong penalties against employers who abuse workers' immigration status to suppress their rights and labor protections. The federal government should aggressively investigate, and criminally prosecute, those employers who knowingly exploit a worker's undocumented status in order to prevent enforcement of workplace protection laws.

Chairman BROWNBACK. I appreciate your doing that and also your constructive comments about what we may be able to do. Hopefully, again, I can ask you some questions later.

Bradley D. LeBaron is President and CEO of Uintah Basin Medical Center in Roosevelt, Utah, and he is here on behalf of the American Hospital Association.

**STATEMENT OF BRADLEY D. LEBARON, PRESIDENT AND
CHIEF EXECUTIVE OFFICER, UINTAH BASIN MEDICAL CENTER,
ROOSEVELT, UTAH, ON BEHALF OF THE AMERICAN
HOSPITAL ASSOCIATION**

Mr. LEBARON. Good afternoon, Mr. Chairman. I am Brad LeBaron, CEO of Uintah Basin Medical Center, in Roosevelt, Utah, and Chairman of the Utah Hospital Association. I am here today on behalf of the American Hospital Association's nearly 5,000 hospital health system and network health care provider members. Uintah Basin Medical Center, my home, is a rural 42-bed not-for-profit facility in northeastern Utah.

Health care is, of course, at a critical juncture. Along with increased regulation and decreased reimbursement, a shortage of qualified workers, especially nurses, greatly threatens our mission to care for our Nation's men, women and children.

Our current and daunting nursing shortage is unlike any that we have seen in the past. Nurses provide critical bedside care in the inpatient setting. They also serve as teachers, patient advocates and mentors. As current nurses retire, as you have shown us, fewer are in training to replace them. One study estimates that 50 percent of the registered nurse workforce is older than 50 years.

Over the past several years, it has become increasingly difficult for hospitals to attract and recruit qualified nurses. Our current vacancy rate at Uintah Basin Medical Center is 7 percent for RNs and 6 percent for LPNs. Three years ago, we virtually had no vacancies.

A sobering outcome of our recent board strategic retreat is that for our hospital our board has deemed the No. 1 strategic priority for the next 3 years being that of health manpower issues. Along with others, we are looking at a variety of options to retain our current nursing staff and to attract new nursing personnel.

In the last 18 months, we have increased RN wages by 17 percent. We have increased our scholarship funding for current employees and people who are not affiliated with the hospital presently by 50 percent. We sponsor job fairs, et cetera.

As we develop long-term strategies to expand our workforce, we face immediate shortages across the country. Using foreign nurses on a temporary basis is one of the few options that we have available to us to address this immediate need.

Until 1995, temporary visa programs existed to help with episodic shortages, but currently only the H-1C visa program, as has been described, is available. But it is woefully inadequate and fraught with complicated conditions. Given the program's strict criteria, at most only 14 of the Nation's 5,000 hospitals and health care facilities even qualify, and none of these are in the State of Utah.

In conclusion, to pretend that we can take care of the nursing shortage domestically is a disservice to our patients. Our current crisis must be solved through a collaborative approach to develop short- and long-term strategies. Revising our immigration policies is one way to apply a salve to help alleviate this growing wound afflicting health care.

Thank you.

[The prepared statement of Mr. LeBaron follows:]

STATEMENT OF BRADLEY D. LeBARON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, UINTAH BASIN MEDICAL CENTER ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. Chairman, I am Bradley D. LeBaron, president and chief executive officer of the Uintah Basin Medical Center (UBMC), in Roosevelt, Utah, and chairman of the Utah Hospital Association. I am here today on behalf of the American Hospital Association's (AHA) nearly 5,000 hospital, health system, network and other health care provider members. We are pleased to have the opportunity to testify on the health care worker shortage crisis, an issue of great concern to the health care community and the general public.

UBMC is a rural 42-bed health care, 501 c3, not-for-profit, independent facility in northeastern Utah. We employ over 300 health care personnel, and care for more than 2,100 inpatients per year, serving a population of 25,000. We are a sole community provider with a broad range of health care services including general acute medical services, home health and hospice.

Mr. Chairman, health care is at a critical juncture. Along with increased regulation and decreased reimbursement, a shortage of qualified workers greatly affects our ability to care for the nation's men, women and children. If nurses, physicians, respiratory therapists, pharmacists and scores of others who take care of the nation's ill and injured are not available, the collective mission of health care providers will be threatened.

This crisis affects every aspect of health care delivery, from direct patient care given by a nurse or respiratory therapist to prescriptions filled by a pharmacist and home health care visits from a nurse's assistant. The most visible of these, though, is a lack of nurses to provide the critical bedside care needed in the inpatient setting for today's patients, as well as those who require care in the future. The average age of our nation's nurses providing care today is 45, and the average age of our nursing faculty continues to rise. As these caregivers, teachers and mentors retire from the workforce, fewer health care workers are in training to take their places, as evidenced by the continuing nationwide decline in nursing school enrollment. Factor in the 78 million baby boomers who will begin retiring in the next 10 years, and our resources will be stressed even further. Demand for health care will exceed capacity.

Over the years, hospitals and health systems have repeatedly experienced temporary shortages of personnel, such as during the nursing shortages of the 1960s, 1970s and 1980s. Following a redesign of work place and personnel policies in response to these shortages—and often a recession in the general economy—the situation improved in most communities as previously-trained nurses were re-employed in hospitals and health facilities.

Our current and daunting shortage is unlike any we have seen in the past. While traditional factors such as an expanding national economy, overall low unemployment rates and competitive compensation packages are contributing to the current shortage, new demographics and other factors are exacerbating the situation.

Most nurses work in hospitals, but many are turning away from this traditional health care setting. Hospital patients are now older, sicker and require a greater intensity of care from nurses and other personnel. Nurses, and everyone involved in health care delivery, are spending an increasing amount of time on paperwork and less time on patient care. Women, who traditionally comprise the majority of nursing personnel, are finding other career options that are less physically demanding, less stressful and come with a higher rate of pay. Baby boomers, who make up a large part of the health care workforce, are approaching retirement. Nursing school and training programs are experiencing annual declines in enrollment, and some have even closed. Even if more students could be recruited into nursing schools, there is now a shortage in qualified nursing faculty, and the average age of nursing school professors is 52.

Over the past several years it has become increasingly difficult for hospitals to attract and recruit qualified nurses. Rural hospitals face this dilemma every day. At UBMC, we have 58 registered nurses (RN) and 38 licensed practical nurses (LPN) on staff; however, our current vacancy rate is at 7 percent among RNs, and 6 percent among LPNs. Three years ago, we had virtually no nursing vacancies. Our current vacancy rate is the worst it has been in my eightyyear tenure with the hospital. In fact, earlier this month, we just barely averted losing three nurses to urban centers for better pay.

Along with other health care facilities around the country, we are looking at a variety of options to retain our current nursing staff and attract new nurses. In the last 18 months alone, we have increased RN wages by 17 percent, in an effort to compete with larger health care facilities in other areas of our state.

UBMC is one of the few rural institutions with a nurse's education program in our town. We have partnerships with the baccalaureate nursing programs at Utah State University branch campus and Weaver State University, as well as with the LPN training at Uintah Basin Applied Technology Center. We graduate 20 nurses a year from these programs. But even last year, 14 nurses left the area to work in other areas of the state and country.

The public's demand for the highest quality patient care at the lowest possible cost has come face to face with the tightest labor market in the past 30 years. For example, government projections state that by 2020 we will face a shortfall of about 300,000 registered nurses.

Mr. Chairman, your colleagues in the Senate and the House, along with health care leaders, are working to find long-term solutions to the challenges we face. Hospitals and health care provider institutions across the nation are looking at retooling their retention and recruitment strategies, offering bonuses and providing other incentives, such as tuition reimbursement and child care, to attract and retain qualified health care workers to their facilities. The AHA formed the Commission on Workforce for Hospitals and Health Systems, asking a diverse population of stakeholders to work together and craft recommendations and bold solutions for this national dilemma. The commission represents hospital administrators, caregivers, academia, business leaders, frontline nurses, organized labor and many others. In addition, the Utah Hospital Association has formed the UHA Workforce Taskforce, to address what is becoming a critical shortage of nurses and other health care staff—in Utah.

Yet even as we develop long-term strategies to expand our workforce, we face immediate shortages across the country. It takes a minimum of two years for a student to complete a professional nursing program with an associate's degree. Unfortunately, even if we were able to recruit scores of men and women into our nursing education programs, we still face daunting shortages. Using foreign nurses on a temporary basis is one of the few options that may help us address this need. According to Peter Buerhaus et al. (Implications of an Aging Registered Nurse Workforce, JAMA, June 2000), "immigration of RNs educated outside of the United States may provide the most feasible strategy." We would be able to fill many critical clinical nursing positions in an expedited manner.

Until 1995, temporary visa programs existed to help address episodic nursing shortages. For example, the now defunct H-1A visa program was used specifically to allow RNs licensed in their own countries to enter the U.S. temporarily. However, the current shortage we are facing is dramatically different, and we need both short- and long-term approaches. Currently, only one temporary program exists, the H-1C visa program for nurses. While I am certainly not an expert on immigration law, I can tell you that even this option is woefully inadequate, and fraught with complicated conditions, making it almost impossible for hospitals to use this as a remedy for their current troubles.

In 1999, Congress created the temporary three-year H-1C visa program, a narrowly crafted measure to enable health care facilities in underserved communities to recruit critically needed health care staff, specifically nurses, from foreign countries. Under this program, 500 foreign nurses per year may enter the country. But this program is almost useless. In order for a hospital to take advantage of this program and sponsor a foreign nurse into our country, the facility must have a minimum of 190 beds; their patient population must be comprised of at least 35 percent Medicare and 28 percent Medicaid recipients; their geographic location must have been designated as a Health Professional Shortage Area as of March 30, 1997; and the facility must meet strict labor certification requirements. Currently, given these rigid criteria only 14 out of our country's more than 5,000 hospitals even qualify for this program. And to my knowledge, not one registered nurse has entered the U.S. under the H-1C program.

The H-1B visa program is another program that, on paper, would appear to assist hospitals in bringing in foreign nurses on a temporary basis. Unfortunately, this is not the case. Last year, Congress amended the H-1B visa program, enabling skilled professionals with an employer-sponsored job in the U.S. to enter the country and work for up to six years. The requirements also state that in order to qualify for an H-1B visa, the individual must have a college degree and the job must require a bachelor's degree as a minimum level of entry. RNs generally do not qualify under the H-1B program since most hospitals and other employers who hire nurses do not require nurses to hold baccalaureate degrees. Another disadvantage is that these visas are limited in number each year, and the quota is generally reached early in the year. This illustrates the crucial need to reform our current immigration policies as it relates to nurses.

Some of my colleagues in Utah have attempted to work through these complex and nonsensical immigration rules, in order to fill critical positions in their facilities. It took one hospital almost 18 months to obtain a foreign nurse to care for their patients using the EB-3 (green card) visa program. Another facility in southeastern Utah is having a difficult time obtaining approvals to immigrate a foreign medical technician. But most rural facilities cannot afford the cost or time delay to obtain foreign nurses or other foreign health care workers.

CONCLUSION

To pretend that we can take care of the nursing shortage domestically is a disservice to patients. This is a problem that cannot be solved by hospitals or any one group alone. And it cannot be solved solely by the federal government. It demands a multi-tiered, collaborative approach among all affected parties to develop short- and long-term effective strategies and solutions to meet the health care needs of today and tomorrow.

Revising our immigration policies toward foreign-born nurses is one way to apply a salve to this growing wound afflicting our health care system.

We have a critical shortage of women and men who are willing to serve in health care. This will only get worse, unless we work together to craft solutions that will allow us to continue our calling of providing compassionate care to all.

Thank you, Mr. Chairman.

Chairman BROWNBACK. Thank you very much, Mr. LeBaron.

Ruth E. Levine is a senior health economist at the World Bank here in Washington, D.C.

Ms. Levine, thank you very much for joining us.

STATEMENT OF RUTH E. LEVINE, SENIOR HEALTH ECONOMIST, WORLD BANK, WASHINGTON, D.C.

Ms. LEVINE. Thanks very much. As you said, I am a senior health economist with the World Bank. My name is Ruth Levine, but the work that I am going to talk about was done several years ago when I was a researcher at the Urban Institute.

With two colleagues at the Urban Institute, Tamara Fox and Sarah Danielson, I studied the impact of the Immigration Nursing Relief Act of 1989, the H-1A program, on the nurse labor market in the Miami-Ft. Lauderdale area. This was part of a five-city study funded by the U.S. Department of Labor.

Using statistical analyses and in-depth interviews, we tried to find out whether INRA allowed health care providers adequate access to foreign labor, while at the same time protecting the interests of U.S. workers. What did we find out?

First, we found out that the entry of foreign-trained nurses under the H-1A program did not harm U.S. workers' interests. There is no evidence that the increased access to the foreign labor under INRA had negative short-term effects on wages, benefits or working conditions in area hospitals, and about half of the hospitals in Miami-Ft. Lauderdale used the H-1A program.

This was because H-1A nurses actually made up quite a small proportion of registered nurses and were widely distributed in the labor market both across institutions and in specialty areas. In addition, and contrary to some common beliefs, we found that foreign nurses weren't paid less than U.S. nurses and were not exposed to worse working conditions, did not concentrate in certain shifts, and so forth.

The presence of foreign nurses had little chance of affecting RN wages or working conditions over the long term. This is again because of the small numbers of foreign nurses in the labor market and the fact that nurse wages are not much affected by supply fac-

tors. It is really the demand side that counts when it comes to nurse wages, such as insurance reimbursement policies and the dynamics of the health care industry.

With respect to other possible negative effects of foreign nurses such as problems with patient care, communication, or the image of nursing as a foreigner's occupation, none of these was evident. The typical foreign-trained nurse is more experienced than nurses coming out of training programs in the U.S. and has a tremendous commitment to the profession. A standard certification process for nurses, in combination with State licensing exams, is effective for quality assurance.

Many of the respondents said that hiring foreign nurses actually increased the ability of hospitals in the area to respond to a diverse patient population. The U.S. nurses themselves often cited the fact that there were more hands on deck as a positive effect of the ability of the facilities to hire foreign nurses. These findings were echoed in the other metropolitan areas that were studied.

If I have a little bit of additional time——

Chairman BROWNBACK. Yes, 1 minute.

Ms. LEVINE. Our second and final conclusion was that the INRA regulations were fundamentally ineffective. They were little more than a bureaucratic exercise. Hospitals filing attestations with the Department of Labor to permit them to hire the H-1A nurses viewed the process simply as government paperwork. They left it largely to an attorney to take care of filling out the form and that was it.

The regulatory language was ambiguous, leaving a lot of room for interpretation. So the key terms like "vacancy rate," "prevailing wage," "timely and significant steps to recruit and retain" simply were undefined and had in the end very little meaning. We found a large variety of ways that hospitals were defining these terms and no follow-up on the part of the Department of Labor to see what the variation was.

