

Access to a Doctor, Access to Justice? An Empirical Study on the Impact of Forensic Medical Examinations in Preventing Deportations

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ABSTRACT

Year after year, the United States has remained the world's largest recipient of humanitarian-based immigration applications. Those seeking protection here must navigate a backlogged and increasingly restrictive system, oftentimes without access to counsel.

Most individuals applying for humanitarian relief must prove that they survived egregious past harms or fear future harms if the United States were to deport them. In turn, immigration judges and Department of Homeland Security adjudicators act as gatekeepers, making daily decisions about whose pain and suffering is devastating enough to justify granting them status in the United States.

For immigrants privileged enough to gain access to them, forensic medical evaluators can play a crucial role in immigration outcomes by documenting narratives of harm, bolstering credibility, and persuading adjudicators to grant relief. However, despite the exponential growth in medical-legal collaborations and requests for forensic medical evaluations in support of immigrants, there is little data about if and how forensic medical evidence impacts adjudicator decision making.

The empirical study discussed in this Article—the largest-of-its-kind quantitative study of over 2,500 cases in which Physicians for Human Rights (“PHR”) facilitated medical evaluations on behalf of immigrants—found that 81.6% of individuals who received a forensic medical evaluation between 2008 and 2018 exper-

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enced some form of a positive immigration outcome. In comparison, immigration adjudicators only granted relief to asylum seekers an estimated 42.4% of the time overall during this same period.

The significant impact of forensic medical evaluations in contributing to a favorable immigration outcome raises questions about whether adjudicators are holding immigrants to overly-stringent evidentiary standards by constructively creating norms that require immigrants to gain access to health professionals with the requisite training to evaluate them. To the extent such evaluations become essential to the successful outcome of the legal case, access to a medical evaluator may indeed translate into access to justice.

INTRODUCTION

When Ms. G fled Honduras with her grandson and special-needs child, she left behind two decades of brutal domestic violence.¹ Her common-law partner had physically and psychologically abused her, leading to lost pregnancies, broken limbs, trauma, and the eventual realization that she would have to leave her home country if she were to survive. When I first met her, she had been living in the United States for twenty years. Her physical scars had healed, and she was thriving and vibrant.

After undergoing a series of unfortunate events, administrative hurdles, and never-ending court backlogs, she finally had the chance to appear before a judge—nearly twenty years after she initially ran from the abuse—to ask for asylum in the United States. With no physical scars to show, we, her legal team, would have to prove that the harms Ms. G faced two decades prior amounted to “past persecution,” a legal term of art in asylum law. Ms. G displayed the resilience of a single mother who had raised children while undocumented and working multiple jobs, making it even harder to prove the extent of her past suffering.

Together, a group of lawyers, doctors, and law and medical students brainstormed how we could document our client’s narrative without costly and time-consuming imaging to identify traumatic brain injury and healed limbs. The medical team suggested that a simple evaluation of Ms. G’s scalp, where her abuser frequently hit her with blunt force, may still reflect decades-old scarring. In addition, Ms. G was able to receive a full psychological evaluation, where a medical evaluator was able to assess her anxiety, recurring nightmares, and disorientation to diagnose her with Post Traumatic Stress Disorder (“PTSD”).

The legal team used these forensic physical and psychological evaluations in her legal case in three primary ways: (i) to provide extra proof of her claims, (ii) to convince the judge that any inconsistencies in her story could be attributed to her psychological condition and not any intent to commit

1. Identity concealed for confidentiality reasons.

fraud, and (iii) to persuade the judge to grant her asylum in an act of administrative discretion. Although she has yet to be granted asylum, Ms. G's deportation has been halted for now because the legal team was able to rely on the medical evaluations of Ms. G and her children to persuade Immigration and Customs Enforcement ("ICE") to stay deportation. For the moment, she remains united with her children and grandchildren.

Ms. G's story is one of dozens of positive outcomes that have stemmed from collaboration between the Immigrant and Non-Citizen Rights Clinic ("INRC") and forensic medical evaluators from the City University of New York ("CUNY") School of Medicine and other medical providers. This collaboration seeks to support INRC clients who are vulnerable to deportation, already in removal proceedings, or seeking benefits before United States Citizenship and Immigration Services ("USCIS"). Through this collaboration, law students and law school faculty work with their medical school counterparts in the initial stages of client representation to conduct forensic physical and psychological assessments that could benefit a client during their immigration representation. These evaluations have been used to advocate before immigration judges and USCIS adjudicators in a variety of cases outside of the asylum context, including asking for discretionary stays of removal, helping make competency assessments, determining whether "hardship" would exist in cancellation cases, and establishing the "substantial physical or emotional harm" sustained by immigrant crime victims who are applying for U-Visa relief.² In short, whether it is measuring "hardship," "substantial harm," "persecution," or painting a larger picture for adjudicators who often make discretionary decisions, the need for forensic medical expertise in immigrant defense has proven vital. Further, such a collaborative approach facilitates a holistic legal services model, which recognizes that many of our clients have interlacing challenges with policing, health, access to education, public benefits, housing, and much more.

Although we anecdotally found our partnership increased positive outcomes for our clients, we noted that the most recently published evaluation of the impact of medical evaluations on outcomes is based on seventeen-year-old data and limited to asylum proceedings.³ Lustig et al.'s study, which relied on PHR data from 2000 to 2004, found that 89% of cases in which asylum seekers received evaluations from healthcare providers resulted in asylum grants. In comparison, a national average of 37.5% of asylum seekers were granted asylum during Lustig et al.'s study period.⁴

This Article discusses the findings of the PHR-CUNY Study, which rigorously updates and broadens the scope of the Lustig et al. study by review-

2. See Section II.A.2, *infra*, for a further discussion on the U-Visa category of immigration relief.

3. See Stuart L. Lustig et al., *Asylum Grant Rates Following Medical Evaluations of Maltreatment Among Political Asylum Applicants in the United States*, 10 J. IMMIGRANT & MINORITY HEALTH 7 (2008).

4. *Id.* at 8. Note that these national figures include all cases, including a minority of cases that received forensic medical evaluations and the vast majority that did not.

ing the impact of forensic medical evaluations in over 2,500 cases that PHR initiated between 2008 and 2018.⁵ A joint project of the CUNY School of Law, CUNY School of Medicine, CUNY Graduate School of Public Health, and PHR, the PHR-CUNY Study takes a cross-disciplinary look at the impacts of forensic medical evaluations on immigration outcomes. The Study compared the “success rates” amongst immigrants receiving forensic medical evaluations to the average national asylum grant rate of immigrants appearing in administrative court and before USCIS. Further, the Study explored the impact of a number of independent factors, including whether gender, age, geography, country of origin, language, legal orientation, and a request for a physical or psychological evaluation.⁶

Overall, 81.6% of individuals in the PHR-CUNY Study who received a forensic medical evaluation between 2008 to 2018 experienced a positive outcome in their immigration proceedings.⁷ In comparison, grant rates for those applying for asylum before USCIS or the Executive Office for Immigration Review (“EOIR”) during this period ranged from a low of 28% to a high of 55.6% depending on the year and the case posture.⁸ Even when compared to similarly situated immigrants who were represented by counsel and not detained, those who received a forensic medical evaluation fared significantly better. For example, when comparing EOIR asylum statistics to the PHR-CUNY Study, those within the Study who applied for asylum were denied only 6.9% of the time. Meanwhile, 44.1% of all represented asylum seekers appearing before EOIR were denied asylum during the same period.⁹ Further, in comparison to a 15.5% national positive grant rate for

5. For extensive details about the PHR-CUNY Study, see Holly G. Atkinson et al., *Impact of Forensic Medical Evaluations on Immigration Relief Grant Rates and Correlates of Outcomes in the United States*, 84 J. FORENSIC LEGAL MED. 1 (2021).

6. For a complete representation of this peer-reviewed study and the methodologies and analytical methods employed, see *id.*

7. Positive outcomes or “success rates” included the categories of granted asylum, granted relief (unspecified), granted withholding of removal, granted VAWA relief, granted voluntary departure, granted U-Visa, granted T-Visa, granted cancellation of removal, granted CAT relief, granted special immigrant juvenile status (“SIJS”), release from U.S. detention, adjustment of status, and termination of proceedings.

8. Asylum Decisions Tool, TRAC IMMIGRATION, <https://trac.syr.edu/phptools/immigration/asylum/> [https://perma.cc/68WR-PT8E] (hereinafter TRAC Asylum Decisions tool). The tool allows users to view data obtained by TRAC through requests made under the Freedom of Information Act (“FOIA”) to the EOIR. Asylum outcomes can be filtered by year, nationality, representation status, custody status, decision, and other criteria. See also USCIS ASYLUM DIVISION, REFUGEES, ASYLUM AND PAROLE SYSTEM (RAPS), Quarterly Nationality Reports by fiscal year, https://www.uscis.gov/sites/default/files/document/data/Affirmative_Asyllum_Decisions_FY09-FY18_Q2.pdf [https://perma.cc/TZG9-9YSM]. Because of the way PHR records data, the Study was unable to ascertain how many applicants *applied* for asylum, but rather only how many were *granted* asylum, and thus cannot calculate the asylum grant rate for those in the PHR-CUNY Study. Additionally, the percentage of individuals that had positive outcomes more generally in immigration proceedings from available DHS statistics could not be ascertained, where data is only available about asylum grant rates specifically. Thus, the closest comparison would be measuring positive outcomes in the PHR-CUNY Study against asylum grant rates in immigration proceedings.

9. TRAC Asylum Decisions tool, *supra* note 8. The 44.13% denial rate for represented asylum seekers appearing before EOIR was determined by looking at data for each fiscal year in the study

asylum seekers in detention appearing before EOIR, detained individuals in the PHR-CUNY Study were able to receive a positive outcome in 72.7% of cases.¹⁰ This analysis shows that though access to counsel and detention status are deeply intertwined with case outcomes, forensic medical evaluations are independently correlated with successful outcomes. If there is a strong correlation between forensic medical evaluations and positive immigration outcomes, should more immigrants have access to such evaluations?

Part I of this Article describes the various principles scaffolding the immigration system that those individuals in the PHR-CUNY Study are navigating. The findings of the Study are an important window into the effectiveness of one stated purpose guiding U.S. immigration policy: a desire to protect those who have been persecuted, have survived crimes, or may be deported to harmful conditions.

Part II outlines the various forms of relief that those in the PHR-CUNY Study applied for, highlighting how adjudicator decision-making in each of these areas is marred with inconsistency, which may be attributed to individual adjudicator preference and bias, as well as differences across immigration courts, adjudicating offices, and federal circuits. Thus, equal access to trained forensic medical evaluators could bring much-needed consistency into harm, credibility, and other assessments involved in granting humanitarian-based relief.

Part III focuses on the forensic medical evaluation itself, summarizing international human rights norms and protocols that govern the documentation of harms that those fleeing persecution have survived. This Part observes that despite a growing need for forensic evaluations for those seeking immigration relief, the sources of guidance, training, and best practices available to medical professionals providing such evaluations are limited and adjudicators and judges often misunderstand forensic evaluations.¹¹

Part IV offers a review of the PHR-CUNY Study findings and observes the impact of numerous independent factors such as country of origin, detention status, type of evaluation requested, language ability, and gender.

period, then filtering for representation status (“Represented”), and then case outcomes (“Decision”). The total number of asylum denials (94,025) among those who were represented between 2008 and 2018 was then divided by the total number of asylum applicants who were represented during that same period (213,058) to arrive at the denial rate of 44.13%.

10. *Id.*

11. Hope Ferdowsian, Katherine McKenzie & Amy Zeidan, *Asylum Medicine: Standards and Best Practices*, 21 HEALTH HUM. RTS. 215, 216 (2019) (“Despite the growing need for qualified experts, there is limited professional, practical, and ethical guidance for interested medical professionals. Similarly, despite growing interest in and satisfaction with this area of medicine, there is a paucity of published best practices relevant to the evaluation of asylum seekers and the training of qualified medical professionals.”); Alempijevic D. et. al., *Forensic Medical Examination of Victims of Trafficking in Human Beings*, 17 TORTURE 117, 119 (2007) (“Certain international standards for forensic medical examination of victims, including the victims of torture and sexual violence, are available in forms of protocols or guidelines. To our knowledge, such standards are not yet available for the examination of trafficking victims. It is impossible to prescribe a standardized format to suit every case, as the circumstances differ so much.”).

Notably, those who submitted forensic physical evaluations to prove their physical harms saw a roughly 10% increase in successful outcomes in their immigration proceedings as compared to those who only submitted a forensic psychological evaluation in support of their application.¹² Consequently, these findings show that physical harms may have been viewed as more persuasive than psychological harms to adjudicators assessing whether individuals qualified for immigration relief.

Part V provides context for the PHR-CUNY Study findings by comparing those in this Study to others similarly situated in terms of representation and detention status. This Part compares outcomes amongst those in the PHR-CUNY Study to average immigration outcomes, to reveal how those who received a PHR-facilitated evaluation were advantaged even when compared to others who are represented or not detained.

Part VI concludes with the policy implications of the PHR-CUNY Study's findings. Changes in law and policy have created stringent corroboration requirements for immigrants seeking relief, fueling an increased reliance on forensic medical evaluations to corroborate immigrant narratives, address inconsistencies, and persuade immigration adjudicators to exercise positive discretion in granting applications. On the one hand, when some immigrants have access to forensic medical evaluations to bolster and corroborate their claims, adjudicators may come to expect such evidence as a matter of course, normalizing reliance on external evidence that is difficult for most immigrants to access. On the other hand, increased exposure to trauma-informed assessments might help educate adjudicators and encourage trauma-informed approaches for all cases, even where such evaluations are not able to be submitted.

I. AN OVERVIEW OF THE UNITED STATES IMMIGRATION SYSTEM

A. *Enduring Principles of U.S. Immigration: Worthiness, Harm, and Race*

Although the core of this Article explores how and if immigration adjudicators consider forensic medical evaluations when assessing applications for humanitarian-based relief, this conversation is incomplete without delineating the various principles scaffolding the present immigration system. The findings of the PHR-CUNY Study are an important window into just one principle touted by U.S. immigration policy: a so-called humanitarian interest in protecting those who have been persecuted in their home countries, have survived egregious crimes, or those who may face harm if deported from the United States.¹³ But the United States has long approached

12. See Part IV, *infra*, for a further discussion.

13. Though humanitarian principles have been touted by the U.S. government, gaps in law and policy and recent developments have displayed how current humanitarian protections are insufficient. Lindsay M. Harris, *Asylum Under Attack: Restoring Asylum Protection in the United States*, 67 LOY. L. REV. 121, 121 (2021) (“The Trump Administration attempted to dismantle the United States’ system to

immigration from a lens of exclusion, with oft-clashing forces of nativism, race, ableism, white supremacy, class, and other socioeconomic motivations.¹⁴ *Are you white enough? Have you suffered enough? Will you contribute enough?* The answers to these questions, entangled with U.S. foreign interventions and subordinations, have guided who is included and excluded.

Since this nation's founding, the United States has disproportionately opened its doors to those seen as preserving the so-called racial and cultural character of the nation. From state-specific immigration exclusions to national origin quotas, these policies sought to keep the United States white and Christian.¹⁵ The remnants of these programs can be seen today in literacy testing and base-level wealth requirements that have advantaged Anglo-Europeans.¹⁶ The United States has also welcomed immigrant talent and labor when it would help fill national needs to maximize production or innovation. These pathways to immigration have evolved into the modern-day work and labor visa categories.¹⁷

Beyond these exclusionary principles, the United States has also envisioned itself as a haven for those fleeing persecution and harm. Many who would have been excluded under the above rubrics of whiteness and labor have been admitted in the name of refuge.¹⁸ Alongside asylum protections, the United States has created various forms of humanitarian-based relief, including special visas for survivors of certain crimes and other vulnerable populations. Those falling under these categories, especially those applying for refugee status, have been described by scholars as “qualitatively different” from “ordinary” immigrants: the juxtaposition of “forcibly displaced” versus “willing migrants.”¹⁹ The United States offers those who would have

protect asylum seekers through changes to case law, executive orders, presidential proclamations, internal agency guidance and sweeping regulatory changes, among other measures. The system largely ground to a halt after the Trump Administration co-opted the coronavirus public health crisis to effectively close the southern border to asylum seekers with its March 2020 Centers for Disease Control order.”).

14. Some scholars have described principles of U.S. immigration aiming to balance principles of “interest” and “morality.” See, e.g., Frederick G. Whelan, *Principles of U.S. Immigration Policy*, 44 U. PITT. L. REV. 447 (1983); Kevin R. Johnson, *Race, the Immigration Laws, and Domestic Race Relations: A “Magic Mirror” into the Heart of Darkness*, 73 IND. L.J. 1111 (1998).

15. ROGER DANIELS, *GUARDING THE GOLDEN DOOR: AMERICAN IMMIGRATION POLICY AND IMMIGRANTS SINCE 1882* 48 (Hill and Wang, 2004); BILL ONG HING, *DEFINING AMERICA THROUGH IMMIGRATION POLICY* 54 (Temple Univ. Press, 2004).

16. HING, *supra* note 15, at 54.

17. Through abusive guest-worker programs like the Bracero Programs and other informal “gentlemen’s agreements” Mexican laborers were abused and racialized and masculinized narratives emerged about types of work appropriate for various immigrant communities. For example, the Dillingham Commission noted immigrant abilities in terms of racial status. Leticia M. Saucedo, *Mexicans, Immigrants, Cultural Narratives, and National Origin*, 44 ARIZ. ST. L.J. 305, 317 (2012).

18. Julian Lim, *Immigration, Asylum, and Citizenship: A More Holistic Approach*, 101 CAL. L. REV. 1013, 1042 (2013) (“Thus, in contrast to refugee law, which looks abroad to see who can be pulled in, immigration law looks inside the nation to see who should be kept out. Despite some overlap, the two bodies of law are thus treated as embodying different legal and normative foundations, furthering divergent policy agendas, and relying on separate legal rules.”).

19. *Id.*

been otherwise excluded access to permanent residency or admission on account of their suffering and fear. In analyzing the immigration stories of Chinese refugees who fled post-revolutionary Mexico, Professor Julian Lim describes how such categorizations move “excludable immigrants” to “admissible refugees,” in turn moving them from the category of “undesirable alien” to “deserving immigrant.”²⁰ Although far outside of the confines of the era of Chinese-Exclusion that Professor Lim describes, many of the immigrants in the PHR-CUNY Study might exist within a similar positionality: if not for their suffering, they may have no other means to gain admission or permanence in the United States. Consequently, U.S. immigration policy has constructively defined what types of harm, suffering, and hardship renders one deserving and admissible. Thus, to the extent they serve to describe and corroborate such harms, forensic medical evaluations are key to expanding adjudicators’ notions of suffering and credibility.

B. *Measuring and Describing Harm as Worthiness*

To qualify for humanitarian-based relief, which comprised 11% of all U.S. immigration in 2011,²¹ an immigrant must make some showing of hardship or harm, either to themselves or a qualifying family member, if they were to be deported.²² In turn, immigration judges, who are administrative judges in the Department of Justice, and adjudicators in the Department of Homeland Security act as gatekeepers of this harm, making daily decisions about whose pain and suffering is devastating enough to gain access to the United States. Referring to this decision-making when deciding whether a detention lasting three days rose to the level of persecution in an asylum assessment, Seventh Circuit Judge Richard Cudahy observed, “[w]hile it is distasteful to have to quantify suffering for the purposes of determining asylum eligibility, that is our task.”²³ Here, too, U.S. immigration policy toward noncitizens who have fled persecution has often been entangled with racism, nativism, and foreign policy considerations.²⁴ Further, adjudicator decision-making about what hardships are serious enough

20. *Id.*

21. Quoctrung Bai & Caitlin Dickerson, *What Can the U.S. Learn From How Other Countries Handle Immigration?* N.Y. TIMES (Feb. 16 2018), <https://www.nytimes.com/interactive/2018/02/16/upshot/comparing-immigration-policies-across-countries.html> [<https://perma.cc/HA4L-642T>].

22. Humanitarian relief has generally included asylum, withholding of removal, protections under the Conventions Against Torture, protections for battered spouses, children and parents, temporary protected status, and victims of human trafficking and other crimes. *Humanitarian*, U.S. CITIZENSHIP AND IMMIGR. SERVS., <https://www.uscis.gov/humanitarian> [<https://perma.cc/8GGT-H7BC>] (noting “USCIS provides a number of humanitarian programs and protection to assist individuals in need of shelter or aid from disasters, oppression, emergency medical issues and other urgent circumstances.”) [hereinafter USCIS Humanitarian]. Though cancellation of removal cases may also be included under this ambit, PHR does not facilitate evaluations solely measuring prospective harm, *see infra* note 38.

23. Scott Rempell, *Asylum Discord: Disparities in Persecution Assessments*, 15 NEV. L.J. 142, 143 (2014) (citing *Dandan v. Ashcroft*, 339 F.3d 567, 574 (7th Cir. 2003)).

24. Johnson, *supra* note 14, at 1140.

to justify immigration relief are riddled with inconsistency, individual adjudicator bias, and differences across federal circuits.²⁵

For those experts providing forensic medical evaluations in support of individuals seeking immigration relief, navigating the various ways such evaluations can impact an immigrant is dizzying. Some U.S. laws require immigrants to describe harms they have previously faced and, in other situations, attest to fear of future harms if deported.²⁶ In some cases, an immigrants' own suffering is rendered irrelevant, and eligibility is based on the harm that an immigrant's deportation would cause to their qualifying U.S. citizen or legal permanent resident family members.²⁷ To qualify for some forms of relief, like asylum, the harm must have taken place abroad, while for others, like protections under the Violence Against Women Act ("VAWA"), the harm must have taken place in the United States.

Even after an immigrant meets the basic eligibility criteria, many forms of relief still have a discretionary component. In other words, even if the applicant meets all of the statutory and regulatory requirements, the adjudicator will only approve the application if they think the immigrant merits a favorable exercise of "administrative grace."²⁸ Discretion entails all criteria that may make an immigrant more sympathetic to relief, including family and community ties, community standing, employment status, skills, and immigration status and history.²⁹ In this context, evidence of medical or psychological illness or suffering may be persuasive to a judge assessing whether or not to grant an application from an eligible applicant.

But how does one prove "persecution," "extreme hardship," "substantial harm," and "extreme cruelty?" Are adjudicators treating these as distinct standards? How does an adjudicator decide which illness, injury, or suffering is enough to warrant positive discretion, and which can be simply overlooked and ignored? Can there be uniform assessment for something that is so hard to measure?

Assessments about whether harm is "substantial" or whether it rises to the level of "persecution" or "extreme hardship" are undeniably assessments where individual biases and philosophies might factor in. In their seminal study, Professors Ramji-Nogales, Schoenholtz, and Schrag meticulously recorded the variations in decision-making at all four stages of the

25. See Jaya Ramji-Nogales, Andrew I. Schoenholtz & Philip G. Schrag, *Refugee Roulette: Disparities in Asylum Adjudication*, 60 STAN. L. REV. 295 (2007); see also Stephen H. Legomsky, *Learning to Live with Unequal Justice: Asylum and the Limits to Consistency*, 60 STAN. L. REV. 413 (2007); Rempell, *supra* note 23.

26. Immigration and Nationality Act § 101(a)(42)(A), 8 U.S.C. § 1101(a)(42)(A) (2005) [hereinafter INA].

27. INA § 240A(b)(1)(D).

28. See *Policy Manual: Vol. 1 Chapter 8*, U.S. CITIZENSHIP & IMMIGR. SERVS., <https://www.uscis.gov/policy-manual/volume-1-part-e-chapter-8> [<https://perma.cc/32FP-2GBM>] [hereinafter Chapter 8 USCIS]; see also *Ameeriar v. Immigr. and Naturalization Serv.*, 438 F.2d 1028, 1030 (3rd Cir. 1971); 16 I&N Dec. 314 (BIA 1977).

29. Chapter 8 USCIS, *supra* note 28.

immigration adjudication process: the asylum office, the immigration court, the Board of Immigration Appeals, and U.S. Court of Appeals.³⁰ They found great disparities, even where adjudicators in the same offices were considering applications from the same countries.³¹ They also noted dramatic differences across geographic territories.³² For example, a Chinese applicant having her case heard in Atlanta Immigration Court had a 7% chance of success on her asylum case, as compared to 47% nationwide. The same applicant would have a 76% chance of success if her case was heard in Orlando.³³ The authors were concerned that such great deviations implied adjudicators may be applying their own personal philosophical considerations to the case at hand.³⁴ Such philosophical considerations might lead to divergence in how immigration adjudicators make assessments about harm as well.