It is safe to say that nothing in the law, its regulation or enforcement actively protected U.S. workers. But at the same time, there really wasn't anything to protect them from. As I said earlier, the foreign-trained nurses were doing no harm to the U.S. workers in the short or the long term.

Finally, there may well be a role for legislation in ensuring that the labor market works with respect to nurses' wages and working conditions. But on the basis of our study, it appears that trying to do this through the regulatory provisions in immigration legislation really has no benefits. So the foreign nurses did no harm and the bureaucratic requirements in the legislation basically did no good.

[The prepared statement of Ms. Levine follows:]

STATEMENT OF RUTH E. LEVINE, SENIOR HEALTH ECONOMIST, WORLD BANK

Thank you for inviting me here today to discuss one aspect of the nursing shortage: the immigration of foreign-trained nurses.

My name is Ruth E. Levine, and I am currently a senior health economist at the World Bank, although the work I will speak about today was conducted while I was a researcher at the Urban Institute several years ago.

As you know, there have been periodic shortages of registered nurses since at least World War II. While each crisis period has its own features, there is much to be learned by looking back a bit in time.

Our last major nursing shortage was in the late-1980s. At that time, about 11 percent of nursing positions in acute care general hospitals were vacant, and about three-quarters of all hospitals reported problems filling posts. Urban centers were most severely affected, primarily in the Northeast, Southern Florida and the West Coast.

One of the several strategies used by hospitals during critical shortages has been the recruitment of nurses trained overseas—primarily, but not exclusively, from the Philippines. In 1989, largely in response to the needs of some large hospitals in New York City, Congress passed the “Immigration Nursing Relief Act” (INRA), which created a special temporary H-1A visa category for RNs. Its regulations included several provisions to reduce potential negative effects of foreign labor.

About 6,000–7,000 nurses were granted H-1A visas in each year that INRA was in effect. While nurses remained on the Immigration and Naturalization Service’s Schedule A (as a shortage occupation) after INRA ended in 1995, the number foreign-trained nurses entering the country declined significantly.

More recently, Congress passed the “Nursing Relief for Disadvantaged Areas Act of 1999,” which created the H-1C visa category for nurses, strikingly similar to the H-1A designation. Once again, the legislation arose because of concerns from a small number of hospitals; and once again regulations attempted to ensure protection of U.S. workers.

With two colleagues at the Urban Institute (Tamara Fox and Sarah Danielson), and funded by the U.S. Department of Labor, I studied the impact of INRA—the 1989 legislation—on the nurse labor market in the Miami-Ft. Lauderdale area. This was part of a five-city study. Using statistical analyses and in-depth interviews, we tried to find out whether INRA allowed health care providers adequate access to foreign labor, while at the same time protecting the interests of U.S. workers.

What did we find, that may be of interest to you today?

FIRST, WE FOUND THAT THE ENTRY OF FOREIGN-TRAINED NURSES DID NOT HARM U.S. WORKERS’ INTERESTS.

There was no evidence that the increased access to foreign labor under INRA had negative short-term effects on the wages, benefits or working conditions in area hospitals. This was because H-1A nurses made up a very small proportion of registered nurses, and were widely distributed in the labor market (both across institutions and specialty areas). In addition, and contrary to common beliefs, we found that foreign nurses were not paid less than U.S. nurses, and were not exposed to worse working conditions.

The presence of foreign nurses also had little chance of affecting RN wages or working conditions over the long term. This is again because of the small numbers of foreign nurses in the labor market, and the fact that nurse wages are not much affected by supply factors. Wages are much more affected by other forces in the market, including insurance reimbursement policy and the dynamics of the health care industry.

With respect to other possible negative effects of foreign nurses, such as problems with patient care, communication or the image of nursing as a “foreigners’ occupation,” none of these was evident. The typical foreign-trained nurse is more experienced than nurses coming out of training programs in the U.S., and has tremendous commitment to the profession. A standard certification process for foreign nurses, administered by the Commission on Graduates of Foreign Nursing Schools, in combination with state licensing exams, is effective in quality assurance.

In the in-depth interviews, most respondents said that hiring foreign nurses actually increased the ability of hospitals to respond to the needs of a diverse patient community. And fellow U.S. nurses consistently recognized that having some extra “hands on deck” made their lives better. It is, after all, nurses themselves who suffer most when there is a critical shortage.

These findings were echoed in similar studies in four other labor markets (Boston, Tampa, New York City, and Los Angeles). An earlier study by Booz Allen Hamilton also no negative effects of foreign nursing labor on wages.

SECOND, WE FOUND THAT THE INRA REGULATIONS WERE INEFFECTIVE—LITTLE MORE THAN A BUREAUCRATIC EXERCISE.

Hospitals filing attestations with the U.S. Department of Labor to permit them to hire H-1A nurses viewed the process simply as government paperwork. The regulatory language was ambiguous, leaving a lot of room for interpretation. For example, the terms “vacancy rate,” and “timely and significant steps” to recruit and retain U.S. nurses were left undefined, and ultimately meant nothing. In addition, we

found that virtually none of the attesting hospitals complied with the basic public information requirements of INRA.

It is safe to say that nothing in the law, its regulations or enforcement actively "protected" U.S. workers. The provisions were weak. But at the same time, as I stated earlier, there really was nothing to protect them from: the presence of foreign nurses was not doing any harm.

In the future, it would make sense to minimize regulatory paperwork. Any attestation process should focus on ensuring that the public is informed about which hospitals are hiring new foreign entrants, perhaps through low-cost vehicles like the Internet, as well as nursing journals.

There may well be a role for legislation in ensuring that the labor market "works" with respect to nurses' wages and working conditions, but on the basis of our research, it appears that trying to do this through regulatory provisions in immigration legislation has no benefits.

Thank you for your attention to my presentation. I would be happy to answer any questions you might have.

Chairman BROWNBACk. Dr. Wear, the Chair of the American Psychological Association Committee on Rural Health, and President of Wear and Associates, out of Seattle, Washington.

Thank you for being here. I advise you I have been buzzed for another vote, so we have a couple of minutes here, if you can get it in in that period of time. I apologize again, but it is just the day we are in.

STATEMENT OF DOUGLAS M. WEAR, CHAIR, COMMITTEE ON RURAL HEALTH, AMERICAN PSYCHOLOGICAL ASSOCIATION, SEATTLE, WASHINGTON

Mr. WEAR. Chairman Brownback, the American Psychological Association appreciates the opportunity to testify today at this hearing on rural and urban health care needs.

I am Dr. Doug Ware, a clinical psychologist from Seattle, Washington, and I also formerly practiced for 15 years in Buffalo, Wyoming. I chair the APA Committee on Rural Health which coordinates work on this Association priority.

Psychologists provide prevention and treatment services for mental health and substance abuse problems, as well as services that treat the behavioral components of acute and chronic physical disease. The APA has committed significant resources to addressing the behavioral health care needs of people living in rural and frontier communities, where behavioral health care providers and services are very often in short supply.

For example, at this time there are almost 800 mental health professional shortage areas in the United States, and 70 percent of them are located in rural and frontier areas. This designation entitles communities to participate in a Federal program called Loan Repayment administered by the National Health Service Corps. This Federal agency is responsible for operating various programs to encourage health providers to practice in underserved communities.

This year, the Senate Health, Education, Labor and Pensions Subcommittee on Public Health will be taking up the reauthorization of the National Health Service Corps. We recommend reauthorization of this valuable program and the expansion of the capacity of the National Health Service Corps to recruit and place psychologists and other behavioral health care practitioners through the provision of both scholarship and loan repayment.

The themes of service delivery, funding issues, personnel shortages and interdisciplinary care, and the ability to provide behavioral health care services in rural communities are some of the underlying themes that are found in a new publication entitled "Behavioral Health Care in Rural and Frontier Areas: An Interdisciplinary Handbook" that has recently been completed by the APA Committee on Rural Health. This does reference all professions, including nursing and several other medical professions, so it is not just the psychological work.

Also, in September 2000 the APA and National Rural Health Association jointly conducted a congressional briefing on an important APA report entitled "The Behavioral Health Care Needs of Rural Women."

Chairman BROWNBACK. Dr. Wear, I am going to have to rush out of here shortly. Do you have a couple of recommendations from your Association that you think we ought to look at? I want to make sure that we get those.

Mr. WEAR. Yes. I am on the last paragraph. Principally, the reauthorization of the National Health Care Service Act, and then these other documents have other recommendations. We can certainly forward those to the committee.

We are working in our realm certainly with trying to provide the kind of training, and we do surveys to make sure we are staffing as well as we can rural areas, sharing some of the similar problems with nurses. We will continue to develop and advocate for those kinds of programs.

So I will let you go with that.

[The prepared statement of Mr. Wear follows:]

STATEMENT OF DOUGLAS M. WEAR, PH.D., CHAIR, COMMITTEE ON RURAL HEALTH
AMERICAN PSYCHOLOGICAL ASSOCIATION

Chairman Brownback and Senator Kennedy, the American Psychological Association appreciates the opportunity to testify today at this hearing on rural and urban health care needs. I am Dr. Doug Wear, a clinical psychologist from Seattle, Washington, formerly a practitioner in Buffalo, Wyoming, and I chair the APA Committee on Rural Health, which coordinates work on this association priority.

The APA has committed resources to addressing the behavioral health care needs of individuals residing in rural and frontier communities where behavioral health care providers and services are often in short supply. For example, at this time there are almost 800 Mental Health Professional Shortage Areas in the United States, and 70% of them are located in rural and frontier areas. This designation entitles communities to participate in a Federal program called Loan Repayment, administered by the National Health Service Corps. This federal agency has responsibility to operate various programs, including Loan Repayment, to encourage health providers to practice in underserved communities. These include rural communities that have immigrant groups who have arrived recently. Examples of these groups include Southeast Asians and Central Americans who have emigrated to escape political oppression and severe economic hardship.

This year the Senate Health, Education, Labor & Pensions Subcommittee on Public Health will be taking up the reauthorization of the National Health Service Corps. We recommend the reauthorization of this valuable program and the expansion of the capacity of the Corps to recruit and place psychologists and other behavioral health practitioners through the provision of both scholarships and loan repayment.

Psychologists can provide prevention and treatment services for mental health and substance abuse problems, as well as services that address the behavioral components of acute and chronic physical disease. Recent immigration to rural and frontier areas of the U.S. has introduced new challenges to the provision of healthcare in these communities. In addition to the adjustment problems of adapting to a new culture, recent immigrants often have special needs that need be addressed. These

include anxiety, depression, and substance abuse problems that are the sequelae to these disorders. It is significant that mental disorders are often accompanied by co-occurring disorders that include addictions. It is known that 70% of individuals treated for substance abuse have a lifetime history of depression.

Some immigrants I have worked with as a psychologist are experiencing language difficulty, culture shock, isolation, and stress which exacerbates any existing mental or substance disorders they might have and sets them up for failure if they are vulnerable. An appreciation and understanding of cultural issues on the part of the psychologist is essential to really be effective. Developing a system of social support is an essential step. In the best of circumstances, there are mentors from the immigrant's own country that have preceded him or her to serve this important role. So often, though, this is not the case, especially in frontier communities where the numbers are very small. Then, it might be a local family, a school class, a church group, or a community organization that will end up attempting to help the new immigrant family acclimate to their new home. Often, group sessions are very helpful to begin helping people get comfortable with each other and find common ground.

Thus I'm gratified that the APA Council adopted a resolution in 1999 finding, in part, "Mental health-related issues, particularly stress associated with trauma, acculturation to language, economics, health care, education, religion, as well as encounters with both individual and institutional bias, are faced consistently by foreign-born residents of this country; and differential degrees of acculturation within immigrant families can negatively affect family communication and even evoke conflict, particularly between parents and their adolescent offspring."

I have often found a need to work with not only the immigrant and his/her family but also with members of the typically very heterogeneous community where the immigrant persons or families reside. They too are stressed, sometimes prejudiced, and unfamiliar with other cultures and value systems. Likewise in the schools or work and community settings, rural psychologists often can take an educative and facilitative role in bridging cultures and finding ways to bring people together.

Thus I'm gratified that the APA Council adopted a resolution in 1999 finding, in part, "Mental health-related issues, particularly stress associated with trauma, acculturation to language, economics, health care, education, religion, as well as encounters with both individual and institutional bias, are faced consistently by foreign-born residents of this country; and differential degrees of acculturation within immigrant families can negatively affect family communication and even evoke conflict, particularly between parents and their adolescent offspring."

I have often found a need to work with not only the immigrant and his/her family but also with members of the typically very heterogeneous community where the immigrant persons or families reside. They too are stressed, sometimes prejudiced, and unfamiliar with other cultures and value systems. Likewise in the schools or work and community settings, rural psychologists often can take an educative and facilitative role in bridging cultures and finding ways to bring people together.

The APA Rural Health Initiative works in conjunction with state psychological associations, federal and state agencies, national health professional organizations with an interest in rural populations, and the U.S. Congress and state legislatures to advance the cause of improved behavioral healthcare for rural Americans.

The APA Office of Rural Health is responsible for the expansion of practice opportunities for psychologists to provide behavioral healthcare in rural areas. It staff and works closely with the APA Committee on Rural Health to administer projects to accomplish this responsibility. Much of the work that has been accomplished by the Rural Health Initiative appears on the Web site RuralPSYCH (<http://www.apa.org/rural/>), a resource center that provides information on policy, practice and training on rural behavioral healthcare. This is accomplished through storing (for easy download) important reports, cross-links to other worthwhile sources of behavioral healthcare, and announcements of projects that have been completed.

In order to ensure that sufficient numbers of psychologists are trained and prepared to meet the behavioral healthcare needs of rural and frontier populations, including those of recent immigrants, the APA conducts a periodic survey of psychology training programs and internships. The result of the survey is displayed on RuralPSYCH. The APA Rural Initiative cooperates with academic institutions developing new psychology doctoral training programs to serve rural communities. The newest one is located at Marshall University in Huntington, West Virginia. It is a program totally dedicated to training psychologists who will practice in rural West Virginia by having all of the clinical practica for students conducted in rural settings reinforces this objective.

The APA Rural Initiative has also addressed the shortage of psychologists in rural areas by encouraging the participation by psychologists in the Loan Repayment pro-

gram of the National Health Service Corps. The program enables psychologists to provide services in communities located in Mental Health Professional Shortage Areas. Many of these areas have migrant workers in addition to recent immigrants. This is an imperative for healthcare providers to deliver care in a culturally competent manner.

To achieve cultural competence, behavioral health providers in rural areas must have an understanding of and an appreciation for cultural differences and similarities within, among and between groups. This requires the acquisition of academic and interpersonal skills that will increase understanding and willingness and an ability to draw on cultural and community-based values, traditions, and customs to work with people from the community in developing interventions, communications, and other prevention and treatment options that address behavioral health problems. The goals of cultural competence include:

- identifying social, economic, political, and religious influences affecting immigrant and ethnic minority populations;
- understanding the impact of interaction between social institutions, culture, and ethnicity on the delivery of behavioral health services;
- understanding the importance of language, culture, and ethnic influences in rural communities and the importance of the oral tradition in some cultures;
- recognizing the impact of the provider's own culture, sensitivity, and awareness as it affects his or her ability to deliver health care, especially with recently arrived immigrants; and
- understanding alternative treatment sources (e.g., Curanderes in Hispanic culture) in some immigrant and ethnic cultures.

The theme of cultural competence and the ability to provide behavioral healthcare services to recently arrived immigrant groups in rural communities is one of the underlying themes that is found in every chapter of a new publication titled *Behavioral Healthcare in Rural and Frontier Areas: An Interdisciplinary Handbook* that has recently been completed by the APA Committee on Rural Health. APA Books will publish this volume in late 2001 or early 2002. In addition to the work of the Rural Initiative, the APA has developed *Guidelines for Providers of Psychological Services to Ethnic, Linguistic and Culturally Diverse Populations*.

In September 2000, the APA and National Rural Health Association jointly conducted a Congressional briefing on an important report completed by the APA Rural Initiative titled *The Behavioral Healthcare Needs of Rural Women*. This report covered many healthcare problems encountered by recently arrived women immigrants and called for action to provide the behavioral healthcare services they need. See <http://www.apa.org/rural/ruralwomen.pdf>

The APA Rural Health Committee and Office of Rural Health are sensitive to the need to provide behavioral healthcare services to rural and frontier residents in the U.S. and are mindful of the special circumstances newly arrived immigrant groups encounter on their arrival. In approaching the task of ensuring high quality mental and behavioral healthcare for rural and frontier populations in the United States, we will continue to develop and advocate for programs that are culturally competent and sensitive to the special needs of immigrant populations who have arrived recently.

Chairman BROWNBACK. Now, I understand that you want to extend this program. Does that include within it anything regarding visas for immigrant nurses?

Mr. WEAR. I don't know about that. It incentivizes people to practice in rural areas and helps with repayment programs. I don't know, I am not sure. We can look into that and get back to you. I would be happy to do that.

Chairman BROWNBACK. If I could, I invite several of you, if you would, to stay around and discuss with the staff. Ms. Sosne, you mentioned that there are a couple of criteria that you were particularly interested in, and, Mr. Shusterman, you cited that 1952 program that was in place. That sounds like an interesting starting point to discuss somewhere we have been before. We can learn or improve or correct from program that as we would look at this today.

To a number of people whom I have talked to, it seems a key problem that we have is of health care workers, and it is at several different levels. We have been addressing it somewhat in terms of physicians. For example, in Ulysses, Kansas, Grant County Hospital has five physicians—two from Canada, one from Pakistan, one from Syria, and one from Trinidad. This is the physician community in Ulysses, Kansas. Now, maybe there are another one or two that I don't know about, but I met with them. They have model U.N. meetings and they are great; they provide excellent health care services.

I hope that we could work together to see that everybody's interests and needs are met. I know your Association represents and works very carefully with a number of nurses who have been foreign trained, and that you want to take care of those needs and interests.

I hope, as well, that the other members of the panel could help us in putting this forward and suggesting if there are any follow-up studies that would be needed. Ms. Levine, the study that you cited, I believe, was a 1998 study?

Ms. LEVINE. No. It came out in 1994.

Chairman BROWNBACK. 1994. I'd like to know whether we need to update the data or not, or if the conditions have changed in that period of time. I want to see whether we should do that, or if there are other members who want to research different angles of this because this is a big issue. It has a significant impact on a number of people.

I have to go back over and vote. If you would like to stay around and visit with the staff, I would invite you to do so please advise us and keep us informed of your thinking and how you might form this issue.

Thank you for traveling great distances, many of you.

The hearing is adjourned.

[Whereupon, at 3:28 p.m., the Subcommittee was adjourned.]

Submissions for the record follow:]

SUBMISSIONS FOR THE RECORD

Statement of Reed L. Russell, Akin, Gump, Strauss, Hauer & Feld, L.L.P., Attorneys at Law, Washington, DC

MEMORANDUM

ELIMINATION OF THE CAP ON ADJUSTMENT OF STATUS FOR ASYLEES UNDER SECTION 209(B) OF THE IMMIGRATION AND NATIONALITY ACT

This memorandum advocates changing an arbitrary and ill-considered immigration statute, section 209(b) of the Immigration and Nationality Act ("INA"). Because of this statute, over 50,000 aliens lawfully admitted to the United States under grants of asylum are currently waiting to have their applications for lawful permanent residence status processed and, therefore, effectively being denied the opportunity to become active and productive members of our society.

Under section 209(a) of the INA, an individual lawfully admitted to the United States as a refugee or through a grant of asylum must remain in the country for one year before he or she may apply to adjust his or her status to that of a lawful permanent resident. 8 U.S.C. § 1159(a). However, there is an additional cap under section 209(b) that limits to 10,000 the number of asylees that may adjust status each year to become permanent residents, regardless of the number granted asylum. 8 U.S.C. § 1159(b).

The cap had no practical impact before 1995, because the number of asylees never reached 10,000.¹ However, in 1995, the INS imposed significant reforms in the asylum process to counteract rampant fraud in applications and to streamline procedures. *See* United States DOJ, INS, Asylum Reform: Five Years Later (Feb. 1, 2000) (“Asylum Reform”). As a result, significantly fewer applications are filed each year but the number of grants now exceeds 10,000 annually. *See id.* Because that number exceeds the cap imposed by section 209(b), the statute has created a significant backlog in the processing of applications for permanent residence. Estimates from the INS as of March 31, 2001 place the backlog at 57,680 persons. Thus, given the 10,000 person per year cap, someone granted asylum today will not be able to adjust his or her status to that of a permanent resident for at least six years.

These individuals already have passed through a rigorous process that allows for grants of asylum only to those persons who come from countries with truly intolerable human rights conditions and who pass a criminal background investigation. *See* 8 C.F.R. § 213. However, because of the delay in obtaining permanent residency, these lawfully admitted aliens often face significant difficulty obtaining employment. Moreover, they suffer the continued anxiety of not knowing whether they will be allowed to remain in the United States based on their asylum status.² Finally, this delay also postpones these individuals’ integration into society as citizens, because they cannot apply for citizenship until five years after obtaining lawful permanent residency status.

This statute is irrational and unsupportable for at least three reasons. First, although it properly allows the processing of refugees based on the rational criteria of the number admitted each year, the statute inexplicably denies the same common-sense treatment to asylees by imposition of the 10,000-person cap. This is so even though the basic standard for admission is the same for refugees and asylees: an inability or unwillingness to return to the home country due to “persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.” 8 U.S.C. § 1101(a)(42). Thus, the system for admitting refugees encourages their integration by allowing a refugee to obtain permanent residency within two years of arrival,³ while it delays that process for six years for individuals who receive grants of asylum, even though the basis for granting them admission to the United States could very well be identical. This situation is nonsensical at best and punitive at worst and it should be eliminated.

The second reason the cap should be eliminated is that it creates an unnecessary administrative backlog and delays the orderly processing of applications for permanent residence. Individuals granted asylum have already been screened through a rigorous process where they must submit testimonial and/or documentary evidence supporting their claims and respond to questions by a trained asylum officer in an interview that often lasts at least one hour and in some cases two or more hours. Indeed, in some cases asylees must prove the bona fides of their claims in immigration court. Moreover, applicants must submit to a criminal background investigation. As evidence of the rigorous standards applied, a February 2000 report shows that even after reforming the system to eliminate most fraudulent claims, the INS still grants less than 40 percent of applications for asylum. *See* Asylum Reform, *supra*. Finally, the arbitrary cap creates an unnecessary strain on INS’s scarce resources, which could be applied to enforcement or other immigration needs. Instead, these resources are allocated to manage a backlog of thousands of asylees that otherwise would be moving through the system in an orderly fashion. Individuals granted asylum already have established themselves as credible and free of a criminal background. Forcing them to wait beyond the statutory one-year probationary period to adjust status serves no apparent purpose and, in fact, creates an unnecessary strain on public resources. Moreover, we are not the first to reach this conclusion.

In 1997, the United States Commission on Immigration Reform, a bipartisan commission of policy makers and immigration experts, issued a comprehensive report on recommended changes in the immigration law. *See* United States Commission on Immigration Reform, U.S. Refugee Policy: Taking Leadership (June 1997) (“Taking

¹The cap was raised from 5,000 to 10,000 in 1990. *See* Pub. L. 101-649, § 104(a)(1) (1990).

²Asylum status can be terminated in some circumstances even after it has been formally granted. *See* 8 U.S.C. § 1158(c)(2)(A).

³The asylee must wait one year before applying for the application and then the application process takes approximately one year once it begins.

Leadership”).⁴ Among those recommendations was an elimination of the 10,000-person cap imposed by section 209(b). *See id.* at 35. Indeed, the Commission also advocated elimination of the statutory one-year waiting period in favor of granting permanent resident status to all individuals when they received a grant of asylum. *See id.* at 34.⁵

With respect to the elimination of the 10,000-person cap, the Commission provided two bases for its recommendation: (i) the inevitable backlog that would occur because of the excess of asylum grants over 10,000 per year and (ii) the rigorous asylum process. *See id.* at 35.

The Commission is seriously concerned that under the current system [the excess of asylum grants over 10,000] will result in an unnecessary backlog of adjustment applications. We strongly reiterate our belief, stressed in our 1995 report on legal immigration, that the federal government should not manage immigration policy by backlogs and waiting lists. Given the recent reforms in the asylum system and the rigorous standard applied in granting asylum, numerical ceilings on adjustment are neither necessary nor good public policy.

Id.

The third reason for eliminating the cap, one that is related to the second, is that the statute is adverse to a basic common-sense principle: that the United States government should seek to integrate lawfully admitted aliens into the society as soon as possible so that they may participate and contribute to their full potential. As the Commission stated in advocating removal of both waiting periods: “Elimination of the delay in adjustment would greatly reduce continued uncertainty and instability in the lives of asylees even after their initial approval and would enable asylees and their families to integrate into the U.S. in a timely fashion.” Taking Leadership at 35.

Individuals granted asylum receive a work authorization card allowing them to obtain employment. However, the INS requires that the work-authorization card be renewed annually until the asylees become lawful permanent residents.⁶ As a result, many employers are reluctant to hire these individuals because of the uncertainty surrounding their residency status. Thus, the combination of the one-year statutory waiting period and the multi-year administrative backlog makes it more difficult for asylees to gain long-term employment and become productive members of society. This result is counter to the common-sense principle that the United States government should be trying to make it easier, not more difficult, for willing and able individuals to be fully employed.

Furthermore, the delay operates in contravention to the well-settled policy of integrating new immigrants into society as productive citizens. A lawful permanent resident has to wait five years before becoming eligible to apply for United States citizenship. This five-year period cannot begin for an asylee until he or she obtains lawful permanent residency status. Thus, by delaying the time for asylees to become lawful permanent residents, the statute also delays the time for them to become naturalized citizens and, thus, prevents them from fully integrating into American society.

Adding to the dilemma, many asylees arrive with families to support. Yet, because of the waiting period, these individuals are forced to support their families through transient and most likely menial jobs for several years. The effect is to impose an unnecessary hardship on individuals and families who are in the United States only because they have suffered from gross injustices in their home country.

In short, section 209(b) (i) irrationally and inexplicably treats one class of lawfully admitted aliens worse than others similarly situated, (ii) causes unnecessary admin-

⁴The Commission was formed in 1990 under the Immigration Act of 1990. Its members have included the following: Archbishop of Boston Bernard Cardinal Law (first Chairman); Barbara Jordan (second Chairwoman); Shirley Mount Husfstedler (third Chairwoman), former Ninth Circuit Judge and Secretary of Department of Education; Professor Lawrence Fuchs, former Executive Director of the Select Commission; Michael Teitelbaum of the Alfred P. Sloan Foundation, Richard Estrada, columnist for the Dallas Morning News; Harold Ezell, former INS Regional Commissioner; Robert Hill, immigration attorney; Warren Leiden, Executive Director of the American Immigration Lawyers Association; Nelson Merced, Massachusetts State Legislator, and Bruce Morrison, former Chairman of the House Subcommittee on Immigration, Refugees, and International Law.

⁵One commission member advocated a two-year conditional permanent resident status. Taking Leadership at 34 n.* However, no one attempted to defend the current system.

⁶Although the regulation provides for a work-authorization card, we are aware of no language in the regulation or the statute providing a basis for the INS's requirement that the card be renewed annually. *See* 8 C.F.R. § 208.7 (work authorization).

istrative delays, and (iii) is counterproductive and contrary to the interests of the United States. We propose several options to remedy this glaring inequity:

- 1) Adopt the recommendation of the United States Commission on Immigration Reform and grant permanent resident status to asylees, eliminating both the one year statutory waiting period for refugees and asylees as well as the 10,000 person cap for asylees; or
- 2) Amend section 209 to delete section 209(b), thus eliminating only the 10,000 person cap on asylees; or
- 3) Enact special legislation providing for an elimination of the waiting period for all those individuals who have received grants of asylum and been present in the United States for at least one year as of the date the legislation.

Granting more timely permanent resident status to asylees would not increase the number of lawful immigrants in the United States or impose additional burdens on scarce public resources. Asylees already are lawfully in the country and eligible to remain for an indefinite period of time. Rather, granting asylees permanent resident status would have the salutary effect of allowing them to seek long-term employment and assimilate into their communities more quickly, thereby hastening their integration into society as full participating and contributing members. We hope that you will see the obvious logic of our position and lend your support to remedy this situation.

**Statement of Robert D. Evans, Director, American Bar Association,
Governmental Affairs Office, Washington, DC**

Dear Senator Brownback:

I am writing to thank you for holding this hearing on asylum, expedited removal and unaccompanied immigrant children and to share the ABA's views.

Backlogged asylum and immigration court systems in the 1990's led to the enactment of legislation and streamlining policies that lack important procedural safeguards and endanger refugees seeking asylum. Instead of safety, shelter and fair process, many asylum seekers who reach our shores today, including unaccompanied immigration children, find themselves deprived of liberty with inadequate access to legal, and they are summarily deported and barred from appealing to the courts. These reforms have turned our ports of entry into paragons of efficiency, but parodies of justice.

EXPEDITED REMOVAL

Since April 1, 1997, INS inspectors at U.S. land borders, international airports and sea ports have possessed extraordinary power to make and execute on-the-spot deportation decisions.¹ Asylum seekers who arrive in the U.S. after stressful and fatiguing journeys must prove a "credible fear of persecution" in order to avoid immediate expulsion and to be allowed to apply for asylum. There is no right to have a lawyer present or a qualified interpreter to assist in the screening process and no involvement of a judicial or quasi judicial officer.