II. HOW FORENSIC MEDICAL EVALUATIONS ARE USED TO SUPPORT IMMIGRANTS

Forensic evaluators are specially trained to obtain facts relevant to an immigrant's history of torture, ill-treatment, or persecution and establish the consistency between this history and the findings of a medical and psychological exam.³⁵ Forensic evaluations can support immigrants appearing before immigration judges ("IJs") and USCIS adjudicators in a host of ways, four of which are described below.

First, medical evaluations can help immigrants persuade courts that they meet the basic eligibility criteria for the relief they seek. For example, one who is seeking asylum must prove that they survived "past persecution" or have a well-founded fear of "future persecution."³⁶ Medical evaluations are often used to corroborate physical or emotional abuse to document that persecution took place in the manner the immigrant describes. If an asylum seeker describes an assault by guerilla forces that involved broken limbs, a forensic medical evaluator may look for physical and psychological indicators of that trauma in the form of scars, poorly healed bones, or resulting mental illness.

30. Ramji-Nogales et al., *supra* note 25, at 375.

31. *Id.* at 296. One empirical research study concluded that these disparities follow up the chain to the Board of Immigration Appeals and courts of appeals, appeal mechanisms that should invite uniformity if functioning properly. Instead, this study found that appeals courts rarely review removal orders issued by the harshest immigration judges to immigrants who appeared *pro se*, foreclosing any ability to check these judges and achieve uniformity. David Hausman, *The Failure of Immigration Appeals*, 164 U. PA. L. REV. 1177 (2016).

32. Ramji-Nogales et al., *supra* note 25, at 375.

33. *Id.*

34. *Id.*

35. Ferdowsian, McKenzie & Zeidan, *supra* note 11, at 217.

36. INA § 101(a)(42)(A), 8 U.S.C. § 1101(a)(42)(A) (2005).

In cancellation of removal cases, an immigrant must prove that deportation would result in “extreme hardship” to a qualifying family member.³⁷ This argument may also be supported by forensic medical evaluations.³⁸ For example, where a parent’s deportation would impact a U.S. citizen child who has severe asthma, a parent might choose to submit a forensic evaluation that documents the child’s condition, and the impact the parent’s deportation would have on the child’s physical and mental well-being.³⁹

Second, forensic medical evaluations can be crucial to establishing an immigrant’s credibility. Alongside corroborating their claims, forensic evaluations can also document psychological conditions impacting the client’s demeanor, memory, and ability to relay traumatic events. With this backdrop, immigration adjudicators are better placed to understand why an individual may not remember certain details, appears with a certain demeanor, or makes errors in recounting their narrative.

Third, forensic medical evaluations can play a central role in discretionary decision-making. In certain cases, immigration adjudicators are encouraged to exercise their personal discretion in deciding whether to grant relief to someone who is otherwise eligible.⁴⁰ Forms of relief with discretionary components include humanitarian parole, temporary protected status, refugee and asylum status, and waivers of inadmissibility.⁴¹ In the context of such discretionary decision-making, supporting documentation regarding the applicant’s physical and psychological health may be persuasive. For example, if a client has terminal cancer, an immigration adjudicator may be more willing to grant a temporary stay of removal or grant an asylum application, as compared to those without exigent medical conditions, even if both applicants are equally eligible and meet all requirements.⁴² For documentation of illness unrelated to trauma, medical records

37. INA § 240A(b)(1)(D).

38. Note that PHR does not actively facilitate forensic evaluations that serve to solely document prospective harm, as extreme hardship determinations in cancellation of removal cases call for. With that said, forensic evaluators do comment on current medical and psychological conditions and may comment on how deportation or changed conditions may impact an individual with such conditions. For example, the protocols ask evaluators to assess what types of coexisting stressors may impact individuals when formulating their clinical impressions. *See* Off. of the High Comm’r for Hum. Rights, Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc. HR/P/PT/8/Rev.1, 1, 53 (2004), <https://www.ohchr.org/Documents/Publications/training8Rev1en.pdf> [https://perma.cc/AU88-MNW6] [hereinafter Istanbul Protocol].

39. *See Mendez v. Holder*, 566 F.3d 316 (2d Cir. 2009) (finding the Board of Immigration Appeals was required to consider evidence relating to, *inter alia*, immigrant’s daughter’s severe asthma, ongoing medical treatment, and son’s need for annual medical examination for his vesicoureteral reflux in determining whether the petitioner’s qualifying relatives would be subject to extreme and unusual hardship if he were to be deported).

40. Chapter 8 USCIS, *supra* note 28.

41. *Id.*

42. In the inverse situation, this also means that those who may be otherwise eligible for relief are denied that relief based on an immigration judge’s discretion, a scenario that often plays out where an individual has a minor criminal record or has been pretextually labeled a national security risk. *See*

(where available) may be sufficient. But in some situations, a forensic evaluator may be able to weave together the compounding impacts of past trauma with current illness to highlight the stressors on the individual and the impacts of potential deportation.⁴³

Finally, the addition of a forensic medical evaluator to the legal team may bring a host of intangible benefits. This includes facilitating better communication between the legal defense team and client by offering insights into the client's psychological and mental wellbeing, uncovering novel claims that the legal team previously did not detect, and giving the immigrant greater confidence, comfort, and empowerment in sharing their narratives with adjudicators.⁴⁴ In addition, some clinicians have described the therapeutic nature of the evaluative process itself. One editorial posited how the evaluation can provide a "new perspective," which "sets up a process in which the individual can access suppressed memories and feelings, gain consciousness of the origin and development of [the individual's] current distress, and put words to previously undefined emotions."⁴⁵

Despite the benefits of a forensic evaluation, the immigration process remains a retraumatizing process for many survivors of torture and persecution.⁴⁶ The repeated retelling of traumatic stories to forensic evaluators, attorneys, and adjudicators alike can set off stressors. Forensic evaluators, who are not in the primary position to offer care, are guided to be especially mindful.⁴⁷ Further, forensic evaluations rarely portray individuals the way

generally Shoba Sivaprasad Wadhia, *Darkside Discretion in Immigration Cases*, 72 ADMIN. L. REV. 367 (2020).

43. See Istanbul Protocol, *supra* note 38.

44. See Sabrineh Ardalan, *Access to Justice for Asylum Seekers: Developing an Effective Model of Holistic Asylum Representation*, 48 U. MICH. J.L. REFORM 1001, 1034–35 (2015) ("For example, with the help of a psychiatrist at the Boston Center for Refugee Health and Human Rights, the same bi-polar client described above was able to receive the medication she needed to stabilize and move forward with her application process. At first, the applicant was very reserved and avoided discussing her past trauma. With the support of her psychiatrist, however, she eventually opened up and explained that security forces in her home country raped her. The psychiatrist provided an extremely helpful forensic evaluation explaining her withdrawn demeanor and affect.").

45. See David Gangsei & Ana C. Deutsch, *Psychological Evaluation of Asylum Seekers as a Therapeutic Process*, 17 TORTURE 79, 79 (2007).

46. Katrin Schock, Rita Rosner & Christine Knaevelsrud, *Impact of Asylum Interviews on the Mental Health of Traumatized Asylum Seekers*, 6 EUR. J. PSYCHOTRAUMATOLOGY 1 (2015). ("Previous studies have shown that most asylum seekers experience the immigration process—including the asylum interview—as being stressful and provoking anxiety."); see also BARTON F. EVANS ET. AL., FORENSIC PSYCHOLOGICAL ASSESSMENT IN IMMIGRATION COURT: A GUIDEBOOK FOR EVIDENCE-BASED AND ETHICAL PRACTICE 83 (Routledge & Taylor & Francis Group, 2018) ("Further, many asylum seekers will have prominent intrusive posttraumatic symptoms and intense emotional flooding that are easily triggered, especially in the context of legal proceedings. In expert reports and during testimony, the forensic mental health expert can prepare the IC adjudicator for the intensity of suffering that will likely be provoked when the asylum seeker is asked to share his or her torture experience on the stand or during affirmative interview.").

47. See 2U, INC., *Supporting Survivors of Trauma, How to Avoid Re-Traumatization*, <https://www.onlinemswprograms.com/resources/how-to-be-mindful-re-traumatization/> [<https://perma.cc/26FA-UD86j>].

they see themselves.⁴⁸ Tasked with documenting and corroborating an individual's experience with torture and persecution for an immigration system where relief from deportation is often hinged on extreme suffering, forensic evaluators, like immigration attorneys, are often focused on defining an individual by the worst thing that ever happened to them in the country they fled from. This narrative often minimizes the traumatizing impact of the immigration system in and of itself, as experienced through detention and deportation, lengthy backlogs and instability, and intrusive questions about traumatic events. Finally, forensic evaluations often do not capture an individual's traits of resilience and survival, possibly serving as another vehicle of disempowerment in the immigration system.

Despite the exponential growth of medical-legal collaborations and growing requests for forensic medical evaluations in support of immigrants,⁴⁹ there is little data about how adjudicators consider such evaluations in making their determinations. Although PHR data provides a window into if and how such evaluations impacted outcomes, the Study is unable to assess whether such evaluations were most helpful in corroborating an immigrant's testimony about suffering and persecution to establish threshold eligibility, bolstering their credibility by medically accounting for memory loss, omissions, and other factors, or persuading a judge to make a discretionary decision. Forensic medical evaluations likely impact all aspects of adjudicator decision-making and strengthen an individual's ability to share their narrative with their counsel and before adjudicators. The subsequent Sections focus on the first two roles that forensic medical evaluation play: supporting eligibility for relief and credibility determinations.

A. *How Forensic Medical Evaluations Support Arguments for Relief*

The PHR-CUNY Study analyzed over 2,500 cases in which PHR-affiliated forensic medical evaluators were requested to provide forensic medical evaluations in support of an individual applying for a benefit before USCIS or an application for relief before an immigration judge. 67% of the cases in the dataset involved the grant or denial of asylum.⁵⁰ Although PHR describes its network as the "PHR Asylum Network," the network has long evaluated immigrants seeking many forms of humanitarian-based relief.⁵¹

48. For an excellent discussion of how the focus on medical testimony in the torts context serves to overstate physical disabilities and further unfair and incorrect stereotypes of people with disabilities as tragic, see generally Anne Bloom & Paul S. Miller, *Blindsight: How We See Disabilities in Tort Litigation*, 86 WASH. L. REV. 709 (2011).

49. For a current list of PHR groups, see <https://phr.org/issues/asylum-and-persecution/student-asylum-clinics/> [<https://perma.cc/WFY6-WKMC>] and for non-PHR groups that are tracked by medical students, see <https://www.phrstudents.com/asylum-clinics> [<https://perma.cc/L4TH-KRX6>].

50. Atkinson et al., *supra* note 5, at 5 (Table 1); see also Appendix A, *infra*.

51. Though far from the only form of relief that is intertwined with medical and psychological hardship, medical-legal partnerships have historically been geared towards the representation of asylum

Other forms of relief that PHR-facilitated evaluations supported included: withholding of removal, protections under Convention Against Torture (“CAT”), U-Visas, T-Visas, Violence Against Women Act (“VAWA”) relief, Special Immigrant Juvenile Status (“SIJS”), and cancellation of removal.⁵²

Attorneys also request forensic medical evaluations on behalf of their clients to support requests to terminate or in administratively close proceedings.⁵³ For instance, in proceedings like *Matter of M-A-M-*, in which immigrants show indications that they lack the competency to understand the proceedings they are in, immigration judges can use a host of tools, including administrative closure, to ensure these individuals are afforded due process.⁵⁴ In addition, in a handful of cases that appear in the PHR dataset, forensic medical evaluations supported requests for release from detention and adjustment of status. Although outside the scope of the PHR-CUNY Study, the Biden Administration’s most recent guidance on prosecutorial discretion guides DHS to consider “a physical or mental condition requiring care and treatment” or “a mental condition” that may have contributed to criminal conduct as mitigating factors, which militate in favor of declining enforcement action.⁵⁵ Thus, forensic medical evidence may be used to influence all enforcement decisions within the purview of DHS including actions beyond case closure, such as joining in motions to reopen, favorable positions on bond, or entering stipulations.⁵⁶

The subsequent Section provides an overview of some of the forms of relief that individuals in the PHR-CUNY dataset most commonly pursued and how adjudicators may have used their forensic medical evaluations when assessing whether the applicants qualified for relief. Although the PHR-CUNY Study demonstrates that forensic medical evaluations are drivers of success, this Section also outlines the many ways adjudicators have disregarded evaluations because they were created for purposes of litigation,

seekers and torture survivors. See Avery League et al., *A Systematic Review of Medical-Legal Partnerships Serving Immigrant Communities in the United States*, 23 J. IMMIGRANT & MINORITY HEALTH 163 (2021), see also Human Rights Initiative at the University at Buffalo, *The Value of Medical Students in Support of Asylum Seekers in the United States*, 36 FAM. SYS. & HEALTH 230 (2018); Kim Baranowski et al., *Supporting Asylum Seekers: Clinician Experiences of Documenting Human Rights Violations Through Forensic Psychological Evaluation*, 31 J. TRAUMATIC STRESS 391 (2018); Madison B. Sharp et al., *Evaluating the Impact of Student-run Asylum Clinics in the US from 2016–2018*, 21 HEALTH HUM. RTS. J. 309 (2019).

52. Atkinson et al., *supra* note 5, at 5 (Table 1); see also Appendix A, *infra*.

53. Termination of proceedings in the immigration context refers to a complete dismissal of the matter. In contrast, administrative closure is “a docket management tool that is used to temporarily pause removal proceedings.” *Matter of W-Y-U-*, 27 I&N Dec. 17, 18 (BIA 2017). It does not terminate or dismiss the case, but rather “remove[s] a case from an [i]mmigration [j]udge’s active calendar or from the Board’s docket.” *Matter of Avetisyan*, 25 I&N Dec. 688, 692 (BIA 2012).

54. *Matter of M-A-M-*, 25 I&N Dec. 474 (BIA 2011).

55. Alejandro Mayorkas, *Guidelines for the Enforcement of Civil Immigration Law*, ICE (Sep. 30, 2021), <https://www.ice.gov/doclib/news/guidelines-civilimmigrationlaw.pdf> [https://perma.cc/2VKV-HPU5].

56. *Id.*

they were not contemporaneous to the described events, or they failed to provide certainty about the causality of the harm.

1. Relief Under Asylum, Withholding of Removal & CAT

Of the 2,584 case outcomes in the PHR-CUNY dataset, 1,735 (67%) involved the grant or denial of asylum applications.⁵⁷ In contrast, 2.8% of the positive outcomes involved a grant of withholding of removal and less than 1% of the applicants in the CUNY-PHR received a grant of CAT relief.⁵⁸ Despite these small numbers, it is assumed that many who applied for asylum simultaneously used their evaluations to support applications for withholding of removal and CAT, three forms of relief commonly applied for together.

Before 1980, the United States had admitted refugees on an ad hoc basis in response to geographic or ideological preferences or political obligations.⁵⁹ The United States codified its commitments to the 1967 United Nations Protocol Relating to the Status of Refugees in the Refugee Act of 1980, with an intention to create a consistent standard for adjudicating refugee claims.⁶⁰ In line with international standards and agreements, the Act defined “refugee” as anyone with a “well-founded fear of persecution.” Although the Refugee Act sought to make asylum law consistent, the process of attaining asylum is far from congruent.⁶¹ Many of the core elements of asylum eligibility lack a singular definition and remain vulnerable to differing and evolving interpretations. Asylum grant rates vary widely across the country based on a variety of factors, including geography, immigration judge, gender, applicants’ country of origin, and race.⁶²

Asylum eligibility hinges on establishing three core elements: that the applicant suffered past persecution or has a well-founded fear of future persecution, a nexus between the harm and a protected ground, and the inability or unwillingness of the applicant’s home country to provide protection from the harm.⁶³ Where one is unable to establish past persecution, they must be able to prove a well-founded fear of persecution in the future. Even after meeting core eligibility requirements, an immigrant may still be denied asylum if the adjudicator finds that they are not credible⁶⁴ or are unworthy of the adjudicator’s expansive discretion to grant or deny an

57. Atkinson et al., *supra* note 5, at 5 (Table 1); *see also* Appendix A, *infra*. Asylum was granted in 89% of the cases which asylum grants or denials were documented.

58. *Id.* Note PHR did not track data specifically about the denial of withholding or CAT.

59. *See* Karen Musalo, *Irreconcilable Differences? Divorcing Refugee Protections from Human Rights Norms*, 15 MICH. J. INT’L. L. 1179 (1994).

60. Refugee Act of 1980, Pub. L. No. 96-212, 94 Stat. 102.

61. *See, e.g.*, Rempell, *supra* note 23, at 142; Ramji-Nogales et al., *supra* note 25, at 295.

62. Ramji-Nogales et al., *supra* note 25, at 375.

63. 8 U.S.C. § 1158(b)(1)(A) (2008).

64. 8 U.S.C. § 1158(b)(1)(B)(iii) (2008).

application based on other external factors such as criminal history, family, community ties, or previous immigration history.⁶⁵

In contrast to the benefits asylum affords, CAT and withholding of removal are forms of relief that simply halt the removal of an individual back to the country without offering any path to citizenship.⁶⁶ Withholding of removal is a mandatory form of relief, one that must be granted to any who can demonstrate that they are “more likely than not” to face persecution if returned to their country of origin—a 51% percent chance of persecution.⁶⁷ Those seeking relief under CAT must similarly demonstrate that it is “more likely than not” that they will be tortured if removed to their country.⁶⁸ Under CAT, torture is defined as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted . . . when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in official capacity.”⁶⁹ As in the asylum context, medical evaluators can support applicants for withholding of removal and CAT relief by documenting past persecution or torture, current mental status, and future vulnerabilities.

At the heart of asylum, withholding of removal, and CAT is the concept of safety from persecution. However, adjudicators—be they immigration judges, asylum adjudicators, or federal judges—have differed on how to define persecution.⁷⁰ The Seventh Circuit describes this problematic development of persecution analysis as of the “I know it when I see it” variety.⁷¹ In seeking to define the core of persecution, some argue that the original vagueness of this term is at least partially intentional, given the transient and evolving nature of persecution.⁷² The result? A confusing maze of cases that reveal that prevailing on a persecution finding, and receiving a grant of asylum, is largely dependent on which adjudicator the applicant draws and what jurisdiction the applicant falls under as opposed to the individual facts of the case.⁷³ This confusion has led to what some courts have described as “capricious adjudication at both the administrative and judicial levels, generating extraordinary disparities both in grants of asylum in similar cases at the administrative level, and in reversals by courts of appeals and denials.”⁷⁴

65. See INA 208 and 8 CFR 208; *Matter of Pula*, 19 I&N Dec. 467, 471 (BIA 1987).

66. 8 CFR § 208.16; 8 U.S.C. § 1231(b).

67. INA. § 241(b)(3); 8 U.S.C. § 1231(b)(3) (2012).

68. 8 C.F.R. § 1208.16(c)(2).

69. 8 CFR § 208.18.

70. Rempell, *supra* note 23, at 192.

71. *Id.* at 143–44.

72. *Id.* See also Ramji-Nogales et al., *supra* note 25, at 379 (2007) (“[T]here has never been a succinct, definitive definition of ‘persecution,’ because the nature of persecution and our understanding of it keep changing.”).

73. Fatma E. Marouf, *The Rising Bar for Persecution in Asylum Cases Involving Sexual and Reproductive Harm*, 22 COLUM. J. GENDER L. 81, 91–93 (2011).

74. Ramji-Nogales et al., *supra* note 25, at 295.

In Professor Scott Rempell's systematic analysis of appellate cases that reviewed persecution findings on the merits over a seventeen-year period between 1996 and 2013, he noted widely inconsistent decision-making.⁷⁵ Among the many theories he offered for these inconsistencies were differences in how various circuits measure harm by considering its frequency. For example, Professor Rempell described a focus on "systematic conduct" rather than "isolated" events in the First Circuit.⁷⁶ In contrast, the Second, Seventh, and Ninth Circuits do not require systematic conduct and may accept isolated events as persecution.⁷⁷ For a forensic evaluator documenting harm, whether or how to highlight compounding harms versus isolated events may differ depending on jurisdiction.

Circuits also differ in their consideration of the extent of harms that rise to the level of persecution. In an attempt to "create some minimum coherence" in the determination of whether harm rises to the level of persecution, the Seventh Circuit offered a definition of persecution as harm that "involves the use of significant physical force against a person's body, or the infliction of comparable physical harm without direct application of force . . . or nonphysical harm of equal gravity."⁷⁸ The court goes on to state that "[t]he line between harassment and persecution is the line between the nasty and barbaric."⁷⁹ In a contrasting definition, the Fourth Circuit narrowed the definition of persecution to only include "threats to life, confinement, torture and economic restrictions so severe, they constitute a threat to

75. Rempell, *supra* note 23, at 147. The author chose to focus on cases from 1996 onwards due to that year's passage of the Illegal Immigration Reform and Immigration Responsibility Act and its resultant shift in jurisdictional review standards which allowed appellate courts to reverse Board of Immigration Appeals decisions regarding persecution determinations if "any reasonable adjudicator would be compelled to the contrary." *Id.* at 147.

76. *Id.* at 196; see also *Rodriguez-Villar v. Barr*, 930 F.3d 24, 27 (1st Cir. 2019) (assessing persecution by discussing the "increase in severity" of abuse).

77. Scott Rempell, *Unpublished Decisions and Precedent Shaping: A Case Study of Asylum Claims*, 31 GEO. IMMIGR. L.J. 1, 29 (2016). In noting the discrepancies between how published IJ decisions discuss physical harm-based persecution and the low rates of physically harmed applicants granted asylum, Professor Rempell notes how judges may perceive harm differently, implicating that this is not an area of settled law justifying a published decision. The Ninth Circuit does not require "systematic conduct," but it does require something more than just a one-off incident of abuse. See also *Aden v. Wilkinson*, 989 F.3d 1073, 1082 (9th Cir. 2021) ("We have recognized that a one-off physical beating did not compel a finding of persecution, even if, in our independent view, a reasonable factfinder could conclude such a beating rose to the level of persecution. Nonetheless, when the incidents have involved physical harm plus something more, such as credible death threats, we have not hesitated to conclude that the petitioner suffered persecution.") (emphasis added). (internal citations omitted) Additionally, the Ninth Circuit has a "cumulative effect" standard. See *Surita v. INS*, 95 F.3d 814, 819 (9th Cir. 1996) ("[W]hile a single incident, in some instances, may not rise to the level of persecution, the cumulative effect of several incidents may constitute persecution.").

78. *Stanojkova v. Holder*, 645 F.3d 943, 948 (7th Cir. 2011).

79. *Id.*

life or freedom.”⁸⁰ At the very least, all circuits agree that persecution amounts to something greater than harassment or discrimination.⁸¹

Looking at asylum cases in which immigration judges made findings on whether past harm rose to the level of “persecution,” Professor Rempell’s study found that four types of harms were universally regarded as persecution. In each of these categories, tangible, physical harm played an outsized role. The first universally accepted harm was described as “brutal and systematic physical abuse,” meaning harm sustained over a long period of time. This is harm “a reviewing body can readily assess” as opposed to a “generic beating.”⁸² As the Eleventh Circuit noted, when assessing physical abuse in this area, “appellate courts regularly survey the extent of any subsequent medical treatment when assessing the severity of harm.”⁸³ Forensic medical evaluations offered in support of this type of persecution might be straightforward physical evaluations documenting scars or injuries that remain identifiable, even decades after the causal abuse. Common medical findings that may fall under this category of persecution may include the long-term sequela of lacerations, abrasions, burns, incisions, traumatic brain injury, and post-concussion syndrome.⁸⁴

The second type is a “sufficiently recurrent combination of cumulatively severe harms,” which is exemplified by cases where threats, physical harm, and curtailments of other freedoms together give rise to a finding of persecution as long as the harms are found to be sufficiently severe.⁸⁵ Here, non-physical harms also may play a large role, including threats, restrictions on religious belief or political practice, and economic disadvantage.⁸⁶ Although no statute or regulation requires physical harm for a showing of persecution, scholars have observed adjudicators denying asylum claims that lacked claims or findings involving physical harm.⁸⁷ Findings from the CUNY-PHR Study support these observations, reflecting that those with physical evaluations were 10% more likely to gain a successful outcome than those with only psychological forensic evaluations.⁸⁸

Although harms that relate to coercive population control have been recognized as persecution by statute,⁸⁹ in her analysis of cases involving sexual

80. *Fatin v. INS*, 12 F.3d 1233 (3d Cir. 1993); see also *Li v. Att’y. Gen. U.S.*, 400 F.3d 157, 172 (3d Cir. 2005) (Sloviter, J., dissenting) (“Admittedly, our definition of persecution differs from that of circuits such as the Seventh Circuit, which has stated that ‘a threat to life or freedom is not necessarily a persecution prerequisite.’” (citing *Borca v. INS*, 77 F.3d 210, 215 (7th Cir. 1996))).