After an initial inspection at the border today, a person who arrives with no documents, false documents, documents belonging to another individual or valid documents believed to have been obtained through misrepresentation is referred to an INS officer for secondary inspection. The secondary interviews are conducted in secured areas of the ports of entry where nongovernmental observers are denied access and where representation by counsel is not a recognized right. The secondary inspection officer can either issue a removal order or, at the officer's option, give the individual a chance to withdraw his or her request for admission. A removal order bars the individual from returning to the United States for five years unless he or

¹Under the 1996 law, an arriving individual who lacked travel documents or who was suspected of carrying invalid documents had the option of withdrawing his or her request for admission to the United States or appearing before an immigration judge for a formal exclusion hearing. Any person who feared returning to his or her home country could apply for asylum. The person also had a right to be assisted by a lawyer at no expense to the government. If the immigration judge denied entry, or asylum, and ordered exclusion, the person could appeal to the Board of Immigration Appeals and could later obtain federal court review through a writ of habeas corpus. Although a person was subject to detention, it was not uncommon for the INS to release ("parole") an asylum applicant while proceedings were pending. A final exclusion order carried a one-year bar on returning to the United States.

she receives a waiver from the Attorney General. Withdrawing, when permitted, allows the individual to choose his or her destination and imposes no penalty to returning lawfully at any time in the future. Deportation orders previously had been made only by immigration judges after a formal hearing at which the alien could be represented by counsel.

An inadmissible person who expresses a fear of returning to his or her home country must be given a brief explanation of U.S. asylum law and asked three specific questions to determine why the individual left his or her home country and whether he or she has fears or concerns about returning there.² If the person appears to be seeking asylum, the officer will have the person detained for a “credible fear” for an interview by an INS asylum officer, and provide a list of assistance programs that he or she may wish to consult.³ If the asylum officer subsequently finds credible fear of persecution, the individual will be allowed to apply for asylum. If the officer does not find a credible fear of persecution, the individual may ask for de novo review by an immigration judge. Although the right to counsel has been recognized in all other proceedings conducted by immigration judges, the Department of Justice has not recognized a right to counsel in these matters.

This expedited removal authority is exercised by about 4,900 INS officers, at nearly 300 ports of entry. More than 83,000 removal orders were issued in FY 2000. During that same time frame about 3,000 people who expressed fears of returning to their home countries were referred to the asylum corps for credible fear interviews—less than 10 individuals per day. This is about half of the number who had sought asylum at the nation’s borders before the law went into effect and may suggest that bona fide asylum seekers are being turned away.

The ABA, along with human rights organizations and refugee service agencies, has concerns about whether this expedited removal authority is being exercised properly. We have received reports that admissible individuals are being denied entry to the United States and that refugees fleeing persecution are not making it through the inspections process to a credible fear interview.

One reason for concern was raised by findings in a 1998 GAO report. See *Illegal Aliens: Changes in the Process of Denying Aliens Entry to the United States* (GAO, March 1998). Although the INS inspectors generally followed the prescribed procedures, reviews at all five locations visited by the GAO “indicated inconsistent compliance with the procedures.” In four locations, INS inspectors did not document asking at least one of the three questions required for determining if a credible fear interview is necessary up to 18 percent of the time. In a subsequent study, INS inspectors did not document asking at least one of the required questions up to 16 percent of the time. *Illegal Aliens: Opportunities Exist to Improve the Expedited Removal Process* (GAO, September 2000). The GAO also was not able to determine whether or not the INS inspectors are correctly or incorrectly making exclusion decisions in the first place and did not investigate reports of abuses during the inspections processes, including denial of food, phone and bathroom privileges, and verbal abuse.

Another reason for concern stems from an in-depth study by Janet Gilboy, a researcher at the American Bar Foundation, who examined the work of immigration inspectors at ports of entry prior to expedited removal. In her study, “Deciding Who Gets In: Decisionmaking by Immigration Inspectors,” 25 *Law & Society Review* 571, 587 (1991), Gilboy reported that immigration inspectors at ports of entry often make judgments based on a traveler’s nationality:

Little or no individualized inspection occurs; presentation of the country passport suffices to judge what type of individual is requesting admission. This handling implicitly reflects inspectors’ notions about the individual’s limited credibility, that is, lack of trustworthiness of statements or documents.

Because the INS has consistently rebuffed efforts by independent researchers to study the expedited removal process, academics and nongovernmental organizations are trying to monitor the process through other means. The most extensive study is being conducted by The Expedited Removal Study (ERS) based at the University

²These questions are: (a) Why did you leave your home country or country of last residence? (b) Do you have any fear or concern about being returned to your home country or being removed from the United States? (c) Would you be harmed if you were returned to your home country or country of last residence? INS Form 1–867A (4–1–97).

³Credible fear of persecution is defined to mean “that there is a significant possibility, taking into account the credibility of the statements made by the alien in support of the alien’s claim and such other facts as are known to the officer, that the alien could establish eligibility for asylum under section 208.” INA § 235(b)(1)(B)(v), (8 U.S.C. 1230(b)(1)(B)(v)).

of California, Hastings College of the Law. See Karen Musalo, *The Expedited Removal Study: Report on the First Three Years of Implementation of Expedited Removal*, Center for Human Rights and International Justice, University of California, Hastings College of Law (May 2000). ERS' preliminary analysis suggest that women and non-English speakers may have greater difficulty navigating through the expedited processes than better-educated men.

In addition, the Lawyers Committee for Human Rights has documented numerous cases of people fleeing religious persecution, ethnic violence, political repression, and human rights abuse being wrongly turned away from the United States. They also have documented incidents involving asylum seekers who narrowly avoided summary removal or who were mistreated by the INS. *Is this America? The Denial of Due Process to Asylum Seekers in the United States* (October 2000). The ABA has received reports about asylum seekers who were returned to dangerous countries before anyone even knew they had reached the United States. The ABA also has received information about asylum seekers whose deportations were intercepted before they suffered a similar fate.

These reports combined with the secrecy that surrounds the expedited removal process, the absence of independent observers, anecdotal evidence regarding mistreatment by INS inspectors and the decline in asylum applications by arriving aliens, fuel concerns that these expedited processes frustrate claims by genuine refugees.

For these reasons, the ABA strongly supports changing the current process to provide procedures that give individuals a fair chance to consult with counsel and present their cases, as proposed in the Refugee Protection Act introduced by you and Sen. Patrick Leahy last year. We also support the elimination of the one-year asylum deadline which impedes claims by bona fide asylum applicants who are fearful or ignorant of the opportunity to apply for asylum, or who lack the resources to do so.

The ABA also makes the following recommendations pertaining to the exclusion process:

1. Removal decisions should be made by immigration judges, not law enforcement officers.

Facilitating the entry and exit of people and goods at the U.S. ports of entry is one of the most important functions of the INS. According to the INS, there are more than 500 million legal admissions annually - more than 1 million per day. Less than 1 percent of individuals seeking admission are denied entry. Given the greater than 99% admission rate, many immigration advocacy organizations and border communities view inspections predominantly as a "service" activity which should be performed by adjudications personnel, not law enforcement officers. Exclusion orders, moreover, should be entered only by impartial adjudicators, preferably immigration judges, following a formal hearing which conforms to accepted norms of due process. The INS reorganization process may provide an opportunity to re-examine the use of expedited removal and to reestablish these principles.

2. The expedited removal program should not be expanded.

The current law permits the Attorney General to use expedited removal for anyone "who has not affirmatively shown, to the satisfaction of an immigration officer, that the alien has been physically present in the United States continuously for the 2-year period immediately prior to the date of the determination of inadmissibility." INA section 235(b)(1)(A)(iii)(II). Although Attorney General Janet Reno declined to implement that provision, the statute remains on the books and the implementation decision has been delegated to the sole discretion of the INS Commissioner. 8 CFR 235.3(b)(ii). A designation by the Commissioner is effective upon publication in the Federal Register and is not subject to judicial review. We have many reservations about the current program and even more about the inherent dangers in giving similar powers to the Border Patrol or expanding expedited removal to the interior of the country.

3. Asylum seekers who have passed the "credible fear" screening process should be released from detention.

Today there is no guarantee that asylum seekers who have passed credible-fear screening will be released from detention. The statute mandates that a person who is inadmissible be taken into custody and held pending a final determination of credible fear. Similar provisions in the law before 1996 were construed as permitting the Attorney General to "parole" [i.e. release] the applicant pending a final decision in his or her case. While the INS does not dispute that arriving asylum seekers can still be paroled once credible fear has been established, such decisions have been delegated to the INS district directors, who may be reluctant to do so. It is not un-

common for a district director to deny release of a person who has passed the credible fear test, or even been granted asylum by an immigration judge, with the explanation that there is “no compelling humanitarian reason” to release the individual.

The ABA has numerous concerns about the growing reliance on immigration detention because it deprives individuals of their liberty and significantly impacts on their ability to secure and maintain a working relationship with counsel. Today, there are more than 20,000 detention beds available to the INS; 55 percent are rented from state and local jails. Although the lack of access to phones, family, counsel and legal information in these places is well-documented, and there is nearly universal agreement that criminal and non-criminal detainees should not be commingled, the INS continues to rely on these criminal facilities. In lieu of exercising the parole option as a matter of public policy, the INS detains asylum seekers in whatever facilities are available, including in local jails with criminals. The INS also insists that release determinations remain in the hands of the district directors, rather than be delegated to the asylum officers who conduct the credible fear interviews. As a result, traumatized asylum seekers continue to be detained with criminals in isolated penal institutions.

We have repeatedly suggested that the INS release people who have passed the credible fear screening test and establish alternatives to detention. The objectives are achievable and would be a significant improvement over the status quo.

UNACCOMPANIED IMMIGRANT CHILDREN

Immigrant children who arrive in the United States unaccompanied by their parents or other legal guardians are a special concern of the ABA. Some of these children are escaping political persecution, while others often are fleeing war, famine, abusive families, or other dangerous conditions in their home countries that may give rise to asylum claims. When they arrive, these children generally have no legal status or support system and face a stressful and confusing ordeal.

Most detained children speak little or no English and are rarely aware of their rights under U.S. law. They frequently are detained in secure facilities, sometimes commingled with juvenile offenders. Although some children may have U.S. family members to whom they can be released, many will remain in INS custody while their cases proceed through the immigration court system. This practice is inconsistent with nationally recognized juvenile justice standards and with the United Nations Convention on the Rights of the Child, which prohibits the detention of children except as a measure of last resort. Over 4,600 unaccompanied children were detained in over 90 different locations last year.

Although the consequences of deportation may be quite dire, U.S. immigration laws do not allow for the appointment of counsel at the government’s expense, even for these vulnerable children. Immigration court is an adversarial setting, presided over by an immigration judge and prosecuted by an experienced INS trial lawyer. These cases decide the child’s future: statistics from the Department of Justice show that asylum seekers are four times more likely to be granted asylum when represented. These children, however, frequently have no choice but to represent themselves. Nervously they wait, with very little understanding of the law and legal process, for their turn to appear before an immigration judge. When these children are later deported, as many inevitably are, there is virtually no follow up to find out what happens to them.

The ABA is working with state and local bars across the country to help these children secure pro bono representation. For many years the ABA, State Bar of Texas and American Immigration Lawyers Association have co-sponsored ProBAR, a project that brings in volunteer lawyers to represent many children who are detained in a remote location in rural South Texas by the INS. Still, the numbers of unaccompanied children who are detained nationwide exceeds available volunteers.

This is an anomaly in our justice system that urgently needs legislative reform. The ABA strongly supports enactment of legislation such as S.121, introduced by Sen. Dianne Feinstein, to provide every child in this situation with a court-appointed attorney to speak for that child in court and to assist him or her in applying for relief under U.S. law. The ABA also strongly supports creating an independent office within the Department of Justice with an oversight role to ensure that children’s interests are respected at all stages of immigration processes and while in immigration custody. We further recommend that incarcerated children automatically receive custody redetermination hearings before immigration judges (even if not specifically requested) and be placed in the “most family-like setting” when they cannot be released to family members or other appropriate adults.

The ABA is committed to the principle that aliens who are facing removal from the United States have a right to fundamental due process and other constitutional

protections. The current expedited removal procedures do not comport with due process principles or respect the right to counsel. The ABA also believes that all children within our borders must be treated fairly by our laws and justice system, regardless of their immigration status.

We thank you for bringing these issues to the attention of the American public and look forward to assisting you as you work to enact legislative reforms this session.

**Statement of Commission on Graduates of Foreign Nursing Schools,
Philadelphia, PA**

The Commission on Graduates of Foreign Nursing Schools (“CGFNS”) submits the following statement for the record of the hearing on Rural and Urban Health Care Needs.

SUMMARY:

CGFNS takes no position on whether additional foreign nurses should be admitted as part of the response to the current U.S. nursing shortage. If the Congress decides to admit additional foreign nurses, however, then the American public must be assured that the foreign workers are competent. In order to achieve this goal: (1) the INS’s current waiver of the screening mechanism for temporary foreign health care workers should be immediately rescinded, and (2) this screening mechanism should apply in full measure to any additional foreign healthcare workers admitted into the United States.

BACKGROUND:

CGFNS is an immigration neutral, non-profit, internationally recognized leader in the education, registration and licensure of healthcare professionals worldwide. CGFNS protects the public in relation to evolving healthcare policies and standards of professional practice for migrating healthcare professionals. Its mandate is to evaluate the credentials and to test the knowledge and English language proficiency of internationally educated nurses and other healthcare workers who seek to practice in the United States. The International Commission on Healthcare Professions (“ICHP”) is a division of CGFNS that was launched in 1996 to administer its Visa Screen program, which is a congressionally mandated screening program for foreign healthcare workers seeking an occupational visa in the United States. The International Consultants of Delaware, Inc. (“ICD”), also a division of CGFNS, is nationally and internationally recognized as an expert in the field of international education. Established in 1977, ICD is a credentialing agency which evaluates international education documents and provides their U.S. equivalents.

NURSING SHORTAGES AND QUALIFIED FOREIGN NURSES.

CGFNS takes no position on whether additional foreign nurses should be admitted into the United States as part of a strategy to address the current U.S. nursing shortage. If the Congress decides to admit additional foreign nurses, however, then the American public must be assured that the foreign workers meet appropriate standards.

CGFNS believes that, as the healthcare industry reacts to the nursing shortage, existing licensure and quality assurance requirements may be shortchanged. It is imperative that, in the efforts to expand the foreign nurse workforce, the health care industry and policy makers retain the “checks and balances” of licensure and certification to ensure that high-quality care is provided to our sick.

State licensing authorities would tell you that fraudulent documents, academic credentials, and licenses are a major challenge to their mandate of protecting the public. Identity theft is a growing problem, as technology appears to facilitate fraud and challenge detection. The challenge is multiplied when foreign languages, different academic regimes, and varying professional standards and licensure requirements are added to the mix. Those charged with protecting the public health and safety know that quality assurance is time consuming and labor intensive.