81. See *Kazemzadeh v. U.S. Att’y Gen.*, 577 F.3d 1341, 1357 (11th Cir. 2009) (Marcus, J., concurring) (citing *Sanchez Jimenez v. U.S. Att’y Gen.*, 492 F.3d 1223, 1232 (11th Cir. 2007)).

82. Rempell, *supra* note 23, at 168–69.

83. *Id.*

84. Ferdowsian et al., *supra* note 11, at 218 (Table 2).

85. Rempell, *supra* note 23, at 170.

86. *Id.*

87. Wendy B. Davis & Angela D. Atchue, *No Physical Harm, No Asylum: Denying a Safe Haven for Refugees*, 5 TEX. FORUM CIV. LIBS. & CIV. RTS. 81 (2000).

88. See Atkinson et al., *supra* note 5, at 9.

89. INA § 101(a)(42).

and reproductive harms, Professor Fatma Marouf notes that even where an applicant has suffered extreme physical harms in the form of female genital mutilation/cutting (“FGM/C”) or the forced insertion of an intrauterine device (“IUD”), adjudicators may look for additional, often physical, “aggravating circumstances” (i.e., significant pain or multiple insertions) for the harm to amount to persecution.⁹⁰ In addition, she notes that the Board of Immigration Appeals (“BIA”) had ignored the psychological effects of coercive reproductive procedures, including the loss of privacy and autonomy surrounding reproductive choice, and the intrusiveness of the physical exam in and of itself.⁹¹ Professor Marouf suggests that adjudicators consider “the multiplicity of harms” associated with FGM/C and forced restrictions on women’s reproduction rather than “an isolated incident.”⁹²

In the scenario Professor Marouf describes, a physical forensic evaluation may be able to capture some physical harms, i.e., confirm FGM/C, the insertion of a birth control device, or the blockage of fallopian tubes due to forced sterilization. To supplement this, a forensic psychological evaluator could confirm the involuntary nature of the procedure and note the impact of loss of autonomy, privacy, and forced medical procedures on one’s long-term mental well-being and health, reiterating that these harms may have just as much, if not more, of a negative impact on the applicant.

Finally, the third and fourth types of harm—“recurrent injury preceding a harm crescendo” and “sufficient harm preceding a substantiated flight precipitator,” respectively—are scenarios where less severe abuses culminate in a particularly egregious form of harm or threat of anticipated egregious harm. Professor Rempell describes this culmination as the “continuous experience of physical and psychological anguish.”⁹³ Although a forensic evaluator conducting a physical exam may be unable to document less severe harms years later, a psychological evaluator could speak to the long-term impacts of the psychological and physical anguish on one’s mental health.

Crucially, most cases in the Rempell study did not fall within the parameters outlined above. The majority of the holdings entailed inconsistent interpretations even where there were similar categories of harms.⁹⁴

90. Marouf, *supra* note 73, at 85.

91. *Id.* at 130–31.

92. *Id.* at 151–52 (“By addressing the multiplicity of harms associated with FGM, including its discriminatory nature and the way in which it violates individual autonomy, the UN Committees connect the practice to a range of human rights violations, rather than treating it as an isolated physical incident, which is how many asylum adjudicators mistakenly view the practice. In other words, drawing on the comments and observations of the UN bodies that interpret human rights treaties would help asylum adjudicators better understand that ‘[t]he human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence’ ”).

93. Rempell, *supra* note 23, at 171–73.

94. *Id.* at 176–90. For example, there was little consensus on how to adjudicate even straightforward claims involving a single instance of abuse and detention.

With this backdrop, it is a forensic evaluator's role to accurately identify, document, and correlate the physical or psychological sequelae of the harm that an individual reports. To the extent adjudicators measure persecution by looking at cumulative harms, the forensic medical evaluation may powerfully highlight the intertwining nature of physical and psychological harms and uplift the compounding effect of trauma over time. Professor Rempell describes this as the "taxonomy of harm,"⁹⁵ which "represents the foundational building blocks of persecution."⁹⁶ Further, even where the extent or severity of physical or psychological harm is deemed a lesser consideration in relation to the persecutor's intent, the forensic medical evaluation may be a source of corroboration for the account the applicant has put forth, bolstering credibility. Future vulnerabilities that may stem from sustained injuries may also be relevant to assessment of fear of future persecution.

2. *The U Nonimmigrant Status ("U-Visa")*

Those granted U-Visas comprised 1.6% of the total positive outcomes studied in the PHR dataset.⁹⁷ Created as part of the Victims of Trafficking and Violence Protection Act of 2000 alongside the T-Visa, the U-Visa opens a path to permanent residence for survivors of criminal activity suffered in the United States and their family members.⁹⁸ Eligibility for a U-Visa requires, among other things, that one has "suffered substantial physical or mental abuse as a result of having been victim of a crime."⁹⁹ The qualifying crimes are enumerated in a specific list, including rape, torture, trafficking, incest, domestic violence, sexual assault, and prostitution.¹⁰⁰ To be eligible for relief, the crime victim must have assisted (or offered to assist) law enforcement in the investigation or the prosecution of the crime and provide proof of such an offer through a law enforcement certification.¹⁰¹

As in the asylum context, a forensic medical evaluator providing evidence for a U-Visa must not only document harms but also provide information on causality. For example, a client from the Immigrant and Non-Citizen Rights Clinic at CUNY Law was the victim of a workplace assault when an angry customer threw a phone at him, shattering glass all over the bodega in which he worked. He needed a medical evaluation to prove the incident caused mental and physical injury that rose to the standard of "substantial harm." A physical examination revealed the injuries and scarring on his hands due to the attack, and a psychological evaluation substantiated the PTSD and paranoia that began only after the attack took place.

95. Scott Rempell, *Defining Persecution*, 2013 UTAH L. REV. 283, 292–310 (2013).

96. *Id.* at 293.

97. Atkinson et al., *supra* note 5, at 5 (Table 1); see also Appendix A, *infra*.

98. USCIS Humanitarian, *supra* note 22 (see Victims of Human Trafficking page).

99. 8 C.F.R. § 214.14(b)(1) (2019).

100. 8 C.F.R. § 214.14(a)(9) (2019).

101. 8 C.F.R. § 214.14(b)(2)–(3) (2019).

Both affidavits were used by the legal team to argue that these harms were substantial and a direct result of the attack.

Prior to the creation of U-Visa protection, the term “substantial physical or mental abuse” had never been used in the immigration context. During their rulemaking process, DHS considered how to define physical or mental abuse by looking towards similar terms in existing regulations. DHS turned to the regulations promulgated following the passage of VAWA, which allowed survivors of domestic violence at the hands of U.S. citizens or lawful permanent residents to seek relief where they had faced “extreme cruelty.” In this context, “battery” and “extreme cruelty” had been used interchangeably with the term “abuse.”¹⁰² In the U-Visa context, DHS qualified “mental or physical harm” with the term “substantial,” but noted the regulations remained intentionally silent on whether “substantial” referred to the severity of the injury suffered by the victim or the severity of the abuse inflicted by the perpetrator.¹⁰³ In the final rule, DHS concluded it was reasonable to consider the severity of both the nature of the harm and the nature of the abuse, guiding adjudicators to make case-by-case determinations based on the factors described above.¹⁰⁴ USCIS retains sole jurisdiction over U-Visa determination. When a case is denied, USCIS’s internal appellate arm—the Administrative Appeals Office (“AAO”)—will perform a *de novo* review.¹⁰⁵

Like persecution assessments for asylum, “there are no specific cases that interpret or determine what constitutes ‘substantial physical or mental abuse’” in this context.¹⁰⁶ Given the lack of statutory guidance and case law precedent, harm-assessments remain dependent on an individual adjudicator’s determination of what harm rises to the level of “substantial” abuse. Further, promulgating regulations recognize that some victims may have had pre-existing physical or mental injuries or conditions at the time of abuse and direct USCIS to consider whether any pre-existing conditions were aggravated in assessing “substantial physical or mental abuse.”¹⁰⁷ Thus, it is essential for applicants to provide detailed documentation sup-

102. New Classification for Victims of Criminal Activity; Eligibility for “U” Nonimmigrant Status, 72 FR 53018 (2007).

103. *Id.*

104. *Id.* Whether physical or mental abuse is “substantial” hinges on: “the nature of the injury inflicted or suffered; the severity of the perpetrator’s conduct; the severity of the harm suffered; the duration of the infliction of the harm; and the extent to which there is permanent or serious harm to the appearance, health, or physical or mental soundness of the victim, including aggravation of pre-existing conditions.” *Id.*

105. *AAO Practice Manual* 3.4, U.S. CITIZENSHIP AND IMMIGR. SERVS., <https://www.uscis.gov/administrative-appeals/aao-practice-manual/chapter-3-appeals> [<https://perma.cc/T4WS-2J7G>].

106. Jean Pierre Espinoza & Jung Choi, *Overview of the U-Visa: “Race Between Approval and Removal,”* 15 BENDER’S IMMIGR. BULL. 645, 647 (2010); *see also* Benjamin Thomas Greer & Scott Davidson Dyle, *Determining the Reasonableness of Non-Compliance: Examining the “Trauma Exception” for T-Visa Applicants,* 15 ST MARY’S L. REV. & SOC. JUST. 385 (2013).

107. New Classification for Victims of Criminal Activity; Eligibility for “U” Nonimmigrant Status, 72 FR 53014-0 (2007).

porting any possible substantial physical or mental abuse, including previous conditions that may have been aggravated due to the crime they survived.

Recognizing the difficulty that survivors of crime may have producing specific types of evidence, Congress statutorily requires USCIS to accept “any credible evidence” in support of the U-Visa application.¹⁰⁸ Even with this wide latitude given to adjudicators, many petitions are still denied where USCIS finds that the alleged harm that an applicant faced was not “substantial.”¹⁰⁹ In many cases, this may reflect a lack of understanding of the frameworks of abuse. For example, survivors of workplace abuse—which may include bullying, harassment, and other forms of victimization—experience negative psychological and physical consequences.¹¹⁰ Immigrant victims may respond to this psychological injury in a variety of ways, including panic disorders, alcohol abuse, or physical symptoms that do not correspond to a mental health disorder diagnosis.¹¹¹ Naturally, the severity of the injury will also be impacted by the victim’s emotional makeup and past exposure to trauma.¹¹² Although all of these factors are crucial in understanding the harm in relation to the U-Visa’s substantial abuse requirements, AAO cases show that adjudicators often employ a simplistic understanding of abuse and trauma.¹¹³

In a review of AAO decisions assessing mental harm in VAWA and U-Visa claims, Professor Virgil Wiebe and Susan Brenes note that an established therapeutic relationship between the client and mental health provider was more compelling to adjudicators than single session evaluations

108. 8 C.F.R. § 214.14(c)(4).

109. See, e.g., Elizabeth M. McCormick, *Rethinking Indirect Victim Eligibility for U Non-Immigrant Visas to Better Protect Immigrant Families and Communities*, 22 STAN. L. & POL’Y REV. 587 (2011) (arguing that indirect victims of qualifying crimes should not be required to prove substantial harm); Eunice Hyunhye Cho et al., *A New Understanding of Substantial Abuse: Evaluating Harm in U Visa Petitions for Immigrant Victims of Workplace Crime*, 29 GEO. IMMIGR. L.J. 1, 5 (2014) (discussing how adjudicators have erroneously conflated the U-Visa’s “substantial physical or mental abuse” standard with “extreme cruelty”); Elie Peltz, *Giving Voice to the Silenced: The Power Act as a Legislative Remedy to the Fears Facing Undocumented Employees Exercising Their Workplace Rights*, 54 COLUM. J.L. & SOC. PROBS. 503, 519 (2021) (“In rejecting workplace-based claims, USCIS officials found the psychological effects of workplace abuse insufficient to meet the substantial abuse threshold without accompanying physical harm. In addition, regulators are more likely to question the nexus between employer misconduct and employee emotional distress than for cases of sexual assault and domestic abuse, which can involve similar forms of psychological trauma.”); Jason A. Cade & Meghan L. Flanagan, *Five Steps to a Better U: Improving the Crime-Fighting Visa*, 21 RICH. PUB. INT’L. L. REV. 85 (2018) (describing how USCIS regularly denies U-Visa petitions where there are few physical injuries).

110. Cho, *supra* note 109, at 16.

111. *Id.* at 22–23 (“The American Psychological Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes methods to address difficulties that arise when applying diagnostic criteria to foreign-born individuals that have been labeled as ‘culture-bound syndromes.’”).

112. *Id.* at 19–43.

113. In Re: 15878296, Form I-918, Petition for U Nonimmigrant Status (Aug. 16, 2021). Though the Petitioner provided evidence of a PTSD diagnosis and indicated he suffered from symptoms of depression and anxiety, the court found that “the record as a whole does not indicate that the Petitioner’s diagnosis and feelings have significantly impaired his ability to function.” *Id.*

by an forensic evaluator clinician prepared to support the filing.¹¹⁴ They surmise the AAO may be looking for a long-standing evaluative relationship as proof of a “real problem.”¹¹⁵ For example, in one matter, the AAO noted that counsel requested a forensic medical evaluation nearly six years after the petitioner was placed in removal proceedings in response to a Request for Evidence (“RFE”) implying the medical evaluation was biased solely because it was created for litigation.¹¹⁶ Additionally, the AAO noted that there was no other evidence that the petitioner suffered or received treatment for the alleged harms.¹¹⁷ Failure to seek treatment for mental illness was also used to make arguments that illnesses did not exist or were not “substantial.”¹¹⁸ This case and trends in other adjudications by the AAO indicate that forensic medical evaluations created solely for the purpose of adjudication may be discounted, underscoring the need for adjudicators to receive greater education about the obstacles to medical care that those without immigration status in the United States face. Forensic medical evaluators can help fill this need by outlining the multiple reasons why someone in need of therapy or follow-up care may not have been able to get access to it.

Linking assessments about the severity of harm to whether one has received medical treatment for that harm ignores the realities of access to healthcare, especially mental health care, in both the United States and the immigrant’s home country. In the United States, many immigrants are denied access to non-emergency health services because of immigration status or lack of medical insurance.¹¹⁹ By linking severity of harm to whether one has received medical treatment for that harm, the adjudicator may be punishing immigrants for not furnishing evidence that was unattainable to them in the first place given cultural, social, and economic realities that impact healthcare access.

As observed in the asylum context, physical harm plays an outsized role in U-Visa adjudication and certification as well. In her ethnographic study of humanitarian-based visa applications in Los Angeles, Sarah Lakhani de-

114. Virgil Wiebe & Sarah Brenes, *Mental Health Professionals and Affirmative Applications for Immigration Benefits: A Critical Review of Administrative Appeals Office Cases Involving Extreme Hardship and Mental Harm*, 11–04 IMMIGR. BRIEFINGS 1 (2011) (“Perhaps ironically, reports created for the purposes of litigation by assessors attempting to adhere to more objective standards may well be given less weight by the AAO than reports by therapists. In the upside down world of immigration adjudication, AAO decisions often give short shrift to stand-alone forensic evaluations, particularly when there is (1) no evidence of therapy either by the assessor or someone else and/or (2) the assessment is based only upon an intake from the subject in a single, short session. The whiff of secondary gain often overpowers the force of professional opinion.”).

115. *Id.*

116. *Id.* (citing Petition for U Nonimmigrant Visa, EAC 08 170 50519, 2010 WL 4088049, *7–*8 (AAO, April 15, 2010)).

117. *Id.*

118. *Id.*

119. Kaiser Family Foundation Report, *Health Coverage for Immigrants* (July 15, 2021) (“Noncitizens are significantly more likely than citizens to be uninsured.”).

scribed how attorneys thought that law enforcement officers were more likely to sign certifications if the violence included a physical aspect, though both physical and mental harm are covered by the statute.¹²⁰ Attorneys observed by Lakhani also thought that multiple incidents of harm were more compelling, leading attorneys to convey to immigrants that where they had severe and repeated physical harm, the chances of a U-Visa certification increased.¹²¹

3. T-Visas

Those granted T-Visas comprised 1% of the positive outcomes in the PHR-CUNY dataset.¹²²

Established in 2000, the T-Visa gives those who survived “severe forms” of human trafficking the right to live and work in the United States, and eventually petition for permanent residence.¹²³ To qualify for a T-Visa, the immigrants must prove they are present in the United States on account of the trafficking, they have complied with reasonable law enforcement requests for assistance, and they would “suffer extreme hardship involving unusual and severe harm upon removal.”¹²⁴

Unlike the U-Visa, which looks only at the nature of the harm sustained as a victim of the enumerated crime, the T-Visa considers harm that might be engendered by removal from the United States (not the harm of the trafficking itself). For example, if a victim has suffered from extreme PTSD, they may need access to ongoing therapeutic health care to ensure medical stability that may not be available in the country to which they would be removed.¹²⁵ To provide support for a T-Visa applicant, a forensic psychological evaluation could attest to these specific needs.¹²⁶

Psychological or physical harm may also be used to prove that the applicant is present in the United States on account of trafficking. Many individ-

120. Sarah Morando Lakhani, *From Problems of Living to Problems of Law: The Legal Translation and Documentation of Immigrant Abuse and Helpfulness*, 39 LAW & SOC. INQUIRY 643, 654 (2014).

121. *Id.*

122. Atkinson et al., *supra* note 5, at 5 (Table 1); *see also* Appendix A, *infra*.

123. Survivors of Trafficking and Violence Protection Act of 2000 (“VTVPA”), 22 USC §§7101; 8 USC §§1101 (a)(15)(T); 8 CFR §214.11 (2012).

124. 8 C.F.R. §214.11(b)(1)–(4) (2012). Note that the “extreme hardship” was also originally required of those seeking battered spouse waivers, a precursor to present-day VAWA protections. Upon observation of how difficult it was to meet this standard, removing this requirement was a central goal of the VAWA. *See generally* Leslye E. Orloff & Janice V. Kaguyutan, *Offering A Helping Hand: Legal Protections for Battered Immigrant Women: A History of Legislative Responses*, 10 AM. U. J. GENDER SOC. POL’Y L. 95 (2002).

125. Matter of G-G-, ID# 38667535, at 5 (AAO Aug. 22, 2019).

126. Wiebe & Brenes, *supra* note 114, at 11 n.127 (“Statements from mental health professionals can be helpful in addressing factors (i)–(iii) by describing the ongoing mental health needs of the applicant, stressing any reasons why disrupting the continuity of the therapy (i.e., through removal from the U.S.) would create hardship for the applicant. The professional should emphasize any ongoing treatment that the applicant is receiving. If the professional is aware of the types and quality of mental health services available in the applicant’s home country, it is important to explain how or why these services would be inadequate to meet the applicant’s needs.”).

uals are unable to apply for a T-Visa years after escaping a trafficking situation. In this scenario, USCIS places the burden on the applicant to show that their *continued* presence in the United States is directly related to the trafficking.¹²⁷ In considering the applicant's physical presence, USCIS will consider how the applicant escaped the trafficking, whether there have been efforts to rehabilitate the applicant's life since the escape, and whether the applicant is currently receiving victim services for injuries and trauma sustained from trafficking.¹²⁸ For example, a trafficking survivor may have sustained mental trauma that would render it impossible for them to make plans to leave the United States. To prove this, a forensic evaluator may be tasked with showing the long-lasting consequences of the trafficking, and the resultant destabilization on life, health, and finances.¹²⁹

Further, a federal exception stipulates that applicants need not comply with reasonable law enforcement requests if they are unable to do so because of physical or psychological trauma.¹³⁰ In availing this exception, an applicant should connect psychological or physical harm caused by the trafficking with their inability to work with law enforcement. A forensic medical evaluation could be offered to document this trauma and the resultant inability to work with law enforcement. Immigration attorneys encourage T-Visa applicants to submit a full psychological examination to support claims of mental trauma in explaining why they cannot comply with a law enforcement request while pursuing the federal exemption.¹³¹

A forensic medical evaluation in the T-Visa context, then, in categorizing physical and mental consequences of the trafficking, must address the impact trauma had on a survivor's ability to function. This is consistent with the Istanbul Protocol's call for forensic psychological evaluators to provide "an assessment of social functioning."¹³² This may require the evaluator to document why an individual was forced to continue to reside in the United States, why an individual may be unable to cooperate with law enforcement, or what impact deportation may have on mental and physical health.¹³³ Evaluators are tasked with showing how harm impacted day-to-day life activities and presence in the United States. For example, a non-precedent decision from the AAO acknowledged the applicant's diagnosis of PTSD and persistent depressive disorder but found both evaluations to be lacking in how these diagnoses impacted daily life and activities. Instead,

127. 8 C.F.R. §214.11(g)(1)(iv) (2012).

128. *Id.*; see also Physical Presence on Account of Trafficking: Eligibility Requirements for T-Visa Applicants, Classification for Victims of Severe Forms of Trafficking in Persons; Eligibility for "T" Nonimmigrant Status" 81 Fed. Reg. 92266 (2018) (phrasing physical presence requirement in the present tense only to require consideration of the victim's current situation, and whether the victim can establish that their current presence in the United States is on account of trafficking).

129. Matter of G-G-, ID# 38667535, at 5 (AAO Aug. 22, 2019).

130. Greer & Dyle, *supra* note 106, at 395.

131. *Id.* at 432.

132. Istanbul Protocol, *supra* note 38, at 50.

133. *Id.*

the AAO noted that the evaluations concluded that the applicant was able to independently live and work without outside help.¹³⁴

In their study of mental health evaluations in T-Visa cases adjudicated by the AAO, Professor Wiebe et al., noted the lack of consistent methods and standards to evaluate the weight of mental health professional statements.¹³⁵ They observe that in reviewing T-Visa cases, the AAO frequently noted the evaluator's qualifications (though rarely questioned them), and gave little weight to a consistent recounting of background facts by the evaluator (yet did note when such facts were inconsistent with the applicant's affidavit).¹³⁶ As seen in other contexts, there was diminished weight given to the applicant's mental illness and vulnerabilities when assessing the trafficker's intent, or to establish whether the applicant remained in the country due to "continued victimization."¹³⁷ The AAO found psychological arguments regarding hardship upon removal compelling where the forensic evaluator was able to speak directly and specifically about the unavailability of mental health services in the home country and a recommended course of treatment.¹³⁸

Whereas international protocols have been established for other areas, including assessing harms to torture victims, Part III, *infra*, there is no single international protocol for forensic medical evaluations for trafficking victims, despite the overwhelming incidence of mental and physical trauma in populations applying for T-Visa relief.¹³⁹ One study of over 192 recent trafficking survivors found that 57% of survivors had PTSD, 62% had memory difficulties, and 63% presented with ten or more concurrent physical health problems.¹⁴⁰ Some practitioners have recommended that DHS design and promulgate a PTSD form, tailored specifically for victims of trafficking, allowing for their treating evaluator to uniformly document the survivor's PTSD.¹⁴¹

In sum, trafficking survivors who apply for the T-Visa are potentially required to provide unique and specific information from forensic medical evaluations for multiple parts of their application. Forensic evaluators should be careful to provide detailed support for how trauma from trafficking impacts an applicant's day-to-day life, and to highlight specific ongo-

134. Matter of J-A-A-, ID# 3563259, at 9 (AAO June 12, 2019); *see also* Matter of R-B-A-, ID# 4900145 (AAO Oct. 31, 2019); Matter of J-C-G-M-, ID# 910373 (AAO Feb. 28, 2018).

135. Wiebe & Brenes, *supra* note 114, at 11 n.127 ("The AAO does not appear to apply a consistent or transparent method to evaluate the weight of mental health professional statements in T-visa applications. However, we were able to discern some patterns indicating how such statements can be helpful, hurtful, or neutral to an applicant's claim.").

136. *Id.* at 12.

137. *Id.* at 13.

138. *Id.* at 14.

139. Greer & Dyle, *supra* note 106, at 421.

140. Cathy Zimmerman et al., *The Health of Trafficked Women: A Survey of Women Entering Post-Trafficking Services in Europe*, 98 AM. J. PUB. HEALTH 55, 56-57 (2008).

141. Greer & Dyle, *supra* note 106, at 395, 425.

ing medical and therapeutic needs that may not be met if the applicant was removed from the United States.