In addition to detecting outright fraud, professional competency must be measured. Pursuant to Section 343 of the 1996 immigration law, CGFNS reviews the foreign education of the health-care worker to ensure that it is comparable to that of a U.S. healthcare worker. In the area of nursing, for example, CGFNS verifies that the applicant completed a full secondary school education and that the applicant’s

professional education is comparable to that of a first level general nurse (“RN”) in the United States. CGFNS measures this in a variety of ways. An RN’s education must include four major components; medical-surgical nursing, psychiatric nursing, obstetrics and gynecology and pediatrics. Language proficiency must also be ensured. The need for appropriate written and spoken English skills in the health care setting is critical to ensuring communication of symptoms, treatment, informed consent and disease prevention and promotion of information between patients, their families and healthcare providers. Finally, CGFNS confirms that the foreign nurse’s license is active and unencumbered (i.e., that the license remains valid and the individual has not been the subject of professional discipline).

CGFNS recommends that the Committee be mindful of the quality measures that have been mandated to ensure the health and safety of patients who receive health care services from licensed health care professionals. As the Urban Institute’s study pointed out, the standard certification process for foreign nurses in combination with the state licensing exams has proven an effective quality assurance mechanism. The public must be assured that those who are presented to them as health care providers have the appropriate education to diagnose, assess and provide treatment as needed and that such individuals are licensed according to applicable professional standards. As the industry grapples with the challenge of providing the quantity of nurses presently in demand, we must not sacrifice quality.

LACK OF CURRENT CERTIFICATION PROCESS FOR FOREIGN HEALTHCARE WORKERS.

Current immigration law provides a thorough, adequate legal regime for screening foreign healthcare workers prior to their entry into the United States. This law was added by section 343 of the 1996 immigration law and is found at section 212(a)(5)(C) of the Immigration and Nationality Act. Unfortunately, the INS has crippled this legal regime by refusing to apply it to temporary foreign workers. INS claims that it needs time to implement the section by regulation—but approximately five years have passed and no temporary foreign health care worker has been screened during this time. This is an unacceptable passage of time during which the safety of U.S. healthcare consumers has been at risk.

INS’s refusal to follow the law requiring certification of temporary foreign workers is all the more irrational given that it has already implemented certification standards by regulation for permanent foreign healthcare workers. See 8 CFR § 212.15. Unqualified foreign nurses or other healthcare workers can do just as much damage to U. S. patients while in H-1B or H-1C status as they can while holding a green card. CGFNS has sued the INS seeking to have its waiver of section 343 declared invalid, and we are currently awaiting the decision of the U.S. District Court for the District of Columbia. If Congress decides to admit additional foreign nurses, it should concurrently rescind INS’s waiver of the certification requirement in section 343 and apply this safety screening to all foreign healthcare workers admitted on occupational visas.

NURSING ASSISTANTS.

The suggestion that amnesty for undocumented health care workers could produce a much-needed cadre of professional and paraprofessional health care workers must be examined closely. Is there any data to suggest that healthcare workers are a significant proportion of that population? Certainly provision of amnesty to such workers should not alter licensure and quality assurance requirements.

The need for certified nursing assistants in long-term care is longstanding—as is the need for training and monitoring of these important caregivers. CGFNS believes, however, that it would be difficult to examine and certify the education and preparation of such unlicensed caregivers from foreign nations. State boards of nursing and health care agencies are having problems today certifying and tracking U.S. trained nursing assistants, as presently required, for the protection of the health and safety of those residing in our nursing homes. Foreign-trained individuals in this profession should be required to satisfy the same standards, but documenting compliance with these standards—given that in most countries it is an unlicensed profession—would be challenging, to say the least.

OTHER ISSUES.

One witness, Carl Shusterman, asserted that there is “something clearly wrong when . . . it is easier to obtain a working visa for a fashion model than for a registered nurse.” We adamantly disagree. It should be harder to obtain a working visa for a registered nurse who is on the front line providing health care and whose assessments, communications and interventions affect the lives of patients. Without casting aspersions on any other profession, nursing is a critical occupation which

can have profound consequences on the health and lives of every American. There is every reason to be cautious regarding which foreign nationals are admitted to practice this profession. To paraphrase a recent Washington Post article on models and politicians, we believe modeling and nursing are pretty separate.

Mr. Shusterman also stated that nurses and other healthcare workers have complained about difficulties communicating with ICHP. CGFNS is very cognizant of the nursing shortage, the large number of applicants for U.S. visas from foreign healthcare workers, and the high volume of recruitment of foreign healthcare professionals. We are presently fielding 2500-3000 calls, 700 e-mails and 300 faxes per week from nurses and other healthcare professionals—recruiters and employers—regarding our services. We have rostered over 5700 nurses for our July 2001 exam—an increase of over 1000 from the March 2001 exam—and expect similar numbers for November 2001. We regret any dissatisfaction that any applicant for the certification processes has experienced. In order to meet the service demands, we have hired additional staff, expanded telephone and fax capacity and are upgrading our information systems. We strive to provide quality service to applicants who require our services. The credentials process is complex and labor intensive, in order to ensure the accuracy and validity of the information that consumers, nurses, universities, state boards of nursing and the INS have come to rely on for the past 25 years. We do not object to constructive criticism—instead we desire to know in what areas our performance needs improvement so that we can make the needed changes. We are confident that our service enhancements can handle existing and future caseloads.

Thank you for your consideration of our views.

Statement of Ralston H. Deffenbaugh, Jr., President, Lutheran Immigration and Refugee Service

I thank Sen. Brownback and the other Members of the Subcommittee on Immigration for this opportunity to present testimony on our nation's treatment of asylum seekers. As a religious refugee service agency, Lutheran Immigration and Refugee Service (LIRS) is deeply concerned about the prolonged detention of asylum seekers who are forced to flee their homelands without proper travel documents. I take this opportunity to present the response of a group of religious leaders who have witnessed these detention practices just three days ago and put forth two proposals for humane and cost-effective alternatives to present practices.

On April 30 LIRS, in cooperation with Hebrew Immigrant Aid Society and other faithbased service agencies, coordinated a tour for religious leaders of the Wackenhut Detention Center in Queens, New York, near John F. Kennedy Airport. These leaders, coming from Christian, Jewish, Muslim, Buddhist and Hindu faiths, were shocked that the United States would subject people seeking asylum who have no criminal convictions to months and sometimes years of such harsh conditions. In the attached joint statement following the tour, they call upon Congress and the Administration to correct these practices.

Under current law, asylum seekers can be released on parole after passing a "credible fear" screening shortly after their arrival. Yet, thousands of asylum seekers are being unnecessarily detained, sometimes for long periods, in detention centers and jails across the United States. This costs taxpayers millions of dollars, and prolongs and exacerbates the suffering of asylum seekers who have come here seeking freedom. LIRS's attached proposal describes a humane and cost-effective alternative that would enable INS to release 2,500 asylum seekers to private nonprofit agencies. The model is based upon very effective programs tested in several communities across the country, all of which have appearance rates for all hearings of 93% or better. If Congress appropriates \$7.3 million for this program, we project that the government will save a net \$11.6 million through reduced detention costs.

Lastly, I include LIRS's proposal for NGO legal orientation presentations for immigration detainees. This is another "tested and proven" program that helps to identify persons with meritorious claims for relief, convinces those without legitimate cases to accept removal, reduces tension and improves security in detention facilities and saves the government money by making the judicial process more efficient and reducing the need for prolonged detention. An appropriation of just \$2.8 million would allow this program to expand to 10 sites and save the government \$10 million.

I urge Congress to correct the policies and practices that lead to the prolonged detention of asylum seekers and, in particular, urge the Members of this Sub-

committee to ask your colleagues on the Subcommittee for Commerce, Justice and State Department Appropriations to fund these two worthwhile programs.

STATEMENT FROM FAITH REPRESENTATIVES FOLLOWING APRIL 30 TOUR OF THE
WACKENHUT DETENTION CENTER

As representatives of diverse faith traditions that lift up hospitality to the stranger as a fundamental principle, we are deeply troubled by the way our country is treating people who come to our shores fleeing persecution in their homelands. Today, we call upon Congress and the Administration to end policies and practices enacted in 1996, which seriously undermine our nation's commitment to refugee protection. We are particularly concerned about the impact of expedited removal and detention on adults and children seeking asylum here.

Historically, our nation has been a beacon of hope and freedom for the oppressed. Many of our ancestors fled religious and other persecution and were welcomed here. Yet today, low-level officials have the power to turn asylum seekers away at our borders through on the spot, unmonitored interviews. Thousands of asylum seekers, including children, are also imprisoned in INS detention centers and county jails while they await decisions on their claims. Women, men and children who have suffered torture and imprisonment, witnessed the murder of their families and destruction of their homes, and endured long and dangerous journeys to reach freedom find themselves behind bars. Some remain there for months or even years, with little access to legal, social, and spiritual care.

As a just and generous country that has traditionally stood for the protection of human rights around the world, we can and must do better. We urge Congress and the Administration to take immediate steps to correct the policies enacted into law in 1996 that are causing such severe human suffering.

Signed

The Rev. Dr. Stephen P. Bouman, Bishop of the Metropolitan New York Synod of the Evangelical Lutheran Church in America; Member of LIRS Board of Directors
Mr. Ralston H. Deffenbaugh, Jr., President, Lutheran Immigration and Refugee Service—LIRS, Baltimore, Maryland

Imam Salihou Djabi, Timbuktu Interfaith Center, New York

The Rev. Dr. Bob Edgar, General Secretary of the National Council of Churches, New York

Mr. Leonard Glickman, President, Hebrew Immigrant Aid Society—HIAS, New York

Ms. Mala Kadar, Ilankai Tamil Sangam, an association of American Tamils Tri-State Area

The Venerable Michael S. Kendall, Archdeacon for Mission Episcopal Diocese of New York

The Bishop Ernest S. Lyght, Resident Bishop, New York Area, The United Methodist Church

The Rev. John McCullough, Executive Director, Church World Service, New York

Mr. C. Richard Parkins, Director, Episcopal Migration Ministries, New York

Rabbi Dan Polish, Director of the Joint Commission on Social Action of Reform Judaism, New York

Carol J. Fouke-Mpoyo, Chair, Riverside Church Sojourners Ministry With Detained Immigrants, New York

Rabbi Arthur Schneier, Park East Synagogue, New York; President, Appeal of Conscience Foundation; Member of HIAS Board of Directors

The Msgr. Kevin Sullivan, Chief Operating Officer, Catholic Charities, Archdiocese of New York

The Right Rev. Orris G. Walker Jr., Bishop of the Episcopal Archdiocese of Long Island, New York

ALTERNATIVES TO DETENTION

OVERVIEW

The 1996 immigration laws drastically increased the number of immigrants subject to mandatory detention. INS' daily detention capacity has expanded from 8,279 beds in 1996 to approximately 20,000 today, and over 60% of those beds are in county jails. INS's detention and removal budget is now over \$1 billion. However, INS is still detaining thousands of people who by law could be released. Two such groups are asylum seekers without sponsors or family to care for them and people whose removal orders are over 90 days old and who pose no danger to the community.

Alternatives to detention are arrangements between INS and private, nonprofit agencies to supervise and refer people to community services rather than detain

them at public expense. To establish an alternatives program, INS contracts with nonprofit agencies that have strong community ties and significant expertise in dealing with refugees and immigrants. The private agency screens potential participants, finds housing, coordinates the necessary services for participants outside of detention, and facilitates compliance with INS and court proceedings. INS retains authority over the program to decide whom to release to the program, to set reasonable reporting and other requirements for program participants, and to redetain those who do not comply with those conditions or are ordered removed.

If Congress appropriates \$7.3 million for alternatives to detention, some 2,500 people eligible for release could be placed in such programs which have demonstrated 93% and higher appearance rates at all hearings. The federal government would save a net \$11.6 million.

BACKGROUND

The U.S. Commission on Immigration Reform expressly recommended that "Alternatives to detention should be developed so that detention space is used efficiently and effectively." In particular, the Commission noted that "detaining individuals who have met an initial threshold demonstrating their likelihood of obtaining asylum is not a good use of scarce detention resources."¹

Asylum seekers are legally eligible for release on parole but some have no one to sponsor them upon release, and remain imprisoned even though they have committed no crime. In detention, they will have difficulty finding legal assistance and may suffer additional trauma. According to the Vera Institute of Justice, which tested supervised release for asylum seekers under contract with INS over three years, "Detention of asylum seekers is particularly unnecessary and unfair since they are so willing to attend their hearings and since so many of them win their cases."²

Other detainees have been ordered removed due to relatively minor convictions in the distant past but cannot actually be sent back. Although many no longer pose any danger to the community, they face indefinite detention and prolonged separation from their families for whom they may be the primary breadwinners. Alternatives to detention can humanely achieve INS' goal of ensuring community reintegration for this population.

ALTERNATIVES TESTED IN SEVERAL LOCATIONS HAVE ALL ACHIEVED 93% OR BETTER APPEARANCE RATES.

INS funded the Vera Institute of Justice, a New York-based nonprofit agency, to test supervised release as an alternative to detention. The 3-year pilot program showed that 93 percent of asylum seekers released to supervision appeared for all court hearings, and saved the federal government almost \$4,000 per person.³ Other nonprofit agencies have tested alternatives with equal success. In New Orleans, INS releases asylum seekers and people with over 90-day-old removal orders to a program run by Catholic Charities with a 96% appearance rate.⁴ In another program coordinated by Lutheran Immigration and Refugee Service, INS released 25 Chinese asylum seekers from detention in Ullin, Illinois to shelters in several communities. This program also achieved a 96% appearance rates.⁵ INS officials have praised both programs.⁶

KEY ELEMENTS OF SUCCESSFUL ALTERNATIVES

Following is an outline of how alternatives to detention work, how responsibilities are divided between INS and the nonprofit and why these elements are important to achieving successful appearance rates in immigration proceedings. Attached is documentation with more detailed descriptions of the Vera Institute's Appearance Assistance Program (AAP), Catholic Charities' alternative in New Orleans and the release of Chinese asylum seekers from Ullin, Illinois.

¹ U.S. Commission on Immigration Reform, *Becoming an American: Immigration and Immigrant Policy*, September 1997, pp. 139, 140.

² Vera Institute of Justice, *Testing Community Supervision for the INS: An Evaluation of the Appearance Assistance Program*, June 7, 2000, Volume I, p. 32.

³ Vera Institute of Justice, Volume I, p. 66.

⁴ Joan Treadway, "Detainees get chance to change their lives," *New Orleans Times Picayune*, Jan. 22, 2001, p. B-3.

⁵ Esther Ebrahimian, "The Ullin 22: Shelters and Legal Service Providers Offer Viable Alternatives to Detention," *Detention Watch Network News*, August/September 2000, p. 8.

⁶ Joan Treadway, *New Orleans Times Picayune*, p. B-3 (quoting INS New Orleans District Director Christine Davis); Esther Ebrahimian, *Detention Watch Network News*, p. 8 (citing INS Field Operations chief Michael Pearson).