4. Violence Against Women Act Relief

Those granted relief under the Violence Against Women Act (“VAWA”) comprised 2% of the positive outcomes in the PHR dataset.¹⁴²

The 1990 Amendments to the Marriage Fraud Amendments of 1986 (“the 1990 Amendments”) encompassed the first provisions of immigration law specifically designed to protect immigrants who were survivors of intimate partner violence while facilitating the prosecution and investigation of the perpetrators of these crimes.¹⁴³ The 1990 Amendments provided “immigrant spouses in a bona fide marriage an escape from the beatings, the insults and fear.”¹⁴⁴ In particular, the 1990 Amendments allowed for one who had entered a good faith marriage and then was “battered by or was the subject of extreme cruelty by his or her spouse” to waive joint petition requirements.¹⁴⁵ Later, these protections were expanded under VAWA,¹⁴⁶ which mirrors the language of “extreme cruelty” and allows survivors of abuse to self-petition for permanent residency where an abusive family member withdraws or refuses to file a petition to sponsor a family member for legal status. Under VAWA provisions, this extreme cruelty includes “any act or threatened act of violence. . . which results or threatens to result in physical or mental injury.”¹⁴⁷

When enacting VAWA, legislators recognized that public conceptions of domestic violence were often mired with “myths, misconceptions, and victim blaming attitudes.”¹⁴⁸ Yet there is little federal court review of adjudicators’ decision-making with regards to what types of harms rise to “extreme cruelty.” In most circuits, courts have found that an IJ’s determination that a petitioner was subjected to “extreme cruelty” is discretionary, and thus precluded from judicial review.¹⁴⁹ Circuits that believe these deci-

142. Atkinson et. al., *supra* note 5, at 5 (Table 1); *see also* Appendix A, *infra*.

143. Pub. L. No. 101-649, 104 Stat. 4978 (1990).

144. *Id.*

145. *Id.*

146. Violence Against Women Act (VAWA I), Pub. L. No. 103-322, 108 Stat. 1941, 1941-1942 (1994) (codified as amended in scattered sections of 8 and 42 U.S.C.). Applicants for VAWA self-petitions or cancellation of removal must also reside in the United States, have resided in the United States with the citizen or lawful permanent resident spouse, be a person of good moral character, show that deportation would result in extreme hardship, and had entered into the marriage in good faith. Moreover, immigrant children or adult parents who are the victims of abuse perpetrated by a U.S. citizen or legal permanent resident parent or child, in certain circumstances, are also eligible for this relief. 8 U.S.C. § 1154(a)(1)(A)(iii) (2012); *see also* 8 U.S.C. § 1229b(2)(A) (2012).

147. *Id.*

148. For an expression of the sense of Congress that expert testimony concerning the nature and effect of domestic violence, including descriptions of the experiences of battered women, should be admissible when offered in a state court by a defendant in a criminal case, *see* H.R.Con.Res.89, 102nd Cong. (1991).

149. *Bedoya-Melendez v. U.S. Att’y Gen.*, 680 F.3d 1321, 1327 (11th Cir. 2012); *Johnson v. U.S. Att’y Gen.*, 602 F.3d 508 (3d Cir. 2010); *Stjepanovic v. Filip*, 554 F.3d 673 (7th Cir. 2009); *Wilmore*

sions are precluded from review reinforce that such an assessment is merely a judgment call and not a reviewable finding. Citing congressional intent, the Ninth Circuit noted “it appears quite unlikely that Congress would have intended to commit the determination of what constitutes domestic violence to the sole discretion of immigration judges,”¹⁵⁰ becoming the only jurisdiction to find an extreme cruelty determination to be nondiscretionary legal standard and thus reviewable.¹⁵¹ The Ninth Circuit described “extreme cruelty” as unlike notions of “hardship” and “good moral character,” which are considered discretionary determinations to guide USCIS in its “limitation of a scarce and coveted status to those applicants deemed particularly worthy.”¹⁵² The Ninth Circuit’s desire to simplify “extreme cruelty” determinations to a factual finding (and thus subject to judicial review) is compelling given research that shows the dangerous nature of the inconsistency in this realm, which has been largely unchecked by the prospect of judicial review.¹⁵³

In a case reviewing a VAWA denial, the Ninth Circuit noted that Congress distinguished between “battery” and “extreme cruelty,” reserving the term “extreme cruelty” for something that encompassed behavior beyond battery and included mental or psychological cruelty as well.¹⁵⁴ The Ninth Circuit decided that behaviors that may have not initially appeared violent but were part of a systematic effort to control and manipulate would fall under the ambit of “extreme cruelty.”¹⁵⁵ In *Lopez Birrueta v. Holder*, the Ninth Circuit affirmed that there need not be heightened violence or physical injury, and state law definitions of “injury” were irrelevant given the strong uniformity sought by Congress in this regard.¹⁵⁶

Notably, VAWA also created a unique evidentiary standard, allowing for “any credible evidence.”¹⁵⁷ The 1990 Amendments had adopted a different approach requiring immigrant survivors of intimate partner violence to submit an affidavit from a licensed mental health professional to prove extreme cruelty to qualify for the relevant provisions. This standard was described as “unworkable, insensitive, and contrary to congressional intent.”¹⁵⁸ Recognizing the inherent difficulty in gaining access to a mental health professional with the requisite training to evaluate a domestic vio-

v. Gonzales, 455 F.3d 524 (5th Cir. 2006); Perales–Cumpean v. Gonzales, 429 F.3d 977 (10th Cir. 2005).

150. Hernandez v. Ashcroft, 345 F.3d 824, 835 (9th Cir. 2001).

151. Sarah A. Moore, *Tearing Down the Fence Around Immigration Law: Examining the Lack of Judicial Review and the Impact of the Real Id Act While Calling for A Broader Reading of Questions of Law to Encompass “Extreme Cruelty”*, 82 NOTRE DAME L. REV. 2037, 2051 (2007).

152. *Ashcroft*, 345 F.3d at 835.

153. Moore, *supra* note 151, at 2063.

154. Hernandez v. Ashcroft, 345 F.3d 824, 835 (9th Cir. 2001).

155. *Id.* at 840.

156. Lopez-Birrueta v. Holder, 633 F.3d 1211, 1217–18 (9th Cir. 2011).

157. 8 C.F.R. § 204.2(c)(2)(i) (2007).

158. Orloff & Kaguyutan, *supra* note 124, at 116.

lence survivor, the standard was amended to require the Immigration and Naturalization Service (“INS”) to accept “any credible evidence” in all VAWA cases.¹⁵⁹ These standards were broadened to ensure that stringent evidentiary rules would not be used to block access to VAWA protections.¹⁶⁰ Such evidence could include affidavits, medical records, and protection orders.

Yet, as observed in the U-Visa context, adjudicators have penalized VAWA applicants, many of whom may be uninsured and undocumented, for not having regular access to healthcare by discounting single session pro bono forensic medical evaluations in favor of assessments from physicians and mental health professionals who immigrants had visited regularly.¹⁶¹ With this context, detailed forensic reports that outlined the pattern of abuse, corroborated the applicants’ affidavits, and provided a causal link between the abuse and the suffered harms were valued.¹⁶² Further, AAO adjudicators sometimes looked negatively upon cases where therapy was recommended but not followed up on.¹⁶³

For example, the AAO, in denying VAWA relief, noted that a petitioner had only provided one forensic evaluation based on “one interview of unspecified length,” which was not based on an “established relationship with the petitioner that would reflect the insight and developmental rapport between a petitioner and a mental health professional.”¹⁶⁴ The AAO also noted that the doctor described her report as “preliminary,” and found the absence of an established relationship rendered the doctor’s opinions “speculative and diminishe[d] the value of her evaluation.”¹⁶⁵ Finally, the AAO commented that the report’s description of the timing and circumstances of each episode of extreme cruelty was not “sufficient to conclude that the incidents actually occurred,” and was “insufficiently detailed to ascertain the credibility of the petitioner’s statement regarding his wife’s actions.”¹⁶⁶ In another example, the AAO also noted how much of the evaluation “reiterates much of the petitioner’s testimony which led to a diagnosis of a major depressive disorder but did not note any specific type of recommended treatment.”¹⁶⁷

159. *Id.*

160. See generally Leslye E. Orloff et. al., *Mandatory U-Visa Certification Unnecessarily Undermines the Purpose of the Violence Against Women Act’s Immigration Protections and Its “Any Credible Evidence” Rules—A Call for Consistency*, 11 *GEO. J. GENDER & L.* 619, 621 (2010).

161. Wiebe & Brenes, *supra* note 114, at 17.

162. *Id.* at 19.

163. *Id.* at 25.

164. See [Redacted], File No. WAC-[Redacted], at 5 (AAO 2011), https://www.uscis.gov/sites/default/files/err/B9%20-%20Battered%20Spouse%20or%20Child/Decisions_Issued_in_2011/May052011_02B9204.pdf [<https://perma.cc/K8AT-CAXN>].

165. *Id.*

166. *Id.*

167. See [Redacted], File No. EAC 04 037 51545, at 6 (AAO 2009), https://www.uscis.gov/sites/default/files/err/B9%20-%20Battered%20Spouse%20or%20Child/Decisions_Issued_in_2009/Apr212009_08B9204.pdf [<https://perma.cc/C4ED-LAL4>].

There is no requirement that a forensic evaluation, much less proof of long-term and consistent therapy and treatment, be provided to prove one's survived abuse. Yet, in some cases adjudicators favored forensic evaluations reflecting a consistent and long-term therapeutic relationship,¹⁶⁸ one that many VAWA applicants are unable to access due to their immigration status and a host of other cultural, financial, and access obstacles.¹⁶⁹ In their national survey following U-Visa and VAWA applicants from filing to granting of permanent residence, Professor Orloff et al., found that VAWA applicants increased their receipt of healthcare exponentially (in some cases up to 51%) once they were granted permanent residence in the United States.¹⁷⁰ This data refutes the tendency of the AAO to equate the lack of therapeutic health records with lack of suffering, and recognizes the difficulty that survivors of violence have in securing health services before they have the security and benefits afforded with permanent immigration status.¹⁷¹

5. *Special Immigrant Juvenile Status* ("SIJS")

Those granted SIJS comprised about 0.6% of the positive outcomes in the PHR-CUNY Study.¹⁷²

Originally enacted to protect undocumented immigrants in long-term foster care, SIJS provides a pathway to permanent residence and citizenship to undocumented youth who have been abused, neglected, or abandoned by one or both parents.¹⁷³ An SIJS assessment includes fact finding (from a juvenile court) about whether parental reunification is impossible due to abuse, neglect, or abandonment and whether it is in the "best interests" of the child in question to not be returned to their home country.¹⁷⁴ A petitioner must then submit this state court order and other evidentiary materials (which may include forensic medical evaluations) with Form I-360 (Petition for Amerasian, Widow(er), or Special Immigrant) to USCIS for

168. Wiebe & Brenes, *supra* note 114, at 17.

169. Leslye Orloff et al., *Transforming Lives: How the VAWA Self-petition and U-Visa Change the Lives of Survivors and their Children After Employment Authorization and Legal Immigration Status*, The National Immigrant Women's Advocacy Project, The American University Washington College of Law (2021).

170. *Id.* at 18.

171. *Id.* at 95.

172. Atkinson, *supra* note 5, at 5 (Table 1); *see also* Appendix A, *infra*.

173. I.N.A. § 101 (a)(27)(j); 8 C.F.R. § 204.11 (2007); Shannon Aimée Daugherty, *Special Immigrant Juvenile Status: The Need to Expand Relief*, 80 BROOK. L. REV. 1087, 1094 (2015). Premised on coordination with state-level juvenile courts, for a child to gain SIJS she must be declared a dependent on the juvenile court system. From there, the state-level adjudicator must make a factual finding that reunification with one or both parents is impossible due to abuse, neglect, and abandonment and that it would not be in the "best interests" of the child to return to the country of their nationality or last habitual residence of their parents. After these state-level findings are issued, known as the Special Findings Order, the child proceeds and applies for SIJS before USCIS for formal SIJS classification and eventually, a green card based on this classification. *Id.*

174. *See* 8 CFR 204.11(d)(2)(i); 8 CFR § 204.11(d)(2)(iii); Matter of D-Y-S-C-, Adopted Decision 2019-0, at 2 (AAO 2019) (explaining that petitioners bear the burden of establishing the state law applied in the reunification, dependency or custody, and best-interest determinations).

adjudication of SIJS. Though USCIS maintains authority to review underlying state court orders to conclude the request for SIJS is bona fide, they should not reweigh evidence that juvenile courts already considered when granting the predicate order.¹⁷⁵

As in the asylum context, SIJS decisions vary immensely across jurisdictions, a divergence that derails congressional intent to protect at-risk undocumented children.¹⁷⁶ Professor Laila Hlass's comprehensive study of SIJS cases nationwide additionally found stark differences in the number of SIJS applications filed across jurisdictions, with some states having few to no SIJS applications.¹⁷⁷ In states with SIJS screening programs, courts had familiarity adjudicating SIJS orders, or children had greater access to counsel programs, there were higher application rates.¹⁷⁸ Other scholars have observed judicial resistance to protecting immigrant children under state dependency laws, effectively denying them the ability to avail SIJS protections.¹⁷⁹ These disparities, whether they touch on access to state courts in the first instance or the adjudication of dependency orders by state courts, are compounded by vague and varying standards for what accounts for "best interest" and "abuse, neglect and abandonment."

Only about half of the states have laws that explicitly list what factors should be considered in a "best interest" analysis.¹⁸⁰ Nine of these states include the "mental and physical health needs" of the child and parent in

175. "Under the Saravia Settlement Agreement, USCIS does not withhold consent based in whole or in part on the fact that the state court did not consider or sufficiently consider evidence of the petitioner's gang affiliation when deciding whether to issue a predicate order or in making its determination that it was not in the best interest of the child to return to his or her home country. USCIS does not use its consent authority to reweigh the evidence that the juvenile court considered when it issued the predicate order." *Vol. 6 Part. 2(J)*, U.S. CITIZENSHIP & IMMIGR. SERVS., <https://www.uscis.gov/policy-manual/volume-6-part-j-chapter-2> [<https://perma.cc/6VRE-SWYT>].

176. Michelle Anne Paznokas, *More than One Achilles' Heel: Exploring the Weaknesses of SIJS's Protection of Abused, Neglected, and Abandoned Immigrant Youth*, 9 DREXEL L. REV. 421, 445–46 (2017).

177. Laila L. Hlass, *States and Status: A Study of Geographical Disparities for Immigrant Youth*, 46 COLUM. HUM. RTS. L. REV. 266, 284 (2014).

178. *Id.* at 302–23.

179. Richard F. Storrow, *Unaccompanied Minors at the U.S.-Mexico Border: The Shifting Sands of Special Immigrant Juvenile Status*, 33 GEO. IMMIGR. 1, 2 (2018) ("Some state courts have cast a suspicious eye on children who apply for SIJS predicate orders, interpreting the language of the statute in ways that contort its plain language. These courts have refused to make predicate orders, appearing to shun their roles as finders of facts regarding the welfare of immigrant children subject to their jurisdiction. They have simultaneously embraced an active but unauthorized gatekeeping role in our immigration system by questioning the motives of the minors who appear before them."); *see generally* Bernard Perlmutter, *Judges Behaving Badly. . . Clinics Fighting Back: The Struggle for Special Immigrant Juveniles in State Dependency Courts in the Age of Trump*, 82 ALB. L. REV. 1553 (2018).

180. "Approximately 22 States and the District of Columbia list in their statutes specific factors for courts to consider in making determinations regarding the best interests of the child, including Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Nevada, North Dakota, Ohio, Oregon, South Dakota, Tennessee, Texas, Vermont, Virginia, and Wisconsin." *Determining the Best Interest of the Child*, Child Welfare Info. Gateway 2 (2012), https://www.childwelfare.gov/systemwide/laws_policies/statutes/best_interest.pdf [<https://perma.cc/K7GT-JLF3>].

making this assessment.¹⁸¹ Further, states have varying interpretations of what accounts for “abuse, neglect and abandonment.”¹⁸² In her arguments for the expansion of SIJS, Professor Shannon Aimee Daugherty argues that SIJS falls short because it is granted on “arbitrary grounds not indicative of a child’s vulnerability.”¹⁸³

The same questions about discretion and bias flagged above reverberate here: how does an adjudicator weigh various mental and physical health needs in assessing the “best interests” standard? What type of evidence should an SIJS-petitioner provide if they do not have access to a forensic medical evaluator? Is lack of forensic evidence used against the petitioner in making these determinations? Here, too, an outsized focus on direct physical harm to the child might cause adjudicators to disregard serious psychological impacts of harm in determining what is in a child’s best interest or what types of harms rise to the level of abuse and neglect.

B. Forensic Medical Evaluations to Corroborate and Support Credibility

Recognizing the emergent situations that those who are fleeing trauma and surviving violence face, and the individual limitations on gathering evidence from a country one has fled, the United Nations High Commissioner for Refugees guided signatories to enact a more lenient standard when adjudicating asylum claims.¹⁸⁴ As a foundational matter in the asylum, withholding, and CAT context, the credible testimony of an immigrant is, in and of itself, sufficient for a grant of relief.¹⁸⁵ Given the noted challenges in producing corroborating evidence, where the adjudicator finds the immigrant’s testimony credible, there should be no further requirement for external corroborating evidence. However, because the burden of proof remains on the immigrant, the BIA has held that “where it is reasonable to expect corroborating evidence for certain alleged facts pertaining to the specifics of the applicant’s claim, such evidence should be provided . . . [or] an explanation should be given as to why such information was not

181. *Id.*

182. See generally Gregory Catangay, *Abandoning the Status Quo: Towards Uniform Application of Special Immigrant Juvenile Status*, 20 U.C. DAVIS J. JUV. L. & POL’Y 39, 49–62 (2016); Brad Reynolds, *Reforming and Clarifying Special Immigrant Juvenile Status*, 47 J. LEGIS. 101, 105–109 (2021).

183. Daugherty, *supra* note 173, at 1104–45. Note Daugherty is specifically describing ways that children living in homes with domestic violence are excluded from SIJ eligibility given varying state-level interpretations of the “one or both parent” standard and calls for a broader statutory allowance for which children are deemed dependent on state courts. *Id.*

184. Office of the U.N. High Comm’r for Refugees (“UNHCR”), *Handbook of Procedures and Criteria for Determining Refugee Status Under the 1951 Convention and the 1967 Protocol Relating to the Status of Refugees*, at 43, U.N. Doc. HCR/1P/4/ENG/REV. 4 (Jan. 1992) [hereinafter UNHCR Handbook], <https://www.unhcr.org/4d93528a9.pdf> [<https://perma.cc/4EAD-7WSP>] (“In most cases a person fleeing from persecution will have arrived with the barest necessities and very frequently even without personal documents.”).

185. 8 C.F.R. § 208.16(c)(2). In the context of claims pursuant to the Conventions Against Torture, “[t]he testimony of the applicant, if credible, may be sufficient to sustain the burden of proof without corroboration.” *Id.*

presented.”¹⁸⁶ Congress explicitly adopted these standards in enacting the REAL ID Act,¹⁸⁷ which sets forth that credibility determinations may be based on: demeanor, candor or responsiveness of the applicant, the inherent plausibility of the account, internal consistencies within written statements, and the consistency between written statements and oral testimonies.¹⁸⁸ These factors, along with a list of other factors, are all measured against other evidence of record, and are to be considered in a “the totality of circumstance” analysis,¹⁸⁹ an “extraordinarily open-ended” standard.¹⁹⁰

With this broad array of factors, the REAL ID Act 2005 expanded the power of IJs to make negative credibility findings without cultural context, trauma-informed analysis, and medical and psychological considerations.¹⁹¹ At the outset, forensic evaluations are crucial in educating adjudicators about how trauma impacts an applicant’s memory, demeanor, responsiveness, and cognition. This education is essential as credibility determinations are often rife with bias and subjectivity, discussed further in Section V.E., *infra*.

Dangerously, negative credibility determinations are largely unchecked due to limited judicial review by the BIA, which grants great deference to lower court findings.¹⁹² As a result, adjudicators enforce a heightened evidentiary burden of corroboration on applicants that ignore the limitations imposed by the Refugee Conventions by requiring burdensome supporting documentation from those fleeing persecution to corroborate their claims and to document the impacts of past trauma on demeanor and memory. Further, adjudicators give little credence to the retraumatizing effect of the immigration system itself, where individuals are required to share accounts of the worst moments of their lives at various stages (e.g., at the border, in detention facilities, and before adjudicators) with little support before adversarial parties, at the risk of family separation, detention, and deportation.

Where an adjudicator finds the medical evidence reliable and compelling, it may play a powerful role in supporting a credibility determination.¹⁹³ Yet, an adjudicator may also draw negative conclusions where there

186. In re S-M-J-, 21 I. & N. Dec. 722, 725 (BIA 1997).

187. See H.R. Conf. Rep. No. 109-72, at 166 (2005) (“Congress anticipates that the standards in Matter of S-M-J-, the standards in including the BIA’s conclusions on situations where corroborating evidence is or is not required, will guide the BIA and the courts in interpreting this clause.”).

188. INA §§ 208(b)(1)(B)(iii), 241(b)(3)(C).

189. Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, Pub. L. No. 109-13, § 1229(a), 119 Stat. 303, 305 (2005).

190. D. Bruce Janzen, Jr., *First Impressions and Last Resorts: The Plenary Power Doctrine, the Convention Against Torture, and Credibility Determinations in Removal Proceedings*, 67 EMORY L.J. 1235, 1244 (2018).

191. Katherine E. Melloy, *Telling Truths: How the REAL ID Act’s Credibility Provisions Affect Women Asylum Seekers*, 92 IOWA L. REV. 637, 670 (2007).

192. *Id.*

193. For example, the Ninth Circuit has found that an IJ sufficiently considered medical and psychological reports that corroborated an applicant’s claims when the IJ acknowledged that the applicant “‘presented testimonial and documentary evidence in support of his claims for relief’ and recognized that ‘there [was] enough evidence within the record to suggest past persecution and/or a well-founded

is little or no supporting documentary evidence, even where the immigrant themselves appears credible.¹⁹⁴ In other cases, an adjudicator may place out-sized weight on forensic medical evaluators to provide certainty as to the cause or extent of past traumas. For example, an immigration judge denied CAT relief to a wrestler from India on credibility grounds because the medical evidence did not speak with certainty as to whether his wrestling profession or the torture he survived led to weakened veins in both of his legs.¹⁹⁵ Upon review, the Sixth Circuit found that findings regarding the reliability of the medical records were not enough to dispose of the petitioner's claim, as "allegations of torture are not automatically incredible simply for failure to produce corroborating documentary evidence" and remanded the CAT claim for further fact finding.¹⁹⁶ This scenario elucidates the ways in which adjudicators need to understand the limits of forensic medical evaluations in affirming a causal linkage between the documented injuries and illnesses to instances of torture and persecution. As described in the U-Visa, T-Visa, and VAWA contexts above, forensic medical evaluations that include "chronological, clinical or substantive details" that observe if and how documented injuries are proximate and causally related to the harms attested are more persuasive.¹⁹⁷

In similar cases, the Sixth Circuit has admonished that the "[p]etitioner's failure to provide medical records related to the beatings [during her detention] does not constitute a reasonable basis for a finding of incredibility. . . . Not all beatings leave physical marks, and the inability of lay persons to identify such evidence alone is not sufficient to determine that the alleged acts never occurred."¹⁹⁸ In contrast, the Second Circuit denied CAT relief when an immigrant "failed to present reliable corroboration of medical treatment" where "the doctor's letter was prepared four years after the alleged treatment and did not indicate that it was based on contemporaneous medical records."¹⁹⁹ The underlying IJ in this case had also relied on the absence of notarization or copy of the doctor's identification to further dis-

fear of future persecution if parts of [Oshodi's] testimony [were] to be accepted." Oshodi v. Holder, 671 F.3d 1002, 1009 (9th Cir. 2012).

194. See 8 U.S.C. § 1158(b)(1)(B)(ii) ("Where the trier of fact determines that the applicant should provide evidence that corroborates otherwise credible testimony, such evidence must be provided unless the applicant does not have the evidence and cannot reasonably obtain the evidence."). For example, the Eighth Circuit found that a petitioner's failure to provide corroborating evidence, including "medical records to corroborate his testimony concerning his two week treatment in Lagos after the 1997 attack on his home," supported the IJ and Board's adverse credibility finding. Osonowo v. Mukasey, 521 F.3d 922, 925–28 (8th Cir. 2008).

195. Singh v. Ashcroft, 398 F.3d 396, 406 (6th Cir 2005). ("[I]n the medical history, there is no mention of what caused this condition [i.e., venous insufficiency of both lower extremities] . . . e.g., torture, or activities of respondent [who was a wrestler], or family history.").

196. *Id.* at 406.

197. Wiebe & Brenes, *supra* note 114, at 31 n.127.

198. Mapouya v. Gonzales, 487 F.3d 396, 415 (6th Cir. 2007).

199. Singh v. Barr, 828 F. App'x 43, 48 (2d Cir. 2020).

count the medical evidence.²⁰⁰ Here the Second Circuit affirmed the denial, arguing that they afford IJs “considerable flexibility in determining the authenticity of . . . documents from the totality of evidence.”²⁰¹

Since the REAL ID’s passage, circuits have varied on whether the immigrant should receive notice for the need for corroboration, and an opportunity to provide such evidence, or explain its absence, if it is requested. The BIA has reasoned that, where the adjudicator determines specific corroborative evidence should have been submitted, the immigrant should be given an opportunity to explain why they could not reasonably obtain such evidence before it is held against them.²⁰² Some circuits have adopted this approach, while others,²⁰³ as outlined below, have gone further, holding that under §1158(b)(1)(B)(ii), an applicant should not only have the opportunity to explain the absence of corroborative evidence, but also be given notice about the type of corroboration that should be expected.²⁰⁴ All circuits agree that an IJ may not rule against a petitioner for failure to corroborate evidence without first giving the individual the opportunity to explain the unavailability of evidence.²⁰⁵

The Third²⁰⁶ and Ninth Circuits²⁰⁷ have directed IJs to provide notice to applicants who need to provide corroborating evidence, and give them the

200. *Id.*

201. *Id.* at 48. The *Singh* court goes on to comment that the immigrant’s “argument that the IJ could have called the doctor to obtain testimony is unavailing” because the immigrant “had the burden to prove eligibility for relief and present evidence “without prompting from the IJ.” *Id.*

202. Matter of L-A-C-, 26 I&N Dec. 516, 519 (BIA 2015).

203. See *Uzodinma v. Barr*, 951 F.3d 960, 966 (8th Cir. 2020); *Georgieva v. Holder*, 751 F.3d 514, 519 (7th Cir. 2014) (“[I]f the immigration judge finds the applicant incredible due to inconsistencies, then the applicant must explain the discrepancies and provide credible, extrinsic evidence in corroboration.”).

204. See, e.g., *Chukwu v. Attorney Gen. of U.S.*, 484 F.3d 185, 192 (3d Cir. 2007); *Ren v. Holder*, 648 F.3d 1079, 1091 (9th Cir. 2011) (“An applicant must be given notice of the corroboration required, and an opportunity to either provide that corroboration or explain why he cannot do so.”). *But see* *Liu v. Holder*, 575 F.3d 193, 198 (2d Cir. 2009) (“While we have sometimes remanded a case if the IJ failed to explain his reliance on a lack of corroborating evidence, the alien bears the ultimate burden of introducing such evidence without prompting from the IJ.”).

205. *Guzman-Vazquez v. Barr*, 959 F.3d 253, 263 (6th Cir. 2020).

206. The Third Circuit held that “the REAL ID Act does not change our rules regarding the IJ’s duty to develop the applicant’s testimony, and in particular, to develop it in accord with the *Abdulai* steps.” *Chukwu*, 484 F.3d at 192 (3d Cir. 2007) (holding that “the failure to produce corroborating evidence may undermine an applicant’s case where (1) the IJ identifies facts for which it is reasonable to expect the applicant to produce corroboration, (2) the applicant fails to corroborate, and (3) the applicant fails to adequately explain that failure”). *Id.* at 191–92.

207. The Ninth Circuit has viewed the REAL ID Act as creating a process that is required to find that otherwise credible applicants did not meet their burden of proof. See *Ren*, 648 F.3d at 1090 (9th Cir. 2011) (“A plain reading of the statute’s text makes clear that an IJ must provide an applicant with notice and an opportunity to either produce the evidence or explain why it is unavailable before ruling that the applicant has failed in his obligation to provide corroborative evidence and therefore failed to meet his burden of proof.”). This is because pre-REAL ID, the Ninth had the “deemed true” rule. See *Ladha v. INS*, 215 F.3d 889, 900 (9th Cir. 2000); *Lopez-Reyes v. INS*, 79 F.3d 908, 912 (9th Cir. 1996) (“Supplying corroborating affidavits, however, has never been required to establish an applicant’s credibility.”). See also *Lizhi Qiu v. Barr*, 944 F.3d 837, 846 (9th Cir. 2019) (“The agency faulted Petitioner for failing to call her husband as a witness and for failing to authenticate the Proof of Diagno-

opportunity to cure the deficiency or provide an explanation for why such evidence is not available.²⁰⁸ For example, in *Min Liu v. Holder*, the court held that substantial proof supported the agency's adverse credibility finding when the petitioner received notice and an opportunity to explain, yet failed to provide easily available medical corroborative evidence required by the IJ.²⁰⁹ Where individuals are unable to secure medical records due to a host of previously discussed access-related barriers, an alleviating solution in a "notice" jurisdiction may be to provide court-funded independent forensic medical evaluators in cases where the adjudicator feels one is necessary. In this scenario, it would be crucial to allow immigrants to choose independent evaluators specially trained to provide evaluations in accordance with the Istanbul Protocols.

In contrast, the Second, Fifth, Sixth, Seventh, and Eighth Circuits have adopted the view that such notice is not required because applicants are put on notice by statute about the potential need for corroborating evidence if their testimony is not found to be specific, credible, and persuasive.²¹⁰

For example, the Second Circuit has held that the noncitizen "bears the ultimate burden of introducing such evidence without prompting from the IJ."²¹¹ Similarly, the Sixth Circuit has held that noncitizens in removal proceedings are "not entitled to notice that the IJ would require him to corroborate his claims with other evidence."²¹² Applying this framing in *Peraj v. Holder*, the IJ found that the petitioner did not meet his burden of proof because he provided "no medical evidence corroborating his testi-

sis. Because the reasons for finding Petitioner not credible are not supported by substantial evidence, she was entitled to notice and an opportunity to produce corroborating evidence or explain why it was unavailable.").

208. *See* *Chukwu v. Att'y. Gen. of U.S.*, 484 F.3d 185 (3d Cir. 2007); *Ren v. Holder*, 648 F.3d 1079 (9th Cir. 2011).

209. *Min Liu v. Holder*, 469 F. App'x 553, 554 (9th Cir. 2012) ("I would expect medical records to be available and respondent has not explained why those records have not been provided to corroborate the timing and nature of the medical treatment that she received because I think that that would corroborate her claims regarding that particular detention, so I would expect either that she produce the medical records or that she explain why they're not available.").

210. *See* *Wei Sun v. Sessions*, 883 F.3d 23 (2d Cir. 2018); *Gaye v. Lynch*, 788 F.3d 519, 530 (6th Cir. 2015) (noting "that federal law does not entitle [an individual in removal proceedings] to notice from the Immigration Court as to what sort of evidence the [individual] must produce to carry his burden."); *Udensi v. Garland*, 850 F. App'x 882, 884 (5th Cir. 2021) ("Prior to disposing of an alien's claim, the IJ is not required to provide 'advance notice of the specific corroborating evidence necessary to meet the applicant's burden of proof and an automatic continuance for the applicant to obtain such evidence.'"); *Rapheal v. Mukasey*, 533 F.3d 521 (7th Cir. 2008). The Eighth Circuit also does not require IJs to provide otherwise credible applicants with notice before requiring corroborative evidence, holding that "replacing previous standards, the REAL ID Act placed the burden on the petitioner to corroborate otherwise credible testimony." *Uzodinma v. Barr*, 951 F.3d 960, 967 (8th Cir. 2020), cert. denied sub nom. *See also id.* at 966.

211. *Liu v. Holder*, 575 F.3d 193, 198 (2d Cir. 2009). The Seventh Circuit takes a similar approach as the Second and Sixth Circuit to the notice requirement. *Rapheal*, 533 F.3d at 530 (7th Cir. 2008) (internal citations omitted).

212. *Guzman-Vazquez v. Barr*, 959 F.3d 253, 260 (6th Cir. 2020). However, in instances where otherwise credible testimony requires corroboration, ". . . an IJ may not require corroborative evidence without giving the applicant an opportunity to explain its absence." *Id.* at 261.

mony that he was beaten by the police.”²¹³ Without records from the event, the court’s desire for further corroboration may have been fulfilled had the petitioner been able to secure a forensic medical evaluation in the United States that corroborated that he was beaten by the police in the past. In a “no notice” jurisdiction, the burden to preemptively gather such costly and hard-to-access evidence falls most heavily on those who are unrepresented.

The Seventh Circuit takes a similar approach:

{T}he REAL ID Act clearly states that corroborative evidence may be required, placing immigrants on notice of the consequences for failing to provide corroborative evidence. . . . {T}o hold that a petitioner must receive additional notice from the IJ and then an additional opportunity to provide corroborative evidence before an adverse ruling, would necessitate two hearings—the first to decide whether such corroborating evidence is required and then another hearing after a recess to allow the alien more time to collect such evidence. This would add to the already overburdened resources of the DHS, and such an approach would seem imprudent where the law clearly notifies aliens of the importance of corroborative evidence.²¹⁴

Ironically, then, to alleviate an “overburdened DHS,” “no notice jurisdictions” place the weight of pursuing forensic medical evaluations on already overburdened asylum seekers who may have already fulfilled their statutory requirements by providing otherwise credible testimony. While in other contexts the AAO has discounted the submission of single session evaluation offered in support of litigation, those in “no-notice” jurisdictions may choose to gather any additional evidence to bolster their claim in the event their judge determines a need for further corroborative evidence. Yet in one case, even where such documentary evidence was provided, the IJ still discounted the medical evidence as submitted “specifically in order to bolster [the] asylum claim.”²¹⁵ However, on appeal, the court questioned why the IJ penalized the immigrant for complying with “his burden under the REAL ID Act to provide corroborating evidence,” finding that the IJ’s refusal to credit a petitioner’s ample documentary evidence, including medical documentation, was arbitrary and capricious.²¹⁶ In another matter, the Seventh Circuit denied a petition for review where the noncitizen failed to

213. *Peraj v. Holder*, 407 F. App’x 540, 541 (2d Cir. 2011) (citing *Chuilu Liu v. Holder*, 575 F.3d 193, 197 (2d Cir. 2009)).

214. *Rapheal*, 533 F.3d at 530 (7th Cir. 2008) (internal citations omitted).

215. *Cojocari v. Sessions*, 863 F.3d 616, 627 (7th Cir. 2017).

216. *Id.* Similarly, the court found that an IJ improperly discredited an applicant when the IJ found the corroborating evidence she offered “neither persuasive nor sufficient to meet her burden of proof.” *Hongting Liu v. Lynch*, 788 F.3d 737, 740–42 (7th Cir. 2015) (“And although she submitted a medical report corroborating that she had been beaten and suffered a head injury, the IJ discounted it because it did not refer to the detention, without explaining why a medical record reasonably should specify the role played by the police in causing the injury.”).

provide corroborative evidence, including proof that he sought medical treatment following an attack central to his claim after an adverse credibility finding by the IJ.²¹⁷

The result? Asylum seekers are subject to varying corroboration requirements in different jurisdictions and a growing norm to seek out external documentary evidence, including forensic medical evaluations, which are hard to obtain, even where their credible testimony should have been sufficient on its own. This maze of cases demonstrates that forensic medical evaluations and other medical documentation have constructively become a required norm in some circuits. Even where immigrants are able to secure such evaluations against all odds, these cases demonstrate that their veracity and reliability can still be questioned by some IJs who may wrongly perceive such evidence to be fabricated or self-serving.

III. THE FORENSIC MEDICAL EVALUATION PROCESS: LIMITED AVAILABLE GUIDANCE ON CREATION AND USE

As described in the overview above, courts look toward forensic medical evaluations in myriad ways to support basic eligibility, credibility assessments, and discretionary decision-making. Though the PHR-CUNY Study shows that generally such evaluations led to excellent outcomes, USCIS and EOIR case examples discussed in the preceding Parts outline how, in some instances, adjudicators devalued such evaluations that lacked specifics about causality of the harm assessed or were not created contemporaneously to the described traumatic events. In other situations, adjudicators decried that such evaluations were “created for the purpose litigation.”²¹⁸ These case observations imply that some adjudicators may be expecting more from forensic medical evaluators than they are able to provide, whilst also questioning the legitimacy of the evaluations themselves, showing a lack of consideration about the careful and specific methods that underlie such evaluations.

International guidance and medical school asylum training programs provide specific guidance for evaluators to ensure evaluations are prepared with integrity and consistency. There are over twenty annual trainings around the United States for medical professionals interested in conducting forensic medical evaluations, and a myriad of medical school asylum clin-

217. *Singh v. Wilkinson*, 843 F. App'x 783, 785 (C.A.7, 2021) (“Because she found Singh not credible, the IJ explained that the REAL ID Act, see 8 U.S.C. § 1229a(c)(4)(B), which governs this case, required him to corroborate the details of his account, and he failed to do so. Singh provided no evidence, the IJ added, to corroborate that he sought medical treatment, was mistreated on account of his political activity, or received threatening phone calls.”).

218. *Wiebe & Brenes*, *supra* note 114, at 25.

ics.²¹⁹ Forensic medical evaluations are now included in the curricula of numerous medical schools, social work schools, and residency programs.²²⁰

The 1999 Istanbul Protocol (“Protocol”) provided the first set of international standards for the clinical documentation of torture and its consequences.²²¹ Since then, some nongovernmental organizations and scholars have published training and reference materials expanding these standards.²²² Created to standardize the documentation and investigation of torture and ill-treatment, the Protocol is of central importance in guiding medical professionals’ approach to forensic medical evaluations for immigrants.²²³ The aim of the Protocol is to facilitate consistent and effective documentation of torture to encourage perpetrator accountability and justice, and for use in asylum evaluations.²²⁴ In general, the guidelines recommend that a medical evaluator: “(1) describ[e] the events of persecution which led to the asylum seeker’s physical findings; (2) documen[t] symptoms that could be related to ill treatment; (3) commen[t] on the degree of consistency between the applicant’s history of alleged trauma and physical findings; (4) explai[n] possible medical causes of discrepant history; and (5) provid[e] testimony in writing, and sometimes also in court.”²²⁵

The Protocol reminds doctors that their role is to collect accurate and objective evidence for medical conclusions and equip them with tools to “objectively determine” whether a person’s claim of torture can be “medically verified.”²²⁶ Importantly, the absence of physical or psychological medical evidence should not be construed as an indication that the torture did not occur.²²⁷ The Protocol emphasizes that “there is no causal link between the finding of ‘not consistent’ and a possible fabrication of evi-

219. Sharp et al., *supra* note 51, at 309.

220. See, e.g., PHR Partner Medical School Clinics (“In 2010, PHR created the first student-run asylum clinic at a U.S. medical school in partnership with the Weill Cornell Center for Human Rights (WCCHR). Since then, the WCCHR/PHR model has expanded to many other medical schools. In addition to providing forensic evaluations for asylum seekers in their respective communities, clinics serve to educate the medical community and general public about asylum issues by conducting research, publishing papers, and presenting at conferences.”). <https://phr.org/issues/asylum-and-persecution/student-asylum-clinics/> [<https://perma.cc/4DRM-4697>]. In 2019 an asylum medicine textbook was also published. See *Asylum Medicine: A Clinician’s Guide*; <https://link.springer.com/book/10.1007/978-3-030-81580-6> / [<https://perma.cc/W69D-XNRJ>].

221. Istanbul Protocol, *supra* note 38.

222. Ferdowsian et al., *supra* note 11, at 216 (explaining that published standards in this field “generally reflect instruction provided by organizations such as Physicians for Human Rights and HealthRight International . . . as well as the 1999 Istanbul Protocol”).

223. Istanbul Protocol, *supra* note 38, at 1.

224. *Id.*

225. Katherine C. McKenzie et al., *Asylum Seekers in a Time of Record Forced Global Displacement: The Role of Physicians*, 34 J. GEN. INTERNAL MED. 137, 140 (2019); see also Istanbul Protocol, *supra* note 38.

226. Brita Sydhoff, *Introduction to International Rehabilitation Council for Torture Victims, Shedding Light on a Dark Practice: Using the Istanbul Protocol to Document Torture* 8 (2009). It also provides legal professionals with guidelines on how to present and consider this forensic evidence in torture-related proceedings.

227. Michael Peel, *Medical Doctors: The Key to Prevent Immunity*, in Sydhoff, *supra* note 226, at 15.

dence.”²²⁸ Forensic evaluators are also guided to expressly outline the potential medical causes of impaired or inconsistent memory.²²⁹ Yet, as discussed in Part II, some adjudicators see the absence of medical evidence as an indication that torture, and other harms assessed for immigration eligibility, did not occur, or were not sufficiently severe.

Instead, physicians are directed to focus on a five-point scale for diagnostic probability or consistency, in which symptoms can be (1) not consistent, (2) consistent with, (3) highly consistent, (4) typical of, or (5) diagnostic of the claimed means of torture.²³⁰ In using this standardized scale, the medical evaluator should not ascertain whether torture actually occurred, but should instead focus solely on offering the range of consistency between the person’s account of torture and the evaluator’s own medical findings. Evaluations must include this discussion of the consistency of the findings with the alleged history of torture or persecution.²³¹ If an attorney asks whether scars or symptoms are a “result” of torture or mistreatment, or could have been produced by other causes, the physician should reiterate her medical conclusions about the degree of consistency and concede that she “cannot say with certainty that the asylum seeker’s account is true.”²³² As described above, some adjudicators wrongly use this uncertainty to undermine the value of the forensic medical evaluation and, despite international guidance to the contrary, expect medical evaluators to confirm a causal link between past harms and current medical conditions.

Though the Protocol is the gold standard forensic medical evaluators assessing torture,²³³ the Protocol is absent from training documents for asylum officers or new IJs and the Protocol is only quoted a handful of times²³⁴ in judicial opinions assessing harm and persecution.²³⁵ Further, despite the

228. *Id.*

229. McKenzie, *supra* note 225, at 140.

230. Peel, *supra* note 227, at 16.

231. McKenzie, *supra* note 225, at 140.

232. *Id.* at 141.

233. Scharlette Holdman et al., *The Role of Culture in Guantanamo’s Capital Cases*, 42 HOFSTRA L. REV. 935, 959 (2012).

234. The Protocol is completely absent from two U.S. government sources: sixty-one of the USCIS’ lesson plans for asylum officers available through the American Immigration Lawyers Association, and asylum-related training materials for new IJs. See generally *Asylum Lesson Plans*, AMERICAN IMMIGRATION LAWYERS ASSOCIATION, AILA Doc. No. 19091604 (Dec. 16, 2019), <https://www.aila.org/infonet/asylum-lesson-plans/> [<https://perma.cc/83SQ-UZXB>]. None of these sources referred to the Protocol or its full title. *Id.* For example, reference to the Protocol is notably absent from a list of international guidance sources on assessing children’s asylum claims, a lesson on credible fear of persecution and torture determinations, and a course on interviewing survivors of torture and other severe trauma. *Id.*

235. In one instance, the Third Circuit found that the BIA had accepted the adverse credibility ruling of the IJ “without question,” even though the judge’s conclusion about the petitioner’s testimony was based in part on conflicts between her testimony at the hearing and statements made in her asylum affidavit and interview. *Zubeda v. Ashcroft*, 333 F.3d 463, 476 (3d Cir. 2003). The court cautioned against placing too much weight on these inconsistencies because of the “numerous factors” that could explain this inconsistency, such as language difficulties and traumatic memories. *Id.* Specifically, the court reasoned that this is “particularly true when we consider that such an alien may have tried to suppress the very memories and details that have suddenly become so important to establishing

universal framework the Protocols provide to ensure the creation of meticulous, reliable, and objective documentation of torture and ill-treatment, it may still be cast away by IJs and other adjudicators. In assessing whether to admit expert witness testimony, IJs should consider whether the offered expert evidence is relevant and reliable.²³⁶ If expert evidence is admitted, IJs maintain the discretion as to how much or how little weight to afford such evaluations.²³⁷ The exclusion of proffered evidence may result in a due process violation.²³⁸ A sampling of judicial opinions reviewing attempts by IJs to limit or exclude forensic medical evidence displays how IJs may misunderstand the purpose of such evaluations or expect forensic evaluations to relay information outside of the parameters set out by the Istanbul Protocol.

Some cases display how IJs may be unfamiliar with how a forensic evaluation that comports to the rigorous process and high ethical standards the Protocol sets out for documenting harms can enhance fact-finding and credibility assessments.²³⁹ For example, the Third Circuit found that the BIA abused its discretion in denying a motion to reopen for further consideration of a forensic psychological evaluation, claiming it was repetitive of prior medical reports.²⁴⁰ The appellate court noted that unlike the four pages of medical records previously submitted by the family physician (offering minimal information about credibility and consistency), the psychological report was completed by a “clinical psychologist who has also received special training in the detection and documentation of torture” and contained multiple pages of “‘Psychological Assessment’ including a diagnosis of Post-Traumatic Stress Disorder and Major Depressive Disor-

his/her claim.” *Id.* at 476–77. This point is supported by a citation to scholarship regarding common psychological responses to torture and human rights violations. *Id.* Another Third Circuit case cited the Protocol’s documentation of the “various psychological responses to torture” in support of the contention that multiple barriers exist to understanding the demeanor of petitioners who have experienced trauma and may be repressing memories. *Dia v. Ashcroft*, 353 F.3d 228, 277 n.6 (3d Cir. 2003) (concurrency in part). Fourteen years after these decisions, Executive Order 13767 in 2017 raised the standard for credible fear of persecution. Under the order, asylum applicants whose trauma has “altered their ‘demeanor, candor, or responsiveness’ may now be perceived as less credible,” intensifying the need for expertise from mental health professionals. Sharp et al., *supra* note 51, at 317.

236. *Matter of J-G-T-*, 28 I&N Dec. 97, 101 (BIA 2020) (“A key purpose of qualifying a witness as an expert is to provide a framework for the Immigration Judge to evaluate the evidence. In assessing whether to admit the testimony of a witness as an expert, an Immigration Judge should consider whether it is sufficiently relevant and reliable for the expert to offer an informed opinion.”).

237. *United States v. Ruvalcaba-Garcia*, 923 F.3d 1183, 1189 (9th Cir. 2019).

238. *See Ladha v. INS*, 215 F.3d 889, 905 (9th Cir. 2000) (remanding for clarification of petitioner’s due process claims based on the exclusion of two documents) (overruled on other grounds by *Abebe v. Mukasey*, 554 F.3d 1203, 1208 (9th Cir. 2009) (en banc) (per curiam)).

239. *Evans et al.*, *supra* note 46, at 12. (“In our experience, this crucial distinction between forensic and clinical evaluation is often not well understood by assessors, attorneys, and judges. The forensic assessor’s job is to provide an independent, neutral, objective evaluation of the relevant psycholegal question at hand and to share that information with the attorney retaining the assessor, whether or not it is beneficial to the examinee’s case.”).

240. *Ezeagwuna v. Ashcroft*, 325 F.3d 396, 410 (3d Cir. 2003).

der.”²⁴¹ Here, the appellate court recognized the usefulness of targeted documentation by trained evaluators.

In other cases, IJs questioned an evaluator’s credentials or found bias where medical professionals are also human rights advocates. For example, the Eighth Circuit found due process violations where an IJ excluded a forensic medical evaluation alleging, in part, the evaluator’s lack of specialization in psychiatry or psychology and her previous human rights work.²⁴² The Eighth Circuit reiterated that “it is not necessary that a physician be a specialist or publish in a particular area to provide assistance in the evaluation of claims of abuse or torture.”²⁴³ Further, the Eighth Circuit “found it more than a little troubling that an immigration judge who is ostensibly working as a neutral arbiter in a fact-finding and decision making capacity would use a physician’s participation in an advocacy and aid organization as a basis to presume a conflict and bias.”²⁴⁴ For these reasons and others, the court found that the exclusion of the forensic medical evaluator’s testimony suggested prejudice under the due process standard.²⁴⁵

In another sampling of cases, IJs excluded forensic psychiatric evaluations when making credibility determinations, even where such evaluations commented directly on memory and cognition or corroborated physical harms. For example, the Fourth Circuit found that the IJ wrongly excluded a forensic psychological evaluation that diagnosed the applicant with depression and PTSD as a “direct result” of the stated trauma.²⁴⁶ In this case, the IJ also ignored a forensic evaluation which confirmed scars “consistent with [the] blunt trauma” described by the applicant.²⁴⁷ The Fourth Circuit vacated the adverse credibility determination and remanded for further proceedings, which took this forensic evidence into account.²⁴⁸

Appellate courts also upheld adverse credibility findings where forensic evaluations were found insufficient because evaluators flagged symptomology generally but did not directly connect the symptomology with specific inconsistencies. For example, the Second Circuit affirmed the BIA’s adverse credibility determination where there were inconsistencies on the record that were not adequately addressed by the submitted forensic evaluation.²⁴⁹ The applicant argued that the inconsistencies could be explained by a forensic psychological evaluation which indicated that he suf-

241. *Id.*

242. *Naing Tun v. Gonzalez*, 485 F.3d 1014, 1027–28 (8th Cir. 2007).