STEP ONE: GROUP SCREENING IN DETENTION BY NONPROFIT AGENCIES.

In a few detention facilities, private nonprofit agencies have worked with INS and the courts to ensure that group legal orientation presentations are conducted for everyone in detention. These presentations ensure that detainees have information about the proceedings and whether or not they may be eligible for relief from removal or for release from detention. This first contact between the nonprofit agency staff and people in detention is a good time to gather initial information about potential candidates for an alternative. In the case of the Chinese asylum seekers detained in Ullin, Illinois, INS paid the expenses for nonprofit legal representatives to conduct legal orientations for all 88 detained Chinese. The information gathered proved critical to organizing effective services and evaluating release options.⁷

STEP TWO: INDIVIDUAL SCREENING BEFORE RELEASE TO AN ALTERNATIVE

INS has the authority to decide whom to release to an alternative to detention. However, an in-depth interview by a nonprofit representative can improve the Service's ability to make this decision. The nonprofit agency interviews each potential participant to ensure that the person meets the program's criteria and understands the responsibilities of participants in the program. Through this interview, the nonprofit may discover important information that affects the release decision. For example, the person may have family, in which case INS can consider releasing the person to his or her family instead of to an alternative. Such screening interviews were found to be critical to the success of Vera's Appearance Assistance Program.⁸

STEP THREE: PROVISION OF SERVICES TO INDIVIDUALS RELEASED TO THE ALTERNATIVE

Access to assistance upon release—such as legal, social, medical, mental health and job placement services—can help ensure compliance with immigration proceedings.⁹ The nonprofit agency makes use of its community links to find available services. It also helps integrate each individual into the community (for example, by helping participants make contacts in their ethnic and/or religious communities). The nonprofit's ability to access these services depends on long-established links with other agencies in the community. The services needed will vary depending on the population being served and on the individual. For example, asylum seekers are newcomers to the country. Help learning how to live in the United States and find legal assistance can be a critical factor in their making their court appearances.¹⁰ Long-term detainees usually already have experience living in this country, but may need intensive support to help them re-start their lives and integrate into the community.¹¹

INS must grant work authorization to all those released, including asylum seekers, so that they can support themselves instead of relying on government or community sources to cover housing and living expenses. It also helps them use their time productively, contributing to the community instead of remaining idle. INS is granting work authorization in New Orleans to everyone released to Catholic Charities, and this is critical to the success of the program.¹² The nonprofit agency running the alternative organizes temporary housing for those released, and assists them in finding a job and locating a place to live more permanently, all with the goal of helping the released person become self-sufficient.

STEP FOUR: ON-GOING ASSISTANCE, MONITORING AND INFORMATION

Providing information about how the legal system works, detailing the requirements for compliance and describing how to meet them, explaining the consequences of not attending a court hearing, helping locate legal assistance and building a relationship of trust all help to ensure compliance.¹³ Immigration proceedings can be very confusing even for people who have lived in this country, let alone newly arrived asylum seekers. The opportunity to talk with a neutral party experienced in working with refugees and accessing services they need, greatly helps keep an asylum seeker engaged throughout the legal process. In New Orleans, program participants voluntarily contact Catholic Charities to ask questions, discuss problems and

⁷ Esther Ebrahimian, Detention Watch Network News, p. 2.

⁸ Vera Institute of Justice, Volume 1, p. 6.

⁹ Vera Institute of Justice, Volume 1, p. 73.

¹⁰ Vera Institute of Justice, Volume 1, p. 31. “

¹¹ Sue Weishar, “NGOs and INS Establish Successful Alternative in New Orleans,” Detention Watch Network News, August/September 2000, p. 4 and Joan Treadway, New Orleans Times Picayune, p. B3.

¹² Sue Weishar, Detention Watch Network News, p. 8.

¹³ Vera Institute of Justice, Volume 1, p. 7.

receive advice and assistance. In the Ullin project, community shelters reminded participants of their hearings and scheduled check-ins with INS, organized transportation and accompanied them to these appointments.¹⁴

STEP FIVE: ENFORCING FINAL ORDERS OF DEPORTATION

People released to alternatives to detention are more likely to be able to stay legally in the country at the conclusion of their proceedings. This is due to effective screening and increased access to legal representation outside of detention with the help of nonprofit agencies. More than half of the asylum seekers in the Appearance Assistance Program (AAP) won their cases.¹⁵

It is inevitable, however, that some people in alternatives to detention will lose their cases and be ordered removed. It remains the responsibility of INS, not the nonprofit agency, to enforce such orders. In order to achieve this, INS may re-detain at any time a person who does not comply with the conditions of an alternatives program. Conditions may include participants reporting to INS in person on a regular basis, showing up at all court hearings, and keeping INS informed of their actual address of residence. INS may also re-detain a participant upon issuance of the removal order. Participants in the AAP still appeared for their hearings 93% of the time even though they were informed that they would be re-detained if ordered removed in court. A comparison group 6 that did not face the possibility of such re-detention had substantially poorer appearance rates.¹⁶

For asylum seekers who lose their cases in court and are ordered removed, Vera Institute suggests that INS could re-detain the person at the hearing, but release them again to a more intensive level of supervision if they decide to appeal.¹⁷ At earlier stages of proceedings, the Vera Institute's experience shows that asylum seekers need very minimal supervision, if any, in order to ensure good compliance rates. Vera Institute explains, "When they are placed in proceedings, they understand that they must seek...protection through the U.S. justice system and attend immigration court hearings."¹⁸ Vera Institute does not recommend that asylum seekers be detained throughout the appeals process.

PARTNERSHIP WITH NONPROFIT AGENCIES

The Vera Institute recommends that the INS "release to alternatives (such as community supervision) as many people as it can, as quickly as it can, while they complete their immigration court hearings"¹⁹ and favors contracting with non-governmental entities.²⁰ We agree.

- Immigrants inside and outside detention are more likely to trust representatives who do not work for the government, and will therefore be more likely to cooperate with them. Trust and confidentiality are important benefits of having non-governmental entities involved in alternatives.²¹ Once immigrants have the trust of a nonprofit representative, they may reveal information that they would not have readily given to INS or to a prison official. The information they receive from the nonprofit is also more trusted. In the process of release of Chinese asylum seekers detained in Ullin, nongovernmental representatives interviewed the entire group of 88 in detention, a step that was critical to the eventual release of some 33 of them.²²
- Nonprofit agencies have the necessary information and expertise to help people access needed services, leading to greater compliance. It takes a good deal of work to find out what legal, social and pastoral services a person needs, and to help them access them. This has been critical to success of all three programs to date.²³ Merely giving released individuals a list of available services is not sufficient. Certain nonprofit agencies, such as refugee resettlement agencies, have multi-lingual, multicultural staff with

¹⁴In addition to the documentation attached, LIRS gathered information about the operation of these alternatives via telephone interviews with Catholic Charities and the shelters housing the Chinese released from Ullin.

¹⁵Oren Root, "The Appearance Assistance Program: An Alternative to Detention," *Detention Watch Network News*, August/September 2000, p. 3.

¹⁶Vera Institute of Justice, Volume I, p. 3.

¹⁷Vera Institute of Justice, Volume I, p. 32.

¹⁸Vera Institute of Justice, Volume I, p. 29-30.

¹⁹Vera Institute of Justice, Volume I, p. 72.

²⁰Vera Institute of Justice, Volume I, p. 74.

²¹Vera Institute of Justice, Volume I, p. 72.

²²Esther Ebrahimian, *Detention Watch Network News*, p. 2.

²³Oren Root, *Detention Watch Network News*, p. 9.

legal and social work backgrounds, as well as strong, established links in the community that facilitate service provision and job placement. These agencies also have solid ties to immigrant and faith communities, both of which can be important in avoiding isolation.

- Help in understanding the legal process, and the consequences of not showing up at INS check-ins and court hearings, is crucial to ensuring that people comply. Such help has been shown to be most effective when it comes from a non-governmental representative who has gained the trust of the released individual.²⁴ The nongovernmental agencies involved in these projects have spent a good deal of time working with participants to explain proceedings to them, remind them of meetings with INS and the courts, and even transport them to those meetings and hearings. They are also able to answer questions on an on-going basis once someone is released, helping the participant to overcome fears and misinformation that otherwise might have caused him or her to stop complying.
- Facilitating access to legal representation is a critical role of a non-governmental agency implementing an alternative to detention. While INS cannot fund legal representation, adequate legal assistance can help reduce delays in proceedings (for example, due to a lack of information on the part of the immigrant), help ensure compliance, and lead to a fairer process. For vulnerable populations such as asylum seekers, legal representation is particularly crucial, and it is hard to find in detention. Attorneys who do represent people in detention encounter much greater difficulties preparing these cases.²⁵

In the case of the Chinese asylum seekers released from Ullin, nonprofit agencies found pro bono attorneys for all of those released to community shelters. Locating quality representation was a time-consuming process, and was only possible because of the long-established relationships that the nonprofit agencies had with bar associations, law firms, and the pro bono legal community. Even after representation was secured, the nonprofit agencies played a critical role answering the questions of attorneys and helping ensure good communication between the attorneys and the immigrants. For example, the local legal service agencies assisting those released from Ullin helped find volunteer interpreters for attorneys to interview their clients—critical assistance to busy attorneys working on pro bono cases. Good communication between an attorney and his or her client also helps make sure the immigrant is engaged in the process, increasing the likelihood of compliance.

- A good working relationship between INS officials, the nonprofit agency carrying out the alternatives program, and other key community members is essential. An alternative to detention requires significant cooperation between INS and the nonprofit to structure the program, work out logistics and respective responsibilities, and work out creative ways to address situations as they arise. Success in doing so depends critically upon these good relationships. In New Orleans, INS, Catholic Charities and community leaders met on a quarterly basis for a number of months, establishing communication, trust and cooperation, before the alternative program was even conceived.²⁶

JUSTIFICATION OF COSTS/DEMONSTRATION OF SAVINGS

COSTS

The Vera Institute of Justice, which conducted the AAP pilot from 1997–2000 in the New York metropolitan area, carefully documented the costs involved in running an alternative to detention. Our costs and savings estimates are based on this documentation with one notable exception. The Vera model included a labor-intensive reporting requirement which was found not to contribute to the appearance rate of asylum seekers. According to Vera, “the most consistent factors [in hearing compliance] are having community and family ties in the United States, and being represented by counsel . . . Participant asylum seekers achieved a higher appearance rate than those released on parole because the program more effectively screened for community ties.”²⁷ Screening for community ties and facilitating access to counsel are two aspects that will be notably enhanced with the participation of NGOs with substantial refugee resettlement experience, community involvement and legal referral networks. Indeed, the even higher appearance rates obtained by the Ullin

²⁴ Vera Institute of Justice, Volume I, p. 73.

²⁵ Esther Ebrahimian, Detention Watch Network News, p. 8.

²⁶ Sue Weishar, Detention Watch Network News, p. 8.

²⁷ Vera Institute of Justice, Volume I, p. 7.

and Catholic Charities examples confirm this. In the AAP program about half of the staff time was devoted to the extraneous reporting requirement.²⁸ Accordingly, at least the variable costs of Vera's projected program could be halved by eliminating that function, amounting to an average cost of \$710,000 per site.²⁹ At that rate, it would cost about \$7.1 million to serve a total of 2,500 persons who otherwise would have to be detained. A national coordinating center to conduct training and maintain consistent quality control would cost an additional \$200,000 bringing the total annual cost of the program to \$7.3 million.

SAVINGS

The average cost of detaining an asylum seeker through his or her hearing is \$7,259.³⁰ The cost of using an alternative is \$2626 per case heard (including the costs of detention prior to screening and re-detention later, if necessary).³¹ Thus, the government can save the difference, or \$4,633 for each asylum seeker released to the alternative program. If 2,500 asylum seekers are released to alternatives, these savings would amount to more than \$11.6 million.

Another group that could be released to the program is those who have already been ordered removed but whose removal cannot be carried out because INS cannot obtain travel documents from the home country. They are eligible for release beginning 90 days after their removal orders. Catholic Charities in New Orleans already successfully serves this group, along with asylum seekers, without the reporting requirements used by the AAP. (Savings from releasing people in this group are likely to be even higher than for asylum seekers, because many might remain in detention indefinitely without these programs. Because firm figures are not available for savings for this population, however, we conservatively base our figures on asylum seekers.)

LEGAL ORIENTATION FOR IMMIGRATION DETAINEES

PROGRAM IMPLEMENTATION PLAN

PREPARED BY:

FLORENCE IMMIGRANT AND REFUGEE RIGHTS PROJECT

LUTHERAN IMMIGRATION AND REFUGEE SERVICE

This document lays out a plan for implementing legal orientation presentations to be conducted by private sector nonprofit agencies in immigration detention centers. Legal orientations reduce government costs and increase efficiency in immigration proceedings. They also help secure the due process rights of persons detained during immigration proceedings and ensure that those with meritorious claims for asylum or other relief from removal can adequately present them.

A 1998 U.S. Department of Justice pilot project found that legal orientation presentations successfully reduce detention time, speed up immigration court proceedings, increase their efficiency and improve security in detention centers. The U.S. Senate and the U.S. Commission on Immigration Reform have recommended that such programs be funded and implemented nationwide.

With an appropriation of \$2.8 million, private sector nonprofit agencies can implement legal orientations at ten major detention sites, generating net projected savings of \$10 million.

BACKGROUND OF THE PROBLEM

With the passage of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRAIRA), Congress greatly expanded the number of people the Immigration and Naturalization Service (INS) must detain. From 1996 to 2000, INS increased its detained population from 8,279 to over 20,000 immigrants and asylum seekers on any given day; annually, the figure is over 200,000.

²⁸ Telephone conversation with Oren Root, Senior Associate, Vera Institute, April 24, 2001.

²⁹ Vera projected \$1.1 million for a site serving 250 persons. Vera Institute of Justice, Volume II, Appendix V, p. 3. This includes \$320,000 in fixed costs and \$780,000 in variable costs, conservatively estimated. Halving the latter and adding it to the former yields \$710,000.

³⁰ Vera Institute of Justice, Volume I, p. 66.

³¹ Vera Institute of Justice, Volume II, Appendix V, p. 5. The AAP's \$12 per day cost is adjusted to \$8, reflecting the fact that the streamlined model proposed costs 66% of the projected AAP, similarly expanded, i.e., \$7.3/11 million.

The detention and removal process is enormously expensive with a budget over \$1 billion annually, including an average detention cost of \$65.61 per bed-day. Reducing the length of immigration removal proceedings saves money by significantly lowering the number of bed-days that individuals spend in detention.

The efficiency of the system suffers when unrepresented individuals seek repeated continuances to find counsel, when extra time is required to identify and narrow the relevant legal issues and when hearing times are extended because of unfamiliarity with the court procedures. Under these circumstances, judges are often hesitant to proceed in the absence of representation. Facilitating access to legal advice and representation can improve the efficiency of removal proceedings while strengthening the courts' commitment to due process.