243. *Id.* at 1028 (“Given Dr. Frye’s medical education and work experience as a physician and nurse in the United States and abroad, she was qualified to comment on physical trauma, physical scars, the consistency between Petitioner’s claims and his physical scars and symptoms, and, based on her experience with trauma victims, psychological effects of trauma.”).

244. *Id.* at 1027.

245. *Id.* at 1028.

246. *Curumi v. Ashcroft*, 119 F. App’x 468, 474 (4th Cir. 2005).

247. *Id.*

248. *Id.*

249. *Guiqiu Jiang v. Holder*, 480 F. App’x 654, 655–56 (2d Cir. 2012).

ferred from depression and noted “his retention was mildly compromised.”²⁵⁰ The court found that this record would not have compelled a reasonable fact-finder to find that the applicant suffered memory loss or cognitive disability to the degree which justified or explained the inconsistencies on the record.²⁵¹ In another example, a forensic evaluation citing “significant memory loss which has affected both short-term and long-term memory processes” was assigned little weight because it did not explain why the applicant remembered some facts (i.e. her children’s birthdays, her phone number, and the date of her husband’s murder) but not others related to her rape.²⁵² In yet another case, a psychological evaluation that diagnosed the applicant with depressive and anxiety disorders and stated the applicant “exhibits a pattern of memory difficulties” was deemed insufficient because the evaluator “was unable to conclude that [the applicant’s] memory difficulties, did, in fact, stem from his psychological disorders.”²⁵³ The Ninth Circuit found that the doctor’s “inability to explain [the applicant’s] memory problems to any reasonable certainty” supported the adverse credibility finding.²⁵⁴

While forensic evaluations may be dismissed or devalued even where they corroborate testimony, inconsistencies between a forensic evaluation and an applicant’s testimony may be fatal to the case. For example, where a clinical psychologist provided a forensic medical evaluation in an asylum matter, the IJ noted on the record that the evaluator was “not a treating psychologist” and the forensic evaluation had taken place “at the request of . . . counsel . . . almost four years after” the applicant entered the country—reiterating observations discussed previously where adjudicators may discount testimony where the forensic evaluator is not the treating physician, the evaluation was not contemporaneous to the harm, and where the evaluation was completed at the request of counsel.²⁵⁵ Ironically, all of these qualities fall within the Istanbul Protocol which explicitly offers a framework through which non-treating physicians can document past harms and torture to enhance fact-finding and render expert interpretation.²⁵⁶ Despite

250. *Id.*

251. *Id.*

252. *Siqeca v. Gonzales*, 157 F. App’x 912, 914–15 (7th Cir. 2005). The IJ “also assigned little weight to Dr. Bastani’s affidavit because he did not believe Siqeca’s depression-related memory loss accounted for all of the inconsistent testimony and documentation in her case. Because it is the IJ’s role to evaluate the evidence presented, it was within the IJ’s discretion to assign little or no weight to the expert affidavits.” *Id.* at 916.

253. *Singh v. Mukasey*, 268 F. App’x 608, 610 (9th Cir. 2008).

254. *Id.*

255. *Zeru v. Gonzales*, 503 F.3d 59, 64 (1st Cir. 2007).

256. Istanbul Protocol, *supra* note 38, at 1 (“The purpose of the written or oral testimony of the physician is to provide expert opinion on the degree to which medical findings correlate with the patient’s allegation of abuse and to communicate effectively the physician’s medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials and the local and international communities on the physical and psychological sequelae of torture.”).

these observations, the IJ did rely on the same discredited forensic medical evaluation when making an adverse credibility finding where, among other factors, there were inconsistencies between the forensic evaluation and the applicant's testimony with regards to how many rapes she had survived.²⁵⁷ The First Circuit agreed that the evaluator's PTSD diagnosis did not address the gaps, omissions, and inconsistencies on the record and upheld the adverse credibility on these factors and the IJ's assessment of the applicant's demeanor.²⁵⁸ In essence, a PTSD diagnosis without detailed information regarding how PTSD may impact memory, demeanor, and recall in this specific situation were not enough to overcome the adverse credibility finding.²⁵⁹

IV. A QUANTITATIVE ANALYSIS: DO FORENSIC EVALUATIONS IMPACT CASE OUTCOMES?

A. *Outcomes of Cases with Forensic Medical Evaluations*

The PHR Asylum Network is comprised of over 2,000 clinicians nationwide who volunteer to provide pro bono forensic medical and psychological evaluations and then write affidavits to document and corroborate persecution, trauma, and other harms that immigrants seek to relay to immigration adjudicators. When PHR receives a request from an attorney for an evaluation on behalf of an immigrant client, it facilitates a match between the attorney and a medical evaluator. As the only nationwide pro bono provider of such services, PHR facilitates more than 700 evaluations each year. Attorneys report back to PHR information about these evaluations, including final immigration case outcomes, which make up the dataset this Study relies on.

Overall, 81.6% of individuals in the PHR-CUNY Study who requested a forensic medical evaluation between 2008 and 2018 received some type of a positive outcome in their immigration cases (these include grants of asylum and other forms of relief including U-Visa, T-Visa, VAWA, and SIJS, among others in both the affirmative and defensive posture).²⁶⁰ The national grant rate for asylum cases during the same period was 42.4%.²⁶¹ Because of the way in which data is recorded by PHR, the number of applicants who *applied* for asylum cannot be ascertained, and thus the asylum grant rate for those in the PHR-CUNY Study cannot be calculated. Similarly, the percentage of individuals who had positive outcomes in immigration proceedings from available DHS statistics cannot be ascertained, as specific data is only available about asylum grant rates. Thus, the closest

257. *Zeru*, 503 F.3d at 70 (1st Cir. 2007).

258. *Id.* at 70–74.

259. *Id.*

260. *See* Atkinson et al., *supra* note 5, at 5.

261. *Id.*

comparison is measuring positive outcomes in the PHR-CUNY Study against the national average of asylum grant rates across affirmative (USCIS/DHS) and defensive (EOIR/DOJ) applicants.²⁶²

PHR recorded outcomes data by tracking whether relief or applications were granted or denied, whether the case was terminated or administratively closed, and whether an individual was ordered deported. For purposes of this Study, a “positive outcome” includes cases in which relief was granted, proceedings were terminated, and where the applicant was released from detention. A “negative outcome” was one in which relief was denied or an individual was ordered deported. Negative outcomes also included situations in which attorneys indicated that relief was denied but no deportation order was issued. “Other” included cases that were administratively closed and six cases where the attorney indicated there was an unknown “other” outcome.²⁶³

Among the 2,584 total cases in the dataset, most outcomes (67.1%) involved the grant or denial of asylum.²⁶⁴ Other forms of relief included in the PHR dataset involved grants of withholding of removal, VAWA, U-Visas, voluntary departure, T-Visas, cancellation of removal, CAT, SIJS, and adjustment.²⁶⁵ Finally, in 11% of cases with positive outcomes, individuals received other unspecified relief, and in 3.8% of cases with positive outcomes, the proceedings were terminated in their entirety without grant of relief.²⁶⁶ This array of case outcomes, though they make up a minority of the studied set, indicate that attorneys may have been requesting forensic medical evaluations to support a variety of arguments outside of the traditional areas in which physicians and lawyers have collaborated (usually in the pursuit of asylum, withholding, and CAT relief). Further, it is very possible that applicants were simultaneously pursuing other forms of relief unrelated to forensic evaluations, such as family-based or employment claims.

B. *The Individuals in the PHR Dataset*

Sections IV.B-C provide an overview of the individuals who made up the PHR-CUNY dataset, offering comparisons to the general pool of individuals appearing before EOIR and USCIS during the study period. These factors are further discussed and analyzed in Part V, *infra*.

262. *Id.* at 2 (“Averaging the EOIR 45.6% success rate (those appearing defensively in the administrative court before immigration judges) and the USCIS 39.1% success rate (those appearing affirmatively before USCIS immigration officers) for the period of our study, yields an overall national asylum grant rate of 42.4%.”).

263. *Id.* at 4–5.

264. *Id.* at 5 (Table 1).

265. *Id.*

266. *Id.*

1. *Time Range Studied*

The PHR-CUNY Study analyzed cases opened by PHR between 2008 and 2018 for which PHR had known case outcomes.²⁶⁷ After medical evaluators are assigned to consult on immigration cases, PHR solicits attorneys for updates on case outcomes. When those are received, PHR systematically enters that information into a database, making up the dataset of 2,584 cases analyzed as part of this Study.²⁶⁸ Thus, the dataset analyzed included only those cases between 2008 and 2018 for which PHR received outcomes data and did not include any of the cases whose outcomes were still pending as of December 2018, cases whose outcomes could not be obtained from the attorneys, or cases where the evaluation was never completed or used in support of the case.

In the seventeen years since the Lustig et al. study was published,²⁶⁹ the terrain for asylum seekers has changed dramatically. For one, the REAL ID Act was passed, guiding judges to look at factors like demeanor, candor, and consistency when assessing the veracity of an asylum claim. Moreover, after decades of struggle, gender-based claims were recognized, a position that was formalized by the BIA in 2014 in *Matter of A-R-C-G*, recognizing that women fleeing domestic violence were eligible for asylum as members of a particular social group.²⁷⁰ In the broader immigration apparatus, the Obama Administration employed the use of “enforcement priorities” during this time period to focus enforcement of immigration laws against individuals who were recent entrants to the United States or had criminal records.²⁷¹ Noncitizen removals hit record highs over this period.²⁷² The chosen time range of 2008 to 2018 captures cases initiated during this changing period in asylum law.

2. *Age, Gender, and Language*

The mean age of applicants in the dataset was 30.8 years.²⁷³ This is similar to the age range cited in DHS and the Office of Immigration Statistics

267. *Id.* at 3.

268. *Id.*

269. As noted previously, this was the last comprehensive study of asylum outcomes in which individuals received PHR-facilitated medical evaluations and included the time range between 2000 and 2004.

270. *Matter of A-R-C-G*, 26 I. & N. Dec. 388 (BIA 2014).

271. See Memorandum from John Morton, Director of U.S. Immigration and Customs Enforcement, on Exercising Prosecutorial Discretion Consistent with the Civil Immigration Enforcement Priorities of the Agency for the Apprehension, Detention, and Removal of Aliens (June 17, 2011), <https://www.ice.gov/doclib/secure-communities/pdf/prosecutorial-discretion-memo.pdf> [<https://perma.cc/KQQ4-VCSS>].

272. Muzaffar Chishti et al., *The Obama Record on Deportations: Deportee in Chief or Not?* MIGRATION INFORMATION SOURCE (Jan. 26, 2017), <https://www.migrationpolicy.org/article/obama-record-deportations-deportee-chief-or-not> [<https://perma.cc/Z3UZ-QK8V>].

273. Atkinson et al., *supra* note 5, at 6.

(“OIS”) statistics, which provide a detailed breakdown by age group.²⁷⁴ 29% of affirmative asylum applicants were ages 25 to 34 years old in the corresponding eleven-year period. Of the remaining, 20% were 0 to 17 years old, 18.26% were 18 to 24 years old, 19.71% were 35 to 44 years old, 9.11% were 45 to 54 years old, 2.74% were 55 to 64 years old, and 1.17% were 65 years or older.²⁷⁵ It should be noted, however, that these statistics are limited to affirmative applicants and do not reflect the trend of increasing numbers of unaccompanied minors seeking asylum in recent years.²⁷⁶

51.7% of those who received PHR-facilitated evaluations were female, and 48.3% were male.²⁷⁷ Statistical reports from DHS and OIS provide a breakdown by genders but are limited to affirmative asylees.²⁷⁸ Of those seeking affirmative asylum before USCIS during the PHR-CUNY Study period, 48.04% were female and 51.96% were male.²⁷⁹ Thus, the PHR dataset included a higher percentage of women as compared to the USCIS data. Demographic data by age or gender is not available from EOIR.

PHR also requested that attorneys provide primary language information about their clients. Of those in the PHR dataset, 38.2% of immigrants indicated English as their primary language, while 61.8% primarily spoke another language—38.5% of individuals spoke Spanish, 15.3% spoke other languages, and 8% spoke French.²⁸⁰

3. *Continent of Origin*

To study outcomes by country of origin, data about origin was organized by continent to ensure that the sample size was large enough to undertake a regression analysis. The largest group, 48.2% of applicants, were from Central and South America.²⁸¹ Those from Africa made up 35.7%, the next largest group, and those from Asia made up 12.8% of the dataset.²⁸²

274. See *Refugees and Asylees*, DEP'T OF HOMELAND SEC., <https://www.dhs.gov/immigration-statistics/refugees-asylees> [<https://perma.cc/2ZMN-X4AR>] (last updated Nov. 12, 2021) [hereinafter DHS Asylee Data], for the OIS' (OIS) annual flow reports on refugees and asylees.

275. *Id.* The percentage per age group is determined by reviewing each of OIS' annual flow reports (2008 until 2018) and dividing the total of each age group by the total number of affirmative asylees in the same period (2008 to 2018).

276. See Nadwa Mossaad, *Refugees and Asylees: 2018*, DEP'T OF HOMELAND SEC., (Oct. 2019), https://www.dhs.gov/sites/default/files/publications/immigration-statistics/yearbook/2018/refugees_asylees_2018.pdf [<https://perma.cc/T2HM-AZ7D>].

277. Atkinson et al., *supra* note 5, at 6.

278. DHS Asylee Data, *supra* note 274 (featuring links to the OIS' annual flow reports on refugees and asylees, which include a breakdown of affirmative asylum applicants' demographics, such as age and gender).

279. *Id.* These percentages were determined using data from the OIS' annual flow reports (2008 until 2018) by dividing the total of female affirmative asylees (80,453) and total male affirmative asylees (87,016) with the total number of applicants (167, 469) within the same time period.

280. Atkinson et al., *supra* note 5, at 6.

281. *Id.*

282. *Id.*

4. *Jurisdictions Where Evaluations Were Requested*

To ensure a sample size large enough to undertake a regression analysis, jurisdictions where the application was filed or the relief was requested were sorted by judicial circuit and circuit region. About 80% of the cases came from circuits covering the Northeast and Mid-Atlantic, whereas the lowest percentage of cases came from the MidWest and Southwest.²⁸³ This data reflects that, during the study period, PHR Asylum Network's had the greatest number of requests from the Boston, New York, and D.C. metropolitan areas.

Further, though beyond of the scope of this Study, the geographical clustering of these services in the Northeast also reflects the location of medical-legal clinics serving immigrants, which are another robust source of forensic medical evaluations like those studied here. The approximate two dozen or so student-run and hybrid asylum/human rights clinics based in medical schools are also predominantly located in the Northeast with a handful scattered in the South and on the West Coast.²⁸⁴

5. *Detention by U.S. Government*

At the time their attorneys requested a forensic medical evaluation via PHR, 7.7% of individuals in the studied dataset were detained.²⁸⁵ In comparison, EOIR data about individuals applying for relief before IJs shows that 19.2% of applicants were detained at the time of their court appearance. Further, in the EOIR data, 9.2% of applicants applying for relief before EOIR had been released after having been detained at some point in their application process, whereas 61.6% of applicants had never been detained.²⁸⁶

6. *Type of Evaluation Requested*

Attorneys requesting forensic medical evaluations through PHR have the option of requesting any of the following: a physical, psychological, gynecological, neuropsychological, and/or psychological/competency evaluation. Attorneys can also request a medical record review. Of the 2,584 cases in the dataset, 481 of the cases had the associated affidavit(s) provided by the forensic medical evaluators.²⁸⁷ Amongst this specific subgroup of cases, 72.6% had a linked psychological affidavit and 32.4% had a linked physical evaluation.²⁸⁸

283. *Id.* at 7 (Table 2).

284. *See* Ferdowsian et al., *supra* note 11, at 222 (Table 4).

285. Atkinson et al., *supra* note 5, at 7 (Table 2).

286. TRAC Asylum Decisions tool, *supra* note 8. The tool allows users to view data obtained by TRAC through requests made under FOIA to the EOIR. Asylum outcomes can be filtered by year, nationality, representation status, custody status, decision, and other criteria.

287. Atkinson et al., *supra* note 5, at 5.

288. *Id.* at 8. Note that some requested both a physical and psychological affidavit.

7. *Type of Harm Evaluated*

78.2% of those applicants who received a forensic medical application in support of an asylum application applied for asylum based, at least in part, on membership in a particular social group.²⁸⁹ This is consistent with the fact that many applicants alleged persecution in the form of sexual or gender-based violence, as explained below. 43.2% indicated the asylum application was filed due to persecution on account of political opinion, and 11% cited persecution on account of religion.²⁹⁰

PHR captured additional limited data on the type of persecution the case referral involved. 58.7% involved sexual or gender-based violence.²⁹¹ Within gender-based violence, 16.9% of cases involved FGM/C, 50.7% involved sexual violence, and 60% involved domestic violence.²⁹² 21.8% of the cases involved gang violence, whereas 14.4% alleged persecution based on sexual orientation.²⁹³ 10.4% of cases involved kidnapping, 17.7% involved foreign detention, and 2.7% indicated sensory deprivation.²⁹⁴ 43.1% of individuals in the dataset alleged that they were subject to torture.²⁹⁵

8. *Evaluator Preferences*

PHR data also reflects the applicant's preference for the medical evaluator's gender. While 63.4% of those seeking evaluations had no preference, 31.5% requested a female evaluator and 5.2% requested a male evaluator.²⁹⁶ In 46.2% of the requests, the attorney requested the medical evaluator be available to provide testimony.²⁹⁷ In 18.5% of these scenarios, the medical evaluator was expressly allowed to provide telephonic testimony.²⁹⁸

C. *Measuring Outcomes Against Independent Variables*

Beyond comparing outcomes amongst immigrants receiving forensic medical evaluations to the average national success rate, independent variables recorded in the PHR dataset provided an opportunity to assess whether numerous independent factors—such as gender, age, geography, country of origin, language, and orientation within the legal system (i.e., whether one appeared affirmatively or defensively)—were correlated with the outcomes. The following emerged when considering such independent variables and are discussed in more detail in the subsequent Sections:

289. *Id.* at 7–8 (Table 2).

290. *Id.*

291. *Id.*

292. Data on file with author. Note these percentages add up to more than 100% because applicants could list more than one type of torture.

293. Atkinson et al., *supra* note 5, at 7–8 (Table 2).

294. *Id.*

295. *Id.*

296. *Id.*

297. *Id.*

298. *Id.*

- *Females had higher odds of receiving a positive outcome.* When analyzed by gender, those who identified as female received a positive outcome rate of 83%, whereas those who identified as male were slightly lower at 80.1%.²⁹⁹
- *Spanish speakers had lower odds of receiving a positive outcome.* As compared to English, French, and “Other” languages, those who spoke Spanish had the lowest grant rate of 74.4%.³⁰⁰
- *Those from countries in Africa had higher odds of receiving a positive outcome.* Country of origin information was grouped by continent and showed that individuals originating from African nations had a 90.5% positive outcome rate.³⁰¹
- *Gang-based claims had a detrimental impact on possibilities of success.* Those who included gang-violence as part of the harm from which they were fleeing had the lowest rate of success at 66.4%. In contrast, 86.5% of those who did not include gang violence as a basis for relief had positive outcomes.³⁰²
- *Foreign detention correlated with higher grant rates.* Those who included foreign detention as part of the harm from which they were fleeing had a slightly higher rate of success, 87.9%, versus those who did not include foreign detention, 80.9%.³⁰³
- *Those who included claims related to sexual orientation had higher positive grant rates.* Those whose claims included being targeted on account of sexual orientation had a 10% higher chance of receiving a positive outcome, 90.8%, than those who did not, 80.7%.³⁰⁴
- *Non-detained individuals had higher positive grant rates.* While those who were not detained had an 82.4% positive grant rate, detained applicants saw a 72.7% positive grant rate.³⁰⁵
- *Physical evaluations correlated with a higher rate of positive outcomes than psychological affidavits.* Attorneys have the choice of requesting physical and/or psychological forensic evaluations for their clients. Clients whose attorneys only requested a psychological evaluation had a lower rate of positive outcomes, 79.7%, slightly lower than the average of all cases in the PHR-CUNY Study. In contrast, those whose attorneys only requested a physical evaluation had a significantly higher rate of success: an 86.4% grant rate. Those who requested both a physical and psychological evaluation had the highest rate of success, 87.8%. Notably, those whose attorneys requested a psychological evaluation had a higher chance of receiving an “other” outcome (namely admin-

299. *Id.*

300. *Id.*

301. *Id.*

302. *Id.*

303. *Id.*

304. *Id.*

305. *Id.*

istrative closure) as opposed to those whose attorneys requested a physical evaluation.³⁰⁶

V. A FRAMEWORK FOR UNDERSTANDING THE PHR-CUNY STUDY

Although the Study sought to evaluate the impact of forensic medical evaluations on case outcomes as the result of adjudicator decision-making, the individuals in this dataset share other characteristics.³⁰⁷ Crucially, all who received a forensic medical evaluation were also represented by attorneys and most evaluated individuals (92.3%) were not detained.³⁰⁸

PHR screens cases to offer forensic medical evaluations for those where attorneys have confirmed considerable psychological or physical symptoms increasing the odds that such an evaluation could provide meaningful corroboration and proof of past trauma.³⁰⁹ Thus, as PHR's cases have an underlying component that is amenable to medical documentation,³¹⁰ individuals who receive such screenings may be eligible for forms of relief that are more generously granted by IJs and adjudicators. For instance, statistical reports from USCIS indicate that immigrants who apply for T-Visas and U-Visas had, on average, a 79.6%³¹¹ and 81.1%³¹² success rate respectively through-

306. *Id.*

307. This dataset includes instances where an evaluation was requested. There is no way to confirm if the evaluations occurred and more importantly if the lawyer included a physician affidavit in any filing. In some situations, an evaluation may have been requested but not used because the application for relief was not filed, a different legal strategy was pursued, or the lawyer felt that the evaluation uncovered information that might have damaged or detracted from the arguments.

308. Holly G. Atkinson et al., *supra* note 5, at 7–8 (Table 2). Further, PHR's Asylum Network has a disproportionate presence in the Northeast and California, jurisdictions that have been historically more favorable to immigrants in removal proceedings.

309. For example, according to the PHR Guide for Health Professionals, “in the majority of political asylum applicants who allege sexual assault during torture, the traumatic event(s) will have occurred months or years before the medical examination. Therefore, most individuals will not have physical signs at the time of the examination Even on examination of the female genitalia immediately after rape there is identifiable damage in less than 50% of cases. Anal examination of males and females after anal rape shows lesions in less than 30% of cases.” *Examining Asylum Seekers: A Clinician's Guide to Physical and Psychological Evaluations of Torture and Ill-Treatment* 54–61, PHYSICIANS FOR HUM. RTS. (2001).

310. A medical component amenable to documentation may include a physical scar due to persecution and/or diagnosis of anxiety disorder, depression, or PTSD that can be documented by doing psychological testing.

311. *Number of Form I-914, Application for T Nonimmigrant Status by Fiscal Year, Quarter, and Case Status Fiscal Years 2008–2020*, U.S. CITIZENSHIP & IMMIGR. SERVS., https://www.uscis.gov/sites/default/files/document/reports/I914t_visastatistics_fy2020_qtr4.pdf [<https://perma.cc/A6K2-9H3K>] (comparing the total number of approved principal applications (not counting derivatives) between 2008 and 2018—6,280—with the total number of adjudicated cases—7,886—to arrive at a grant rate of 79.6%).

312. *Number of Form I-918, Petition for U Nonimmigrant Status by Fiscal Year, Quarter, and Case Status Fiscal Years 2009–2020*, U.S. CITIZENSHIP & IMMIGR. SERVS., https://www.uscis.gov/sites/default/files/document/reports/I918u_visastatistics_fy2020_qtr4.pdf [<https://perma.cc/EWE7-7VYQ>] (comparing the total number of approved principal applications (not counting derivatives) between 2009 and 2018—96,314—with the total number of adjudicated cases—118,723—to arrive at a grant rate of 81.1%). This is in line with USCIS's grant rates listed in its U-Visa Filing Trends Report, which

out the duration of the study period. In comparison, average asylum grant rates throughout the study period stood at approximately 53.15% for affirmative applications through USCIS³¹³ and 45.57% for asylum applications processed through EOIR.³¹⁴ Still, as those who received T-Visa and U-Visa grants made up less than 3% of the dataset, higher grant rates for these forms of relief had minimal impact on the overall analysis.

The following Section lays out the characteristics of those who were able to secure PHR-facilitated evaluations, a group that in many ways reflects the most advantaged of those who appear in the immigration system because they have attorneys and are by-and-large not subject to detention by ICE. Thus, as was repeatedly asked, is the fact that immigrants with forensic medical evaluations fared significantly better in their immigration proceedings a testament to the power of the evaluation itself, or simply the result of a multitude of beneficial factors that made it possible for a particular immigrant to get an evaluation in the first place? Investigating this question bears on the intrinsic value of the evaluation itself.

A. *The Power of Representation*

As outlined above, immigrants who are beneficiaries of PHR-facilitated evaluations are advantaged in the immigration system in a host of ways, first and foremost by having representation. Because of the complexities and risks of integrating a forensic medical evaluation into a legal strategy without attorney supervision, PHR only accepts requests from attorneys or paralegals.

Although immigration law is often compared to the tax code in terms of complexity, there is no right to government-funded counsel for immigrants defending themselves against deportation. Most immigrants appear *pro se*, forced to navigate a complex, back-logged, and ever-changing system against trained government lawyers. In the first nationwide study of removal cases decided on the merits, Professors Ingrid Eagly and Steven Shafer found that only 37% of immigrants had access to counsel during a study period between 2007 and 2012.³¹⁵ Of those who secured representation, only 2% obtained pro bono representation from non-profit organizations,

includes grant rates combing both principal and derivative applications. See *U-Visa Filing Trends Report* 5-6, U.S. CITIZENSHIP & IMMIGR. SERVS. (April 2020), https://www.uscis.gov/sites/default/files/document/reports/Mini_U_Report-Filing_Trends_508.pdf [<https://perma.cc/Y2V3-A3CC>].

313. DHS Asylee Data, *supra* note 274. Annual Flow Reports from 2008 to 2018 provide statistical and demographic information in three-year increments. Average rates are calculated using statistics of a given year from that year's corresponding Annual Flow Report. Due to reporting inconsistencies, statistics reported in subsequent Annual Flow Reports may not match the figures from the year it was originally published.

314. Mossaad, *supra* note 276. Averages are calculated using statistics of a given year from that year's corresponding Statistics Yearbook due to inconsistencies in subsequent reports.

315. Ingrid V. Eagly & Steven Shafer, *A National Study of Access to Counsel in Immigration Court*, 164 U. PA. L. REV. 1, 7 (2015).

law school clinics, or law firm volunteer programs.³¹⁶ Oftentimes immigrants are navigating this system *pro se*, while also incarcerated by ICE, with little or insufficient access to interpreters, and while facing physical and mental health challenges compounded by a retraumatizing immigration system.

To understand the value of a forensic medical evaluation, then, it is appropriate to compare how those who received a PHR-facilitated medical evaluation fared when compared to others represented by counsel through the immigration process. In a survey of annual asylum statistics released by EOIR, Syracuse University's Transactional Records Access Clearinghouse ("TRAC") analysis shows that 81.05% of asylum seekers were represented by counsel in the studied period between 2008 and 2018. Of those represented, 53.88% received an asylum grant, while 44.13% were denied relief. In contrast, only 10.06% of those who were not represented received a positive asylum grant, while relief was denied in 87.73% of cases.³¹⁷ Comparing EOIR asylum statistics to the PHR-CUNY Study, those within the Study who applied for asylum were denied only 6.9% of the time, a significantly lower rate of denial than the 44.13% of represented asylum seekers who were denied asylum in the larger pool. These data show that, while access to counsel is deeply intertwined with the positive case outcomes, forensic medical evaluations have essential value in and of themselves.

A host of studies have quantified the impact that access to counsel has on immigration cases, all finding that access to counsel significantly increases successful outcomes for immigrants appearing before EOIR and USCIS. In their study of the impact of the New York Immigrant Family Unity Project ("NYIFUP"), The Vera Institute of Justice analyzed EOIR data, which revealed that 46% of cases beginning in detention were successful when clients had legal representation—an exponential difference from the 6% success rate for detained clients who appear without representation.³¹⁸ Legal representation helped individuals exercise their rights, safeguarded due process protections, improved communications between the court and the immigrant, raised relevant legal arguments, and allowed the immigrant to benefit from a holistic range of services.³¹⁹ In looking at the benefits repre-

316. *Id.* at 8.

317. TRAC Asylum Decisions tool, *supra* note 8. Additionally, a small percentage of cases (1.99% and 2.21%, respectively, for both represented and not represented applicants) were provided other forms of relief, in which the applicant was denied asylum but was allowed to legally remain in the United States through another form of permanent or temporary relief.

318. Jennifer Stave et al., *Evaluation of the New York Immigrant Family Unity Project: Assessing the Impact of Legal Representation on Family and Community Unity* 24, VERA INST. JUST., (2017) https://storage.googleapis.com/vera-web-assets/downloads/Publications/new-york-immigrant-family-unity-project-evaluation/legacy_downloads/new-york-immigrant-family-unity-project-evaluation.pdf [https://perma.cc/ELG8-4E97]; Eagly & Shafer, *supra* note 317, at 1; Talia Peleg & Ruben Loyo, *Transforming Deportation Defense: Lessons Learned from the Nation's First Public Defender Program for Detained Immigrants*, 22 CUNY L. REV. 193 (2019).

319. Stave et al., *supra* note 320 at 44.

sentation provides, “NYIFUP attorneys who participated in focus groups repeatedly returned to the theme of how important their access to other subject-matter experts was,” and cited the “use of outside experts to enhance their legal arguments.”³²⁰ The PHR-CUNY Study reveals that forensic medical evaluators can play a similar and complementary role, connecting immigrant clients with holistic services and assessing and enhancing legal arguments related to harm-related assessments, credibility, discretion, and competency.

In total, administrative closure and termination made up about 10% of PHR outcomes during the study period (of which about 3% of cases were terminated, and 6% were administratively closed).³²¹ These procedural patterns, all of which prevent immediate deportation, reflect the power that a forensic medical evaluation may have in influencing adjudicators and immigration enforcement to temporarily prevent deportation or exercise prosecutorial discretion even if the immigrant is not found eligible for asylum or other forms of relief. This data tracks research on the impacts of counsel that find that represented cases often have “remarkably different procedural patterns” that reflect a higher likelihood of case termination and involve applications for relief.³²²

B. *Barriers to Immigration Status for those Incarcerated by ICE*

Alongside the benefits of representation, 92.3% of those who received a PHR-facilitated evaluation were not detained by ICE at the time of the request for evaluation.³²³ In turn, this population had greater access to attorneys and a heightened opportunity to prepare for their proceedings through the ability to gather affidavits, moot testimony, and engage with experts. Further, as criminal arrests and convictions are a common factor used to assess who is subject to discretionary and mandatory ICE detention, it is likely that these individuals were not detained because they had fewer entanglements within the criminal immigration system, and were thus less likely to be barred from relief and more likely to be granted discretionary relief. Freedom from incarceration also meant that most in this population appeared on “non-detained” dockets, which were staffed with adjudicators with higher asylum grant rates and were given more time to prepare for court appearances. In contrast, those who are detained have cases fast-tracked. For some, this means hearings are scheduled within days, without access to counsel or the opportunity to obtain the most compelling evidence or enhance legal arguments.

Thus, the fact that these individuals were not detained is a critical reason that they were able to access resources like forensic medical evaluations.

320. *Id.* at 44.

321. Atkinson et al., *supra* note 5, at 5 (Table 1); *see also* Appendix A, *infra*.

322. Eagly & Shafer, *supra* note 317, at 25.

323. Atkinson et al., *supra* note 5, at 7 (Table 2).

Those in detention are less likely to have legal counsel, and in turn, less likely to be able to request help from pro bono evaluators like PHR-affiliated forensic medical evaluators, who typically only take referrals from attorneys. While PHR attempts to find medical evaluators to conduct forensic medical evaluations for clients in immigration detention when attorneys specifically request such evaluations, it is difficult to find clinicians who are able to travel to detention centers to provide such services. Additionally, because of the fast-tracked nature of detained cases, there is insufficient time to schedule evaluations of detained individuals. Finally, ICE's practice of transferring individuals from immigration detention centers near their homes to remote detention facilities creates insurmountable challenges to access to counsel and trained forensic medical evaluators.³²⁴

Given the data bias towards non-detained applicants, another framework to assess the PHR-CUNY results is to compare these outcomes to those of the larger pool of non-detained immigrants appearing before IJs and USCIS adjudicators. In studying EOIR Statistics from the study period, immigrants who were free from incarceration had a 58.69% asylum grant rate and a 1.95% grant rate for other unspecified types of temporary or permanent relief where asylum was denied.³²⁵ Of these individuals, 89.4% were represented by counsel. Those who were detained and later released had a significantly lower asylum grant rate of 44.42%, even though they were represented at almost the same rate as those who were never detained.³²⁶ But the grant rate for asylum drops most dramatically for those who were detained and never released; according to EOIR statistics, these individuals were granted asylum in only 15.55% of cases.³²⁷ Further, for reasons outlined above, only 46.93% of detained individuals had access to legal representation, as compared to the higher representation rates seen in populations never detained and those who were detained but subsequently released.³²⁸

In comparison, in the PHR-CUNY Study, those free from incarceration had positive resolutions of their immigration cases in 82.4% of cases, a significant advantage compared to the approximately 60% grant rate of asylum and other unspecified forms of relief amongst the general pool of

324. See *Locked Up Far Away: The Transfer of Immigrants to Remote Detention Centers in the United States*, HUMAN RIGHTS WATCH (Dec. 2, 2009), <https://www.hrw.org/report/2009/12/02/locked-far-away/transfer-immigrants-remote-detention-centers-united-states#> [<https://perma.cc/EM9P-9CEJ>] [hereinafter *Locked Up HRW*].

325. TRAC Asylum Decisions tool, *supra* note 8. According to TRAC, a decision of “other relief granted” means that the individual was denied asylum relief but “was allowed to legally remain in the country through the granting of another form of permanent or temporary relief.” See *About the Data*, TRAC IMMIGRATION, https://trac.syr.edu/phptools/immigration/asylum/about_data.html [<https://perma.cc/Q5KC-EUHT>].

326. *Id.*

327. *Id.*

328. *Id.*

non-detained individuals appearing before EOIR during this period.³²⁹ For those in the PHR-CUNY Study who were detained at the time their attorney requested a medical evaluation, this positive grant rate fell to 72.7%.³³⁰ This lower grant rate for detained individuals is consistent with EOIR data, but still represents a significantly higher positive outcome rate when compared to a 15.5% asylum positive grant rate for asylum seekers in detention who were never released, and a 44.42% rate for those detained and then released in the general pool of individuals appearing before EOIR during this period.³³¹ In sum, detained individuals in the PHR-CUNY Study consistently surpassed national averages for positive asylum outcomes amongst detained, released, and non-detained individuals alike.

C. Tracking Benefits of Geography

As outlined above, another marked difference between those in the PHR-CUNY Study and the general pool of asylum seekers is geography. 75.5% of PHR-facilitated medical evaluations took place on behalf of clients residing within the First, Second, Third, and Fourth Circuits, an area largely concentrated in the Northeast.³³² 10% of evaluations took place in the Ninth Circuit.³³³ In contrast, 3.3% (84 out of 2584) of evaluations were done in the Fifth Circuit (which covers Louisiana, Mississippi, and Texas), which is the jurisdiction that receives the most transferred detainees.³³⁴ Though not the only source of forensic medical evaluations, PHR is the largest national organization facilitating such evaluations, so this data indicates great disparities in access to forensic medical evaluations across geographies. Forensic medical evaluations were clustered in jurisdictions with immigration courts more favorable to immigrants, while those appearing in more rural jurisdictions or in border-area courts with lower grant rates had less access to forensic specialists. Though a consideration of ICE's punitive transfer of individuals to rural detention facilities to purposely create barriers of access to representation and resources is outside the scope of this Article, expansion of forensic medical evaluations in these jurisdictions may serve to educate IJs with low grant rates about the impacts of trauma on credibility and the trauma-informed best practices.

Alongside the geographic differences between who within the United States gets access to forensic medical evaluation, asylum-seeking populations forced to remain outside of the United States rarely have access to counsel and forensic medical evaluators, and in turn, have been granted

329. Atkinson et al., *supra* note 5, at 7 (Table 2).

330. TRAC Asylum Decisions tool, *supra* note 8.

331. *Id.*

332. Atkinson et al., *supra* note 5, at 7 (Table 2).

333. Locked Up HRW, *supra* note 329, at 6.

334. *Id.*

relief in less than 2% of cases.³³⁵ Although outside of the range of period studied, under the Migrant Protection Protocols (also known as the “Remain in Mexico Program” or “MPP”), asylum seekers are forced to wait indefinitely in Mexico, many in squalid and dangerous conditions, for their asylum hearings in the United States. Many in MPP have waited upwards of two years in Mexico for their hearings. Data gathered in December 2019 revealed that of the almost 60,000 individuals who were put into this program, only 5% had access to an attorney.³³⁶ For the vast majority of those in MPP, access to PHR’s Asylum Network was an impossibility.³³⁷ Although there are limited similar services offered for those within Mexico, and a growing use of tele-health evaluations to document harms,³³⁸ the vast majority of asylum seekers in the MPP have no access to an attorney, much less a forensic medical evaluation. Those in MPP are often forced into courts with some of the lowest asylum grant rates in the nation.

Regression analysis of the PHR-CUNY Study data found no meaningful differences between the grant rates across various circuits. Therefore, any disadvantage to those living in unfavorable circuits may have been equalized by having access to a forensic medical evaluation.

D. A Preference for Evidence of Physical Harm while Undervaluing Psychological and Emotional Harms

With regard to the type of evaluation requested, 72.6% of requests were for psychological evaluations, while 32.4% were for physical evaluations.³³⁹ Those whose attorneys requested physical evaluations alone saw an almost 10% increase in successful outcomes in their immigration proceedings as compared to those whose attorneys requested psychological evaluation alone.³⁴⁰ These findings are consistent with observations from immigration scholars and researchers who have found that a focus on nonphysical harms has been both underrecognized by courts and underdeveloped by practitioners.³⁴¹

335. See *Texas v. Biden*, No. 2:21-CV-067-Z, 2021 U.S. Dist. LEXIS 152438 (N.D. Tex. Aug. 13, 2021).

336. *Policies Affecting Asylum Seekers at the Border*, AM. IMMIGR. COUNCIL (Jan. 29, 2020), <https://www.americanimmigrationcouncil.org/research/policies-affecting-asylum-seekers-border> [https://perma.cc/J6VD-N849].

337. See Kathryn Hampton et al., *Forced into Danger: Human Rights Violations Resulting from the U.S. Migrant Protection Protocols*, PHYSICIANS FOR HUM. RTS. (Jan. 2021), <https://phr.org/our-work/resources/forced-into-danger/> [https://perma.cc/8SZB-NEYQ].

338. See Mishori et al., *Better than Having no Evaluation Done: a Pilot Project to Conduct Remote Asylum Evaluations for Clients in a Migrant Encampment in Mexico*, 21 BMC HEALTH SERVS. RSCH. 508, 508 (2021).

339. Atkinson et al., *supra* note 5, at 8 (Table 2).

340. *Id.*

341. See, e.g., Marouf, *supra* note 73, at 95 (“Since adjudicators are often uncertain about how to handle nonphysical forms of harm, especially psychological harm, which is uniquely difficult to analyze objectively, the tendency is simply to ignore such harm in determining whether the applicant exper-

Frequently, nonphysical harms—be they economic deprivation, psychological abuse, or violations of rights—are often harder to identify and overlooked. For example, in her analysis of the differences in how sexual and reproductive harms are treated in the asylum context as opposed to other harms, Professor Fatma Marouf observes that adjudicators may fail to recognize the non-physical harms that result from sexual and reproductive harms as persecution.³⁴² Professor Marouf also highlights the adjudicator’s possible cognitive bias in requiring serious bodily harm to a woman’s sexual and reproductive function to give rise to a finding of persecution, often holding applicants to a higher standard and comparing their injuries to the most extreme form of the relevant practice (i.e., comparing outcomes in cases involving FGM/C with those of severe infibulation).³⁴³ Because the seminal cases involved the most extreme forms of a harm, judges may skew their judgments regarding persecution against that particular example of harm, and in turn, minimize other harms faced by the women even though they equally rise to the level of persecution.³⁴⁴ Forensic evaluators can play an important role in preventing such a result by emphasizing and outlining the trauma that comes from perceived “lesser” harms as just as worthy of relief as extreme case examples.

Professors Deborah Anker and Sabi Ardalán also highlight the ways in which courts have failed to recognize emotional and psychological harms that LGBTQIA+ individuals suffer when forced to suppress their identities, and highlight the growing push to recognize such emotional or psychological harm as a serious indicator that the applicant’s suffering rises to the level of persecution.³⁴⁵ In the PHR-CUNY dataset, 90.4% of individuals whose claims related to their sexual orientation saw positive outcomes, a significantly higher positive outcome rate than the average in the pool.³⁴⁶ In these cases, having a trained forensic medical evaluator engage in a careful assessment of physical and psychological harms may have been especially persuasive in highlighting deserving claims from LGBTQIA+ individuals that would have otherwise been overlooked or ignored.

Although those who requested physical evaluations saw the likelihood of a positive outcome increase as compared to those who requested psychological evaluations, attorneys in this Study continued to push forward claims of psychological harms. Those whose attorneys requested a psychological evaluation had a higher chance of receiving an “other” outcome (namely ad-

iened past persecution.”); Deborah Anker & Sabi Ardalán, *Escalating Persecution of Gays and Refugee Protection: Comment on Queer Cases Make Bad Law*, 44 N.Y.U. J. INTL. L. & POL. 529, 531–38 (2012).

342. Marouf, *supra* note 73, at 117.

343. *Id.* at 113–16.

344. *Id.* Professor Marouf potentially attributes this bias to the heuristic principle of “anchoring,” a “cognitive shortcut” that may lead an adjudicator to consider a seminal precedent like *Kasinga* as an anchor in subsequent FGM cases, “as it represents the initial (and most salient) example of a particular category of harm.” *Id.*

345. See Anker & Ardalán, *supra* note 341, at 531–38.

346. Atkinson et al., *supra* note 5, at 6.

ministrative closure) as opposed to those whose attorney requested a physical evaluation.³⁴⁷ Further, those who requested psychological evaluations were slightly more likely to receive administrative closure versus a denial of benefits or final order of removal.³⁴⁸

E. *The Impact of Race and Country of Origin*

Discrimination against Black immigrants is well-documented in the immigration system. For example, Black immigrants are disproportionately targeted for deportation on criminal grounds and face higher credible fear denial rates.³⁴⁹ Thus, it was surprising to observe that in the PHR-CUNY dataset, individuals from African nations received some of the highest grant rates in the dataset (90.6%).³⁵⁰ The fact that those from Africa received significantly higher grant rates in the Study is not inconsistent with the numerous studies that have shown anti-Blackness is an unequivocal reality within the immigration system.³⁵¹

Black and African asylum seekers are generally less likely to win their asylum cases than those belonging to other races.³⁵² In turn, the relatively higher grant rate seen in the PHR-CUNY results may indicate that adjudicators overly rely on corroborative evidence from Africans. In other words, Black immigrants may only become “believable” to adjudicators once there

347. *Id.*

348. *Id.*

349. See Juliana Morgan-Trostle & Kexin Jhand, *Part II: Black Immigrants in the Mass Criminalization System*, in THE STATE OF BLACK IMMIGRANTS (Jan. 2022), <http://baji.org/wp-content/uploads/2020/03/sobi-fullreport-jan22.pdf> [<https://perma.cc/2DRZ-SUVH>] (discussing how Black immigrants are much likelier than immigrants of other nationalities to be targeted for criminal conviction); see also *Biden Administration Poised to Eliminate Critical Safeguard Amid Escalating Reports of Erroneous Credible Fear Decisions*, HUMAN RIGHTS FIRST (Dec. 8 2021), <https://www.humanrightsfirst.org/resource/biden-administration-poised-eliminate-critical-safeguard-amid-escalating-reports-erroneous> [<https://perma.cc/K3AR-DL7G>] (analyzing immigration judge affirmances of credible fear denials and reporting that the highest denial rate during the study period was for asylum seekers from Haiti).

350. Atkinson et al., *supra* note 5, at 7 (Table 2).

351. Given that data is only available by country of origin, note that grant rates from Africa do not include Black populations from the Caribbean, Middle East, and other parts of the world. Both PHR and ICE track data based on country of origins, not by race or ethnicity, and therefore analysis about race is largely tied to assumptions based on country of origin. For example, to analyze grant rates for Black immigrants in comparison to South Asian immigrants, one would have to calculate grant rates from majority Black countries against those from majority South Asian countries. This data point might be overly inclusive by including others who are not racially Black or South Asian who arrive from majority Black or South Asian nations and underinclusive because they exclude Blacks and South Asians who are fleeing from countries where they are minorities. Peniel Ibe, *Immigration is a Black Issue*, American Friends Service Committee Blog (Feb. 16, 2021), <https://www.afsc.org/blogs/news-and-commentary/immigration-black-issue> [<https://perma.cc/PG6G-295M>] (outlining numerous articles and organizations documenting the various forms racism impacts Black immigrants at every stage of the immigration system).

352. Molly O’Toole & Andrea Castillo, *‘Betrayed’ Black Asylum Seekers say Trump Administration is Ramping up Deportations by Force and Fraud*, L.A. TIMES (Nov. 27, 2020), <https://www.latimes.com/politics/story/2020-11-27/black-asylum-seekers-trump-officials-push-deportations> [<https://perma.cc/H9TB-AT2T>].

is corroborating forensic medical evidence attesting to their pain and persecution.

The unshakeable impact of race on credibility determinations by adjudicators has been well-studied and documented.³⁵³ REAL ID requires adjudicators to look towards subjective measures like expressions and demeanor, notions often observed through a lens of white, cis-gendered male normativity, without regard to cultural differences in communication styles and social cues.³⁵⁴ Judge Posner of the Seventh Circuit noted the difficulty in “read[ing]” demeanor, and commented on the lack of any systematic or empirical-based guidance on credibility resolutions in asylum cases in one of several opinions critical of immigration courts.³⁵⁵ Scholars have outlined the many negative impacts that the REAL ID’s credibility provisions have had on female asylum seekers,³⁵⁶ sexual minority applications,³⁵⁷ and other vulnerable groups due to its insertion of bias and personal inferences into adjudications. Ironically, Black immigrants may be held to higher evidentiary standards that constructively require corroborating evidence from forensic medical evaluations, even when they have lower levels of access to medical care in the United States and receive lower quality of care across a wide range of preventative, diagnostic, and therapeutic services.³⁵⁸

The significant disparity in grant rates may also relate back to the underlying reasons for the asylum grant amongst those from Africa. The PHR-CUNY Study found that cases involving FGM/C had a positive outcome in 91.4% percent of cases, roughly a 10% increase compared to the broader grant rate in the pool.³⁵⁹ Those who were subject to foreign detention and those fleeing LGBTQIA+-related persecution also had higher chances of success when compared to those who fled for other reasons, like gang violence.³⁶⁰ Loosely, this data corresponds with norms and policies in asylum law given the study period. 27% of cases from Africa in the dataset involved FGM/C. Other frequent underlying causes among African applicants included LGBTQIA+-related persecution, at 11%. Cases from Africa also

353. Arianna Garcia, *The REAL ID Act and the Negative Impact on Latino Immigrants*, 9 SCHOLAR 275, 292–93 (2007).

354. See Julia Simon-Kerr, *Unmasking Demeanor*, 8 GEO. WASH. L. REV. ARGUENDO 158, 161 (2020); Nicholas Narbutas, *The Ring of Truth: Demeanor and Due Process in U.S. Asylum Law*, 50 COLUM. HUM. RTS. L. REV. 348, 349–50 (2018). See also Michael Kagan, *Is Truth in the Eye of the Beholder: Objective Credibility Assessment in Refugee Status Determination*, 17 GEO. IMMIGR. L.J. 367, 374 (2003).

355. *Djouma v. Gonzales*, 429 F.3d 685, 687–88 (7th Cir. 2005). See also Adam B. Cox, *Deference, Delegation, and Immigration Law*, 74 U. CHI. L. REV. 1671, 1672 (2007).