An estimated 90 percent of immigration detainees go unrepresented due to poverty and the remote locations of detention sites.³² These individuals, often with limited education and proficiency in English, alone must navigate the labyrinths of U.S. immigration law, which has been compared to the U.S. tax code in its complexity. Many are confused about their rights, options and prospects. Some unnecessarily delay their cases even though they are not eligible for relief, while others with meritorious claims erroneously waive their rights and are wrongly deported.

LEGAL ORIENTATION PRESENTATIONS

The Florence Immigrant and Refugee Rights Project, Inc. in 1989 created the model legal orientation process at the Florence (AZ) INS Service Processing Center. The program consists of a live presentation for all detainees before or at the time of their initial hearing with follow up screening and case assessment for those without private counsel. Additional legal assistance, referral or representation is provided when available.³³

The Florence Project's legal orientations benefited the INS and the Court by increasing the efficiency of the process.³⁴ The U.S. Senate and U.S. Commission on Immigration Reform have recognized the value of such programs.³⁵

During fiscal year 1998 the U.S. Department of Justice funded a pilot project through EOIR to document the benefits of legal orientations. The project was implemented at three detention sites by three private sector nonprofit agencies³⁶ over a three-month period. Based on case data from the pilot period, the evaluators from EOIR found that legal orientations save both time and money for the government while also benefiting detainees. They determined that legal orientations reduced overall bed days in detention by 4.2 days per detainee and found that "[d]uring the pilot, cases were completed faster and detainees, with potential meritorious claims to relief, were more likely to obtain representation." In addition, they found that such programs were useful management tools that "strengthen the capability of INS to operate safer detention facilities." In conclusion, the evaluators recommended that the government should expand legal orientations to all INS detention facilities.³⁷

RATIONALE FOR PUBLIC-PRIVATE PARTNERSHIP IN LEGAL ORIENTATIONS

Private sector nonprofits with demonstrated legal expertise in immigration matters, experience in working with detained immigrants and ability to refer cases to pro bono counsel are best suited to provide independent professional advice to detained individuals and have spearheaded limited efforts to assist immigrants in removal proceedings. They do not, however, have the resources to sustain funding of this type of systemic initiative on their own nor are there sufficient alternative pri-

³²Margaret H. Taylor, Promoting Legal Representation for Detained Aliens: Litigation and Administrative Reform, 29 Conn. L. Rev., 1647, 1663 n.60 (1997) (citing FY 96 EOIR statistics entitled "Immigration Judge Decisions in FY 96 by Custody and Representation Status").

³³Christopher Nugent, Strengthening Access to Justice: Prehearing Rights Presentations For Detained Respondents, Interpreter Releases, Vol. 76, No. 27, July 19, 1999.

³⁴Immigration Control: Immigration Policies Affect INS Detention Efforts, United States General Accounting Office Report, GAO/GGD-92-85, June 1992.

³⁵Senate Resolution 284, 103d Congress 2d Session, 1994 (enacted); Letter from U.S. Senators Dennis DeConcini, Orrin Hatch, Edward M. Kennedy, Paul Simon, and Alan K. Simpson to Attorney General Janet Reno, November 14, 1994; U.S. Commission on Immigration Reform, *Becoming an American: Immigration and Immigrant Policy*, September 1997, pp. 135-37.

³⁶The agencies and detention sites included the Florence Project at the Florence INS SPC in Florence, AZ, Catholic Legal Immigration Network (CLINIC) at the San Pedro Detention Center near Los Angeles, CA, and South Texas Pro Bono Asylum Representation Project (ProBAR), a project of the American Bar Association, at Port Isabel Detention Center in Harlingen, Texas.

³⁷U. S. Department of Justice, Executive Office for Immigration Review, "Evaluation of the Rights Presentation," 1998.

vate sector resources.³⁸ The government is statutorily barred from funding legal representation in immigration proceedings.³⁹ The scope of the statute, however, does not prohibit funding items and programs that facilitate immigrants obtaining representation such as legal orientations.⁴⁰

OBJECTIVES

- To implement legal orientation programs at 10 detention facilities so that all at those sites receive legal information, evaluation and counseling as well as referral for representation when available
- To measurably increase the efficiency of immigration court proceedings, decrease the duration of detention and reduce tension and behavioral problems in the facilities
- To measurably increase detainees' ability to make a timely decision about their cases through early and accurate legal information and orientation
- To provide information, training, technical assistance and ongoing advice through a National Support and Training Center to private nonprofit agencies conducting legal orientations at designated sites
- To evaluate and quantify the costs, savings, benefits, and other effects of the legal orientations and evaluate the merits of expansion to other sites
- Through an interagency national working group, to develop system-wide procedural recommendations for the INS, EOIR, and private nonprofit agencies to improve justice and efficiency through legal orientation programs

PROGRAM IMPLEMENTATION

A. NATIONAL IMPLEMENTATION

EOIR will administer the program at the national level using the standard government "Request for Proposal" (RFP) process. The agency will select the appropriate organizations and be accountable for ensuring that all proposed activities are carried out.

An interagency working group should be established at the national level, bringing together the INS, EOIR, and the designated agencies share information and ensure consistent implementation of the program. Such a group has met several times in past years to discuss the feasibility of such program and would be ready to build on those relations and that practical experience. This working group will also address the movement of detainees, access to facilities and court procedures, and will provide oversight and guidance to the local sites of the project.

The establishment of a National Legal Orientation Support and Training Center will also help ensure quality, consistent implementation of legal orientations nationwide. The Center will offer the nonprofit agencies training and consultation in program development and substantive legal issues, will coordinate evaluations and will assist EOIR and the interagency working group to develop standards for the programs. The original model for legal orientations has been developed and refined over a ten-year period at the Florence INS Service Processing Center in Florence, AZ. The D.O.J. pilot project found that this model was effectively used at all three pilot sites and recommended its replication at other sites to standardize the provision of information and evaluation. The agency chosen to carry out the training should have significant expertise in implementing this model.

B. LOCAL IMPLEMENTATION AT EACH DETENTION SITE

At each detention site, the nonprofit agency will be in charge of implementing the program and will be primarily responsible for the screening, assessment and referral functions. These tasks will include:

- To review the charging documents filed with the court of those attending the orientation
- To give a presentation to all detainees before or at the time of their initial court appearance, integrating questions and answers throughout
- To briefly screen each respondent at the end of the orientation to determine whether he or she wants to accept removal, seek voluntary departure or have an individual interview with the nonprofit's staff

³⁸ Letters from officers of the Open Society Institute, the Ford Foundation, the Fund for Immigrants and Refugees, the Lawyers Trust Fund of Illinois and the New York Community Trust, August–September 2000.

³⁹ Immigration and Nationality Act § 240(b)(4)(A); 8 U.S.C. 1229a.

⁴⁰ David A. Martin, INS General Counsel, Memo, "Funding of a Pilot Project for the Representation of Aliens in Immigration Proceedings," December 21, 1995.

- To conduct individual interviews when requested to assess potential relief from removal and release eligibility
- To distribute additional written orientation materials at the conclusion of the interview
- To orient pro se respondents before each additional court hearing
- To provide further legal assistance, referral or representation when available and at no expense to the government

A basic formula for core staffing includes at least one attorney and paralegal per courtroom in addition to one full-time clerical support person and part-time supervisory support. For example, in a detention facility with 500 beds and two courtrooms, at least 5.5 staff members are required (including attorneys, paralegals, clerical and part-time supervisory support). The lead agency will supervise and educate the core staff. Legal staff would maintain time records to ensure that government funding is not used for direct representation.

C. KEYS TO SUCCESS

Previous assessments of successful legal orientations have identified several key elements that are necessary to make the project a success. These include:

Cooperation: Effective implementation of legal orientations requires cooperation between all parties at both the local and national levels. Adjustments to sometimes long-standing operating procedures are a necessary element of the model, particularly information-sharing and access to detainees. Accordingly, each site will form a local working group, bringing together the Officer-in-Charge of the detention facility, the EOIR court administrator, the INS trial attorneys and the nonprofit agency as well as INS District level staff when necessary. This working group will set initial site-specific base-line conditions, program goals and cooperative operating procedures will continue to meet over the course of the program to address concerns or problems that arise.

Access and Collaboration: In preparation for implementation, the local working groups will review the facility operating procedures and access rules to ensure that they meet the guidelines set forth in the INS Detention Standards. The program will respect the distinct roles and obligations of the stakeholders. It will be the responsibility of the nonprofit agency at each site to make postorientation decisions regarding service, representation or referral. No federal government entity will make such determinations.

Security: The program will respect the security and custodial obligations of the INS and EOIR within the guidelines set forth in the INS Detention Standards.

Lead Agency: A single "lead agency" will be identified at each detention site to provide the continuous presence of a core staff to implement the legal orientations, centralize key functions, provide continuity in the court and a central, accountable clearinghouse for problem solving. Each of the local sites will have a single agency as the point of contact with primary oversight for the screening, assessment and referral functions, representing the interests of all local nonprofit agencies. A core staff from the lead agency will be present at all master calendar hearings.

MEASURING SUCCESS

The local working groups at the ten detention sites, in consultation with the national working group, will measure the effect of legal orientations upon the following:

- The efficiency of the immigration courts
- The provision of legal screening/advice and an appropriate level of legal services to all immigration detainees in the selected sites
- The efficiency of deportation of individuals with no legal recourse
- Number of detention days
- Number of security incidents
- Qualitative assessment of improvements in detainee access to justice and due process rights

At the end of the twelve-month period, the national interagency working group, in coordination with the local groups, would report to EOIR on their findings. In addition, the agencies will produce a written report of their activities at each site.

EXPANSION TO ADDITIONAL DETENTION SITES

The plan proposes implementation of legal orientation programs to ten detention sites during a oneyear period. This is based on a realistic assessment of how many legal orientation programs could be implemented in one year. However, expansion to additional detention sites in future years will take advantage of the efficiencies, savings, and protection of due process rights afforded by legal orientations. The

year-end reports conducted by the private sector nonprofit agencies and the national interagency working group will assist in evaluating the merits of expansion to other sites. The reports will also provide guidance to the various governmental and non-governmental agencies in their efforts to continue to improve justice and efficiency through the continued expansion of legal orientations.

JUSTIFICATION OF COSTS/DEMONSTRATION OF SAVINGS

OVERVIEW

With \$2.8 million appropriated for legal orientation presentation programs at ten major detention facilities, the government will save \$12.8 million in detention costs for a net savings of \$10 million.

\$2.2 million covers the costs of legal orientation presentations at \$200,000 per site, and includes an additional \$200,000 for the training center. INS and EOIR expenses at the sites are estimated at \$600,000 yielding a total cost of \$2.8 million. Using EOIR's FY 2000 immigration court processing figures at ten major facilities, the per person cost of the presentations is \$63, about the average cost of one night in detention. According to EOIR's evaluation, those who attend such presentations spend an average of 4.2 fewer days in detention. Consequently, the program can yield net savings of over \$200 per person, or about \$10 million if implemented at 10 detention centers.

PROGRAM COSTS

GRANTS TO NGOS

It will cost an estimated \$200,000 for a non-governmental organization to carry out legal orientations at a detention facility for a year. This is based on a site with two courtrooms. Personnel costs are estimated at \$133,000, and include a project director at .5 FTE (\$25,000), two attorneys at .5 FTE each (\$40,000), two paralegals at .5 FTE each (\$25,000) and administrative support staff at .5 FTE (\$10,000), and benefits estimated at 33% of salary. Non-personnel costs include 50% of yearly operating costs, and are estimated at \$67,000. This includes office rental, telephone, purchase of two laptop computers, a photocopier and a fax machine and other basic office expenses.⁴¹

Costs of the national training center are estimated at \$200,000 annually. Personnel costs of \$80,000 include a training coordinator at 1.0 FTE (\$50,000, including benefits) and an administrative assistant at 1.0 FTE (\$30,000, including benefits). Office operations are estimated at \$50,000 a year. Costs of organizing and hosting trainings for NGO staff at all sites and travel for site visits are an estimated \$70,000.

COST TO INS AND EOIR

EOIR reports in its evaluation of the 90-day pilot project that at one site, INS incurred a cost of \$20,000 over the 3 months to pay for guards to bring detainees to court the evening before their hearing for the presentation. These costs were not reported at the other two sites, but two court administrators reported that hosting the presentations required some time for court support staff.⁴²

We doubled the one site's cost figure to cover unreported costs and to allow for the possibility that more than one-third of the facilities would incur such costs and estimate, therefore, that combined costs amount to \$40,000 over three months at three sites, for an average of \$54,000 per site per year. For ten sites, this adds up to \$540,000. For administration of the program at the national level, EOIR will require a small percentage of program costs, estimated at 3% of \$2.2 million or \$66,000. Thus, the total cost to the government is estimated at \$606,000, rounded to \$600,000.

⁴¹The EOIR pilot project grants were approximately \$20,000 each to cover 3 months of presentations, implying an annual cost of \$80,000 per site. However, this figure cannot be extrapolated to a larger, nationwide program. The three agencies in the pilot had existing programs and were supplemented by privately-raised funds. This is not sustainable and would not ensure consistent legal orientation for all detainees at a facility. Agencies will still need to raise their own funds to cover other activities that cannot be government-funded, such as legal representation for people in immigration proceedings.

⁴²Evaluation of the Rights Presentation," Executive Office of Immigration Review, 1999, p. 14.

SAVINGS RESULTING FROM THE PROGRAM

EOIR's evaluation estimates a savings of approximately \$8 million were the program to be expanded to 16 detention sites, based on the pilot's average savings of 4.2 detention bed-days for every detainee who attends a rights presentation, an average cost of \$65.61 per bed-day, and a total of 29,131 detainees appearing in court at 16 detention facilities in FY 1999.⁴³

To estimate savings for legal orientations at ten sites, we choose ten courts at detention facilities for which the Yearbook provides figures of "immigration matters received." These are all facilities at which INS detention standards are now in force (they are all INS-operated or contracted facilities, not county or local jails). These standards require the facilities to allow legal orientation presentations by non-profit organizations. The total number of immigration matters received at these ten courts in FY 2000 was 46,392.⁴⁴

If legal orientations save an average of 4.2 bed-days per detainee at \$65.61 per bed-day, and 46,392 people attend presentations, INS' gross savings amount to \$12.8 million. If, as described above, it costs a total of \$2.8 million to carry out legal orientation presentations at ten sites for a year, the net savings to the federal government is an estimated \$10 million.

As legal orientations cost about \$63 per person, and, as EOIR's evaluation demonstrates, save an average of 4.2 days in detention, the net savings per person is about \$212.