356. Melloy, *supra* note 191, at 640.

357. Melanie A. Conroy, *Real Bias: How REAL ID’s Credibility and Corroboration Requirements Impair Sexual Minority Asylum Applicants*, 24 BERKELEY J. GENDER L. & JUST. 1, 1 (2009); Mary Kate O’Connell, *Closeted or Credible: How Misinterpretation of the Real Id Act Prevents Closeted LGBTQ+ Applicants from Establishing Credible Asylum Claims*, 28 AM. U.J. GENDER SOC. POL’Y & L. 223, 225 (2020).

358. David Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Medical Care*, 21 HEALTH CARE FIN. REV. 75, 75 (2000); Donna L. Washington et al., *Transforming Clinical Practice to Eliminate Racial-Ethnic Disparities in Healthcare*, 23 J. GEN. INTERNAL MED. 685, 685 (2008).

359. Data on file with author.

360. *Id.*

had the highest rates of foreign detention, which impacted 35.30% of cases.³⁶¹ Thus, the higher success rate of those from Africa in the PHR-CUNY Study may be somewhat attributable to their underlying reasons for seeking asylum.

Nevertheless, given that these same underlying asylum patterns likely extend to Black asylum seekers outside this Study, this explanation does not fully reconcile with the fact that Black asylum seekers continue to see low rates of success in their removal cases even when they may have stronger cases given the underlying reasons for seeking asylum as observed in the PHR-CUNY Study. Further, based on the persecution Black immigrants may be fleeing, it is possible this grant rate should be even higher if it were not for racial bias within the immigration system.

VI. POLICY IMPLICATIONS

Immigrants in the PHR-CUNY Study had positive outcomes at a significantly higher rate than the national average, even when compared to other similarly situated immigrants who were both represented by counsel and not incarcerated. Further, positive outcomes increased dramatically for those immigrants who historically had some of the lowest chances of success in obtaining immigration relief: that is, those originating from Africa and those detained. Although these results may be due to a mixture of factors related to the population who undergo these evaluations alongside the evaluation itself, increased medical-legal collaborations in client representation have helped defense teams expand legal arguments and corroborate and develop client testimony. Importantly, such a collaborative approach facilitates a holistic legal services model, which recognizes that many of the clients have interlacing challenges with policing, health, access to education, public benefits, housing, and more.³⁶² The results of the Study therefore beg the question: If there is a strong correlation between forensic medical evaluations and positive immigration outcomes, should more immigrants have access to them?

A. *Forensic Medical Evaluations For Some Can Be a Pathway to Normalize a Trauma-Informed Approach for All*

As described above, through the development of appellate-level jurisprudence culminating in the passage of the REAL ID Act, applicants have been forced to meet an increasingly rigid criterion to display their credibility.³⁶³ When some immigrants have access to forensic medical evaluations to bolster and corroborate their claims, does this set the bar higher for all appear-

361. *Id.*

362. Ardalan, *supra* note 44, at 1004–05.

363. Anker & Ardalan, *supra* note 341, at 531.

ing in immigration court? For example, if some immigrants are appearing in proceedings testifying to their trauma with a formal diagnosis of PTSD from their forensic medical evaluator, is the immigrant testifying to this trauma without a formal diagnosis disadvantaged?

In many ways, this conundrum is comparable to scenarios where universal representation programs have been offered to certain groups of individuals in limited jurisdictions. There, too, some populations receive access to representation, and in turn enhanced abilities to gather and submit evidence in support of their applications. Studies of such access programs have found that in many ways, access to justice for some immigrants increases benefits for all immigrants.³⁶⁴

Increasing access to forensic medical evaluations may have similar benefits to those who are not the direct recipients of such evaluations. Increased access to medical evaluations and their increased use in courts and USCIS offices could increase adjudicator awareness, lead to the development of favorable case law and policies, and draw attention to specific harms immigrants seeking humanitarian relief have endured. Such benefits could reach beyond the individual receiving the evaluation alone and create a positive ripple effect for all pursuing immigration relief with a component of harm-assessment.

For example, could the provision of medical evaluations open the door to a broader interpretation of persecution? As discussed in Section V.D, *supra*, some scholars have called for a greater emphasis in considering the psychological harms of being forced to shield a religious identity or sexual orientation.³⁶⁵ In the seminal case, *Fatin v. I.N.S.*, the Third Circuit accepted that the psychological impact of being forced to hide one's religious status would be persecution in and of itself.³⁶⁶ Other scholars have noted the need for expansions of eligibility for parents of potential FGM/C victims, which rely on articulating the deep psychological impact on a parent whose child may be at risk of this procedure if returned to their home country.³⁶⁷ In

364. For instance, former NYIFUP attorneys and Professors Talia Peleg and Ruben Loyo describe how NYIFUP representation for some led to increased fairness for all within the immigration system, greater levels of appellate work, and the eventual development of case law that benefited all in the system. Peleg & Loyo, *supra* note 318, at 233 ("For instance, in some of our cases, judges granted relief to our clients over the objection of the DHS attorneys. This has included numerous grants of protection under the Convention Against Torture ("CAT"), which imposes on respondents the high burden of proving they are 'more likely than not to be tortured' upon removal. These BIA decisions, although often not precedential, can be persuasive in other cases. We have shared them with colleagues around the country to push the boundaries of the law in favor of immigrants nationwide."); see also Nina Siulc et al., *Evaluation of the New York Immigrant Family Unity Project* 5, VERA INST. JUST., (Nov. 6, 2017), <https://www.vera.org/publications/new-york-immigrant-family-unity-project-evaluation> [https://perma.cc/4PAW-ZKMJ].

365. Anker & Ardalan, *supra* note 341, at 529.

366. *Fatin v. I.N.S.*, 12 F.3d 1233, 1242 (3d Cir. 1993).

367. Jennifer L. Mesko, *Toward A Compassionate Solution: The UNHCR Guidance Note and Asylum for Parents of Female Genital Mutilation Vulnerable Children*, 11 WHITTIER J. CHILD & FAM. ADVOC. 299, 324 (2012).

these scenarios, a detailed forensic psychological affidavit could highlight the impacts of such a deprivation of rights, expanding the notion of persecution beyond traditionally accepted rubrics of physical harm and psychological torture in an individual case, while simultaneously expanding accepted notions of psychological harms across the bench or asylum office.

Similarly, regular interaction with forensic medical evaluators could serve to educate adjudicators about the latest findings of and developments regarding the impacts of trauma on credibility, encouraging trauma-informed adjudication of cases without such evaluations.

With the expanded use of medical evaluations, there is also potential for medical evaluators to influence traditional notions of persecution and help adjudicators and attorneys identify novel claims. For example, in their work with Garifuna women from Honduras, Drs. Atkinson and Ottenheimer alert medical evaluators to be vigilant of the possible history of involuntary sterilization in HIV-positive women from marginalized and oppressed ethnic groups.³⁶⁸ Moreover, they specifically flag that documentation of sterilization may strengthen asylum claims, and provide specific recommendations for how evaluators should assess individuals where there is a suspicion of sterilization, including documenting the psychological impacts of such sterilization.³⁶⁹ In another case, when the IJ (affirmed by the BIA) rejected a minor asylum applicant's argument for past persecution solely because his injuries did not require physical attention, the Fourth Circuit cited PHR medical studies about the special vulnerability of children: "[t]he immigration court must take the child's age into account in analyzing past persecution. . . . We find this rule . . . to be especially vital against the backdrop of studies documenting mental health issues in child asylum seekers."³⁷⁰ These examples display how the medical community is critical to the formation and expansion of legal arguments.³⁷¹

In addition to advantages for those bringing individual cases before immigration adjudicators, increased access to medical evaluations has been foundational to litigation strategies calling for increased access to healthcare for immigrants detained by ICE³⁷² and due process protections for vulnerable populations with disabilities appearing before immigration adjudicators. In this manner, increased collaboration between medical providers and lawyers can lead to actionable strategies and strengthen critical legal argu-

368. Holly Atkinson & Deborah Ottenheimer, *Involuntary Sterilization Among HIV-Positive Garifuna Women from Honduras Seeking Asylum in the United States: Two Case Reports*, 56 J. FORENSIC & LEGAL MED. 94, 98 (2018).

369. *Id.* at 97–98.

370. Portillo Flores v. Garland, 3 F.4th 615, 629 (4th Cir. 2021).

371. Note that the medical community is not immune from bias and ableism. See Lisa I. Iezzoni et al., *Physicians' Perceptions of People with Disability and their Healthcare*, 40 HEALTH AFF.'S 297, 297 (2021).

372. See, e.g., Faour Abdallah Fraihat, et al. v. U.S. Immigration and Customs Enforcement, et al., Case No. 5:19-cv-01546-JGB-SHK (C.D. Cal. Apr. 20, 2020), ECF No. 132 (Civil Mins.—General).

ments related to “credibility,” “persecution,” “hardship,” “discretion,” and “substantial harm” in immigrant defense.

B. Remove Barriers to Increased Medical-Legal Collaboration for Better Outcomes for Courts, Legal Teams, and Immigrant Health

The results of the PHR-CUNY Study provide quantitative support for what access to counsel programs nationwide have previously asserted: that medical collaboration is key to any comprehensive legal support team. For example, Chief Judge Katzman’s foundational Study Group on Immigration Representation recognized that medical resources are central to adequately presenting claims for relief and supporting applications for permanent and temporary discretionary measures.³⁷³ Those who provide indigent services across substantive areas like housing, benefits, and public defense have also echoed the importance of medical-legal collaborations in representation.³⁷⁴ The integration of medical experts also brings a trauma-informed lens and expertise that can be beneficial to legal service providers who are vulnerable to vicarious or secondary trauma.³⁷⁵ Attorneys, policy makers, funders, and adjudicators alike should consider how to expand medical-legal collaboration when developing their own internal organizational policies, developing new access to justice models, and providing other court-funded services. On a local, state, and national level, policymakers should consider how to lessen various barriers to accessing forensic medical evaluations outlined below.

First, given their position in the immigration process as those seeking relief from deportation or other immigration benefits, it is likely that most who would benefit from forensic medical evaluations are undocumented or living with a temporary form of immigration status. Many immigrants in the United States are undocumented, and nearly half of these individuals are uninsured.³⁷⁶ Thus, even in cases in which a causal relationship between the trauma suffered and psychological and physical injuries incurred could be substantiated with a medical affidavit, these individuals have little access to healthcare in general, let alone a health professional who can identify and document these injuries for an immigration adjudicator. Although physicians may be caring for undocumented immigrant clients in community health clinics and emergency room settings, immigrants may not think to ask these providers for medical evaluations in support of their immigration cases, and providers may lack the capacity, training, or context to provide

373. *Accessing Justice II: A Model for Providing Counsel to New York Immigrants in Removal Proceedings*, 1, 11–12 N.Y. IMMIGRANT REPRESENTATION STUDY STEERING COMM. (2012) [hereinafter NYIRS II].

374. See, e.g., Diana Hernández, “*Extra Oomph: Addressing Housing Disparities through Medical Legal Partnership Interventions*,” 31 Hous. Stud., 871 (2016).

375. Lindsay M. Harris, *Learning in Baby Jail: Lessons from Law Student Engagement in Family Detention Centers*, 25 CLINICAL L. REV. 155, 206–07 (2018).

376. Samantha Artiga & Maria Diaz, *Health Coverage and Care of Undocumented Immigrants*, HENRY J. KAISER FAMILY FOUNDATION (2019).

the chronological, clinical, and substantive evaluations that immigration adjudicators often expect.³⁷⁷

Studies of effectiveness of T-Visa programs around the country, for example, found that a key external barrier to effective service provision for trafficking victims was access to health care.³⁷⁸ This research describes the barriers to receiving medical care including the shortage of “free” clinics and the fact that many clients were not eligible for free services in localities on account of their undocumented status.³⁷⁹ Not only does such a lack of access have a detrimental impact on an individual’s health, but it also impacts their ability to gain immigration relief.

Further, even for those with insurance and access, forensic medical evaluations almost always incur significant out-of-pocket costs, as they are neither diagnostic nor therapeutic, and outside the usual practice of clinical medicine. Medical professionals performing forensic evaluations have undergone supplemental training in the Protocol and best practices of affidavit writing.³⁸⁰ Thus, whether insured or not, the most likely pathway to obtaining a forensic medical evaluation is by securing a pro bono evaluation in coordination with a facilitating agency like PHR or other medical-school clinics and medical-legal collaborations offering such services in limited geographies.³⁸¹

Current reviews of medical-legal partnerships serving immigration populations document a largely ad-hoc network of medical human rights clinics with a single national organization, PHR, which responds to requests from attorneys to pair them with an evaluator.³⁸² In many cases, organizations like PHR serve as initial screeners, triaging limited resources to cases in which a forensic medical evaluation will have the greatest impact. In some limited situations, attorneys respond to physician referrals by sending potential applicants to legal clinics. A handful of clinics offer integrated medical and legal services from a single site.³⁸³ Significant knowledge gaps remain about what services small, non-profit medical clinics may be offer-

377. Wiebe & Brenes, *supra* note 114, at 11 (citing Matter of [name not provided], Petition for Immigrant Battered Spouse, EAC 07 095 50026, 2009 WL 3555574 (AAO, July 8, 2009)).

378. Deanna Davy, *Understanding the Support Needs of Human-Trafficking: A Review of Three Human-Trafficking Program Evaluations*, 1 J. HUM. TRAFFICKING 318 (2015).

379. *Id.*

380. Elizabeth Scruggs et al., “An Absolutely Necessary Piece”: A Qualitative Study of Legal Perspectives on Medical Affidavits in the Asylum Process, 44 J. FORENSIC & LEGAL MED. 72, 78 (2016).

381. Avery League et al., *A Systematic Review of Medical-Legal Partnerships Serving Immigrant Communities in the United States*. J IMMIGR. MINOR HEALTH. 163–74 (2021).

382. Due to the complexities and risks of integrating a forensic medical evaluation into a legal strategy without attorney supervision, PHR only accepts requests from attorneys or paralegals. Risks may include the chance of introducing inconsistencies in the narrative or prejudicial details. Further, operating with limited resources, organizations like PHR want to ensure that the medical affidavits will in fact be submitted in evidence. Based on author’s interview with Kathryn Hampton, Senior Asylum Officer, Physicians for Human Rights. Notes on file with author.

383. *Id.*

ing to immigrant populations.³⁸⁴ Even with the growth in medical school clinics, demand far outweighs the availability of trained professionals. For example, Physicians for Human Rights, the largest referral source for pro bono evaluations in the United States, has resources to arrange only about 700 evaluations per year, a small number compared to the tens of thousands of individuals who seek asylum annually.

Some, like those awaiting hearings in backlogged courts and USCIS Field Offices, have the benefit of time and can wait weeks and months for their forensic medical evaluations and the subsequent documentation from the forensic evaluator. PHR, for example, asks attorneys to request forensic medical evaluations at least eight weeks before the affidavit is required.³⁸⁵ For those who need evaluations within a shorter time frame, it is even more difficult to find an evaluation on an emergency basis. Through the increased use of immigration detention, the expansion of expedited removals, and “last in, first out” policies that adjudicate asylum claims in an expedited manner, many are forced to put together gargantuan evidentiary filings on short notice. As a result, a larger percentage of immigrants have less time to build their case and collaborate with experts like forensic medical evaluators.

Pro se litigants and those who are detained have even greater barriers to access forensic medical evaluations. Other barriers—such as lacking cultural competency, language differences, and access to medical care for those in detention facilities and rural areas—also contribute to difficulties in obtaining such evaluations. Further, as ICE detention centers have been sites of severe medical neglect, access to a forensic medical evaluation in this context may lead to access to much-needed medical oversight and care beyond supporting an application for relief.³⁸⁶ To the extent such evaluations may be essential to the successful outcome of the legal case, at times even central to establishing baseline eligibility, this lack of access could translate into foregoing immigration status.

Finally, there is abundant evidence describing the deficiencies of medical care for those in ICE custody. In one study of individuals detained in the New York City Metropolitan Area, the New York Lawyers for Public Interest (“NYLPI”) described “wide-ranging failures” to provide medical care to seriously ill immigrants who remain in detention. Practitioners in this study recommended advocates to recruit qualified doctors to provide outside evaluations of detainees’ health conditions and expand immigrant legal services funding to cover advocacy for the health conditions for de-

384. *Id.*

385. *Receive a Pro Bono Medical/Psychological Evaluation of Your Client*, PHYSICIANS FOR HUM. RTS., <https://phr.org/get-involved/participate/request-a-forensic-evaluation/> [https://perma.cc/RHM4-L6JE].

386. Ingrid Eagly et al., *Detaining Families: A Study of Asylum Adjudication in Family Detention*, 106 CALIF. L. REV. 785, 793 (2018).

tained people.³⁸⁷ Although forensic medical evaluations in the PHR-CUNY Study were not primarily focused on the health of the immigrant in detention (instead looking at past harms and future vulnerabilities), the results reinforce NYLPI and others' recommendations to expand health access in detention. PHR-CUNY data show that such access pays dividends in achieving positive case outcomes, which may lead to release from detention. Meanwhile, as discussed previously, such evaluations may have tangible benefits on the health and well-being of those being evaluated and facilitate recommendations and referrals for ongoing health needs.

C. Ensure Fairness and Consistency in the Way Forensic Medical Evaluations are Used in the Decision-Making Process

In response to the varied and haphazard approach to various harm-based assessments that is reflected in case law, scholarship, and this research, some scholars have proposed a “standard test” to ensure consistency across geographies, jurisdictions, and other factors.³⁸⁸ For example, in the SIJS context, some have called for a singular “best interests of the child definition.”³⁸⁹

In his study of persecution assessments in the asylum context, Professor Rempell also notes that courts require varying level of detail about the harm applicants experience.³⁹⁰ Where limited details are provided, adjudicators make differing inferences about the harm that was sustained.³⁹¹ For example, Rempell notes that in some cases, courts tie severity of harm to whether the applicant sought medical treatment, whereas in other cases, courts relied on other treatment-related markers (i.e., whether the applicant had to receive stitches).³⁹² The wide-ranging disparities require a reassessment of how to infuse greater consistency into persecution assessments.

In the U-Visa context, a national survey on types of criminal activity experienced by U-Visa recipients from 2008 to 2011 found that over 75% of the U-Visa cases filed nationally were based on the following categories: domestic violence, sexual assault, or human trafficking. As adjudicators begin to associate U-Visas with a certain type of harm (in this case, an emphasis on intimate partner violence), their understanding of what may qualify as “substantial abuse” may be skewed towards a certain context. Although “substantial abuse” in the context of intimate partner violence has been explored by scholars,³⁹³ some scholars have called for greater clarity in the

387. NEW YORK LAWYERS FOR THE PUBLIC INTEREST, *DETAINED AND DENIED: HEALTHCARE ACCESS IN IMMIGRATION DETENTION* 3 (2017).

388. Paznokas, *supra* note 176, at 451.

389. *Id.* at 452.

390. Rempell, *supra* note 23, at 199.

391. *Id.*

392. *Id.*

393. Eunice Hyunhye Cho et al., *supra* note 109; see also Leslye Orloff & Paige Feldman, *National Survey on Types of Criminal Activities Experienced by U-Visa Recipients*, LEGAL MOMENTUM (2019); Nawal H. Ammar et al., *Calls to Police and Police Response: A Case Study from Latina Immigrant Women in the U.S.*,

context of other crimes, including workplace-related crimes.³⁹⁴ In this vein, scholars and practitioners have noted differing standards for what constitutes “substantial harm” in the workplace setting as compared to domestic violence settings.³⁹⁵ These disparities have inspired a call for a social science-based framework to assist adjudicators in enforcing a uniform standard in the U-Visa context.³⁹⁶

With the ever-changing nature of both the harms that those seeking humanitarian relief have survived and the medical community’s ability to identify and document them, any further codification in the above described areas must be informed by research across medical, social-science, historical, and legal disciplines in understanding the many forms trauma and resilience take.³⁹⁷

These disparities have many implications for health care professionals offering forensic medical evaluations in support of those seeking humanitarian relief. For example, if courts seem to look to stitches as a measure of severity when making persecution determinations, should health care professionals note why stitches were not needed for an equally severe laceration that was healed using alternative methods? Further, where a patient was not able to access healthcare after surviving harms, are their injuries assumed not to rise to the level of persecution because they did not solicit medical care? This lack of clear guidance about what constitutes persecution can muddy efforts at the forensic evaluation level and make it difficult to create clear training rubrics for evaluators providing assessments. Phase II of the PHR-CUNY Study will review a sampling of the associated forensic medical evaluations that appear in the PHR dataset to take a deeper look at how format, substance, and other qualities of the affidavit may impact adjudicators.

CONCLUSION

Whether it is measuring credibility, hardship, substantial harm, persecution, or painting a larger picture for adjudicators who often make discretionary decisions, the need for forensic medical expertise in immigrant defense have proven vital. Immigrants in the PHR-CUNY Study had positive outcomes at a significantly higher rate even when compared to other

7 J. INT’L POLICE SCI. & MGMT. 230 (2005); Mangai Natarajan, *Domestic Violence among Immigrants from India: What We Need to Know—and What We Should Do*, 26 INT’L J. COMP. & APPL. CRIM. JUSTICE 301 (2003); Leslye Orloff et al., *Battered Immigrant Women’s Willingness to Call for Help and Police Response*, 13 UCLA WOMEN’S L.J. 43 (2003); Anita Raj et al., *Immigration Policies Increase South Asian Immigrant Women’s Vulnerability to Intimate Partner Violence*, 60 J. AM. MED. WOMEN’S ASS’N 26 (2005).

394. Eunice Hyunhye Cho et al., *supra* note 109, at 2.

395. *Id.* at 11.

396. *Id.* at 5.

397. See generally Raquel Aldana et al., *Trauma as Inclusion*, 89 Tenn. L. Rev. 4 (2022) (employing a cross-disciplinary framework to document and assess immigration law’s understanding of trauma).

similarly situated immigrants who were represented by counsel and not detained. Although these results may be due to a mixture of factors related to the population who receive these evaluations alongside the evaluation itself, increased medical-legal collaborations in client representation have helped defense teams expand legal arguments and corroborate and develop client testimony. Importantly, such a collaborative approach facilitates a holistic legal services model, which recognizes that many in immigration proceedings face interlacing challenges of policing, access to health and education, public benefits, housing, and much more.

On the one hand, these findings indicate that forensic medical evaluators can powerfully influence judicial decision-making and help adjudicators and attorneys identify novel claims regarding hardship. In this manner, increased collaboration between medical providers and lawyers can lead to actionable strategies and strengthen critical legal arguments related to “persecution,” “hardship,” “discretion,” and “substantial harm” in immigrant defense. Increased access to forensic medical evaluations and their increased use in courts and USCIS offices could increase adjudicator awareness, lead to the development of favorable case law and policies, and draw attention to specific harms immigrants seeking humanitarian relief have survived. Such benefits expand beyond the individual receiving the evaluation alone and create a positive ripple effect for all pursuing immigration relief with a component of harm-assessment.

But the outsized impact of forensic medical evaluations also raises questions about whether adjudicators are holding immigrants to unrealistic evidentiary standards, constructively creating norms which require immigrants with temporary or no immigration status to gain access to health professionals with the requisite training, competencies, and capacity to evaluate them. Thus, even where immigrants may be able to corroborate their psychological and physical injuries with a medical affidavit, many lack access to a health professional who can identify, much less document, these injuries for an immigration adjudicator. To the extent such evaluations may be essential to the successful outcome of the legal case, lack of access to a medical professional may translate into lack of access to justice.

APPENDIX A: SUMMARY OF PHR-CUNY STUDY OUTCOMES³⁹⁸

Case outcomes definitions (n = 2584).

Positive Outcome	n	%
Granted Asylum	1555	73.7
Granted Relief (unspecified)	233	11.0
Termination of Proceedings	80	3.8
Granted Withholding of Removal	60	2.8
Granted VAWA	43	2.0
Granted U-Visa	33	1.6
Granted Voluntary Departure	29	1.4
Granted T-Visa	21	1.0
Granted Cancellation of Removal	19	0.9
Granted CAT	19	0.9
Granted SIJS	12	0.6
Released from Detention	3	0.1
Adjustment of Status	2	0.1
Total	2109	100
<hr/>		
Negative Outcome	n	%
Asylum Denied	180	57.5
Ordered Deported	115	36.7
Relief Denied	11	3.5
Application Denied (no deportation order)	7	2.2
Total	313	100
<hr/>		
Other Outcome	n	%
Administrative Closure	156	96.3
Other	6	3.7
Total	162	100

398. Reproduced, with permission, from the PHR-CUNY Study. Atkinson et al., *supra* note 5, at 5 (Table 1).