Based on the statistics from the EOIR evaluation, however, it is likely that on average, legal orientations save more than 4.2 bed-days. The report arrived at this figure by comparing how long it took at the three sites to complete a case before the pilot period, with how long it took during the pilot period. The average difference between the number of completed cases before and during the pilot for all three sites was 4.2 bed-days.⁴⁵ However, legal orientation presentations were occurring in the same manner at Florence before and during the pilot. Therefore, at Florence there is not much difference between the number of completed cases before and during the pilot. Therefore, including Florence in the calculation brings the average down.⁴⁶

SUPPORT FOR LEGAL ORIENTATION FOR IMMIGRATION DETAINEES

"We urge you to actively pursue such a pilot program and to seriously consider the Florence Service Processing Center Project as a model. It is our understanding that the project at the processing center in Florence has not only cut the time and costs associated with the deportation of aliens, but at the same time has ensured that aliens are apprised of their rights in deportation proceedings."

- —Senators Dennis DeConcini, Orin Hatch, Edward Kennedy, Paul Simon and Alan Simpson, Letter to Attorney General Janet Reno, November 14, 1994

"In our view... INS is not prohibited from expending appropriated funds for things that will facilitate aliens' obtaining representation."

- INS General Counsel David Martin, December 21, 1995 Memorandum

"The system suffers further because many aliens are unrepresented and thus do not receive advice on whether to go forward because they have a chance of being granted relief. . . . the removal process works much more efficiently when aliens

⁴³Evaluation of the Rights Presentation," Executive Office of Immigration Review, 1999, p. 12.

⁴⁴Statistical Yearbook, Executive Office of Immigration Review, January 9, 2001, Table 1, p. B3. Detention facilities included are: Batavia SPC, Eloy Bureau of Prisons Facility, Florence SPC, Houston SPC, Krome North SPC, New York Varick SPC, Oakdale Federal Detention Center, Otay Mesa, Port Isabel SPC, and San Pedro SPC. This total is larger than the FY 1999 figure EOIR used in the rights presentation evaluation for 16 facilities. The 2000 Statistical Yearbook documents an overall increase of immigration matters received at all courts of 10% over FY 1999 figures (p. B2).

⁴⁵"Evaluation of the Rights Presentation," Executive Office of Immigration Review, 1999, pp. 11-12.

⁴⁶While the EOIR evaluation does not provide a breakdown of these figures by site, it does provide a breakdown of another set of figures that supports the assertion that the average number of bed days per person would be the same before and during the pilot. On page 8, statistics are presented per site regarding the length of time it took to process unrepresented detainees who did not apply for relief from removal. This is not the same as the figures used to calculate the 4.2 average—those figures include all cases, represented and unrepresented and including those who applied for relief. For unrepresented detainees not applying for relief, at both San Pedro and Port Isabel (where presentations had not taken place before) it took on average 9 days less during the pilot project to process these cases. At Florence, it only took 2.3 days less, which is not a substantial difference. As the report itself states, this is because Florence was conducting rights presentations before as well as during the pilot.

receive advice of counsel. Those with weak cases generally do not pursue relief through proceedings if they understand from counsel that they will be wasting their time.”

- The U.S. Commission on Immigration Reform, *Becoming a Citizen: Immigration and Immigrant Policy*, September 1997

“The Executive Branch should be authorized to develop, provide, and fund programs and services to educate aliens about their legal rights and immigration proceedings. Such programs should also encourage and facilitate legal representation where to do so would be beneficial to the system and the administration of justice... the alien would not have a right to appointed counsel but the government could fund services to address some of the barriers to representation.”

- The U.S. Commission on Immigration Reform, *Becoming a Citizen: Immigration and Immigrant Policy*, September 1997

“I strongly support the work of the Florence Project and the need for similar efforts in INS detention facilities around the countryI can tell you with certainty that the detainee population here suffers from less anxiety and stress, which are major causes of unrest, than detainees at other SPCs. ... As the Officer in Charge it is extremely helpful in managing the facility to have the Project staff on hand to work with those who need special attention.”

- Donald B. Looney, Officer in Charge, Florence INS SPC, 27-year veteran of INS, Letter of May 5, 1998

“Based on case data from the pilot period, the rights presentation has the potential to save both time and money for the government while also benefiting detainees. During the pilot, cases were completed faster and detainees, with potential meritorious claims to relief, were more likely to obtain representation. Moreover, the rights presentation is a useful management tool for controlling a detained population. As a result, the rights presentation may strengthen the capability of INS to operate safer detention facilities.”

- Evaluation of the Rights Presentation, U.S. Department of Justice, Executive Office for Immigration Review

Statement of Allen S. Keller, M.D., Division of Primary Care Medicine, New York University School of Medicine, New York, N.Y.

On behalf of the Bellevue/NYU Program for Survivors of Torture, the National Consortium of Torture Treatment Programs and Physicians for Human Rights, I am submitting this statement in strong support of the Refugee Protection Act. This legislation is essential in addressing the ill effects of current immigration policy, which fundamentally undermines the rights and safety of refugees and asylum seekers coming to this country seeking protection.

I have more than 15 years experience in working with and caring for refugees and asylum seekers. In 1985, I worked as a medical volunteer with the American Refugee Committee in a refugee camp along the Thai-Cambodian border. I am the founder and director of the Bellevue/NYU Program for Survivors of Torture. This program is jointly sponsored by New York University School of Medicine and Bellevue Hospital, the nation's oldest public hospital. The Bellevue/NYU program provides comprehensive medical, psychological care and social services to victims of torture and refugee trauma. Since the program began in 1995, we have cared for nearly 600 men women and children from over 50 different countries.

I am on the Executive Committee of the National Consortium of Torture Treatment Programs. This consortium consists of 23 treatment centers throughout the United States who provide care to survivors of torture and refugee trauma. The oldest torture treatment center in the United States is the Center for Victims of Torture, which was started in 1985 and is located in Minneapolis, Minnesota.

I am on the international advisory board of Physicians for Human Rights (PHR). PHR has a network of health professionals who voluntarily provide medical and psychological evaluations for survivors of torture and other human rights abuses applying for political asylum in the United States. I have participated in this asylum network since 1992 and have conducted nearly 100 evaluations of asylum seekers. I have also participated in a number of PHR investigations including documenting the medical and social consequences of land mines in Cambodia (1993), a high incidence of torture among Tibetan refugees who fled to Dharamsalla India (1997), and patterns of human rights abuses among Kosovar refugees (1999).

Torture is a worldwide health and human rights concern and is documented to occur in more than 90 countries worldwide. Survivors of torture arriving in this country have been persecuted for daring to question ruling powers, for expressing religious beliefs, or simply because of their race or ethnicity. For example, among the patients I have cared for are monks and nuns from Tibet, student leaders from Africa, and ordinary citizens from Bosnia.

Torture can have devastating physical and psychological consequences. I have seen the scars from shackles, the marks from cigarette burns inflicted during interrogation and the wounds and broken bones from severe beatings. I have listened to stories of shame and humiliation, of haunting nightmares, and memories that will not go away. One patient of mine, for example, who was repeatedly submerged in a vat of water while being interrogated, would feel like he was gasping for air whenever he showered or went out in the rain.

As a physician caring for survivors of torture and refugee trauma, I am very concerned about the current immigration policy of expedited removal, which provides for the immediate deportation of individuals who arrive without valid travel documents. Not surprisingly, torture victims often have to flee their countries without such documents since it is the torturers who control them.

I have come to appreciate the extraordinary difficulty asylum seekers and refugees have in recounting their traumatic experiences, even months or years after the events took place. Individuals may have difficulties remembering all of the specific details of their trauma, either because they are trying to block out these disturbing memories, or because they may have been subjected to extreme conditions such as repeated episodes of torture/abuse, imprisonment under poor conditions (including deprivation of sleep, light, and food), which may make it difficult for them to remember all of the details. Individuals may feel very anxious about not being able to remember everything. Additionally, individuals may have suffered neurological impairments such as cognitive deficits or hearing/visual loss from head trauma, or they may be experience significant physical symptoms such as musculo-skeletal pain from prior beatings, which impedes on their ability to effectively communicate.

Describing prior disturbing events under any circumstances can evoke symptoms of anxiety including fear, nervousness, palpitations, and dizziness. In fact, one of the hallmarks of Post-Traumatic Stress Disorder, which is a form of anxiety, is a trying to avoid thinking about the traumatic events. Furthermore, individuals may have strong feelings of shame and humiliation in recounting certain events such as sexual assault. Also individuals may have feelings of guilt from having escaped while friends and family did not. Individuals who recount events subsequently often have difficulty sleeping and recurrent nightmares of the events.

For these reasons, many individuals want to avoid discussing their trauma. An asylum seeker may find recounting events to an immigration officer, immediately upon arrival after a long and difficult trip and in a foreign language, often without assistance, to be particularly stressful. A refugee's inability or extreme reluctance to tell of their experience under such circumstances is understandable. Unfortunately, such reluctance can be mistaken for a lack of credibility, especially by someone who does not have experience evaluating survivors of torture. Under current immigration policy, which allows for expedited removal, I am concerned that survivors of torture and other traumatic events are being turned back by INS inspectors at airports or other points of entry.

The current law requiring individuals to apply for asylum within one year of arriving in this country also poses an unfair burden on asylum seekers. Many of the individuals I have evaluated and cared for are not aware of this policy. Others are not able to testify within one year because of the psychological and emotional consequences of their abuse.

For example, one woman I cared for before the 1996 law went into effect was arrested in her country after participating in a pro-democracy demonstration. During the course of her incarceration, she was repeatedly raped by police, who told her they were "going to teach her a lesson for participating in such activities."

She once told me that she wasn't going to apply for asylum because she couldn't bear to have to tell her story. It was only after a trusting, therapeutic relationship with her was established that she was able to reveal the events of her abuse. It would have been psychologically devastating for her to have to recount these events immediately upon her arrival in this country, or even within a year of arrival. In all likelihood, she would have been unable to meet the one-year filing deadline.

Another area of concern with current immigration policy is imprisoning arriving asylum seekers in INS Detention Facilities, including county jails, pending adjudication of their asylum cases. This can often take months or years. Prior to being transferred to detention facilities, asylum seekers are often held at airports for several hours in hand cuffs and leg shackles. Individuals are subsequently kept in these re-

straints while being transported to detention facilities and at other times as well, including, in some instances, during their asylum hearings. Imprisonment and treating asylum seekers like criminals is retraumatizing and can have harmful effects on their physical and emotional well being. Many of the INS Detention Centers are windowless warehouses with little or no opportunity for detainees even to see the light of day. Imprisonment and such deprivation can result in exacerbating disturbing memories and nightmares of abuse the asylum seekers had suffered previously. Depression can be caused by detention and feelings of isolation, hopelessness and helplessness.

Asylum seekers may experience worsening of physical symptoms, including musculoskeletal pain, because of their restricted activity. Somatic symptoms, such as headaches, stomach aches and palpitations can also result from detention.

For example, Patrick is a young man from an African country. He witnessed his father beaten and killed for being a member of an opposition political party. Patrick was subsequently imprisoned and repeatedly tortured. He later escaped, and eventually made his way to this country. An INS asylum officer interviewed him. Patrick was tired, scared, and neither spoke English well nor adequately understood the process. The asylum officer wrongly concluded—in an interview conducted without an interpreter that Patrick was not from Congo because he could not speak French. The INS ordered that Patrick be deported. An immigration judge—in a “review” in which Patrick was unaided by counsel or an interpreter—failed to correct the asylum officer’s mistake. Subsequently, Patrick was shackled and placed on a plane back to his country. As he was being dragged onto the plane he was crying and saying, “Please, America is a human rights country. Why do you want to deport me? I don’t want to be killed.” Fortunately for Patrick, the plane’s pilot heard his cries and refused to take off.

Shortly after that incident, I examined Patrick in an INS Detention Facility. He had scars from where the shackles had been applied both in his country as well as ours. Subsequently, he remained in detention for more than 3 years. During that period, Patrick suffered from significant periods of depression and anxiety, for which he was inadequately treated. He frequently experienced extreme difficulty sleeping and nightmares of the abuse he had suffered in his country. He also frequently suffered from muscle aches, headaches and palpitations. I believe these symptoms resulted from his imprisonment here.

After more than three years, Patrick was granted asylum and released. He is now working and making productive contributions to our society, though he still experiences nightmares and disturbing memories both of the abuse he suffered in his native country as well as his imprisonment upon arrival in our country.

Another asylum seeker detained by the INS, whom I recently interviewed, had been brutally beaten by authorities in his native country because of his ethnicity. “I came to America to be free,” he told me. “I came here to find peace and to live in peace. I never expected to be put in jail. They don’t call it jail, they call it detention. But it is jail. Being in this jail reminds me a lot about what happened to me in my country. If I were free, I could be doing normal activities and I wouldn’t think so much about what happened. I’m not saying these things would be eliminated, but I would feel much better because I am a free person.”

While in INS Detention, many asylum seekers are held in county jails, again demonstrating that asylum seekers are treated like criminals. Many asylum seekers have never been in prison before. Furthermore, authorities in detention facilities utilize segregation (solitary confinement) or the threat of segregation as a means of behavior control. This is particularly cruel given that many individuals who were imprisoned and tortured in their own countries may have been placed in solitary confinement as part of their abuse.

One detainee I interviewed described this: “I saw an officer searching the bags of one of the detainees. Another detainee asked the guard not to search the man’s bag without him being there. The officer called another officer and they took the detainee who had objected to the search away. He was in segregation for 3 days. I felt very sorry for that man. They showed him no respect. This is not how to treat another human being, and certainly no reason to put him in segregation. It made me sad and worried for myself. Could something like that happen to me?”

Another detainee I interviewed recounted this event. “One day, a guard was doing a bed count in my bunk. One of the other men in the bunk asked him why they were doing that since they had just counted. That was all he said. The guard came back with several other guards, put my bunkmate in handcuffs and took him away. He was there for four days. There are some people in isolation for a month or a month and a half” They subsequently had a hearing, and realized he hadn’t done anything wrong and released him. But that was after four days. The guards like

to threaten people with segregation. People get very scared of segregation because it is a room where you are by yourself, and it is small and very cold.”

Treating individuals who have suffered horrific human rights abuses like criminals is morally reprehensible and can have harmful effects on their health. Furthermore, while in detention, asylum seekers often have difficulty accessing health services, particularly mental health services, which are essential to their recovery from the traumatic events they have suffered.

Among the individuals being detained in these adult facilities are children, who given their youth, may be even more vulnerable to the ill effects of detention including worsening of symptoms of depression and anxiety. Furthermore, it is troubling that the INS is relying on dental x-rays to make determinations of the age of individuals. Such examinations are subject to variability. Even in the case of the most skilled individual performing age determination, the age range specificity is fairly wide and may be plus or minus 3 years or more for individuals between 16 and 18 years old.

The Bellevue/NYU Program for Survivors of Torture, in collaboration with Physicians for Human Rights, is currently conducting a study evaluating the health status of asylum seekers held in detention by the INS. The results of this study will be available by the early fall.

Current immigration policy poses an unfair and unhealthy burden on survivors of torture and other victims of human rights abuses who come to the United States seeking safety and political asylum. In our zeal to make our borders secure, we cannot -we must not- forget who we are. A country of immigrants. A country of refugees.

