

Research Paper

Impact of forensic medical evaluations on immigration relief grant rates and correlates of outcomes in the United States

Holly G. Atkinson^{a,*}, Katarzyna Wyka^b, Kathryn Hampton^c, Christian L. Seno^d, Elizabeth T. Yim^e, Deborah Ottenheimer^f, Nermeen S. Arastu^g

^a CUNY School of Medicine, 160 Convent Avenue, Harris Hall, Suite 113, New York, NY, 10031, USA

^b Epidemiology and Biostatistics, CUNY Graduate School of Public Health and Health Policy, 55 W. 125th Street, Room 805, New York, NY, 10027, USA

^c Physicians for Human Rights, 256 W. 38th St., Ninth Floor, New York, NY, 10018, USA

^d Managing Editor, CUNY Law Review, CUNY School of Law, Two Court Square, Long Island City, NY, 11101, USA

^e CUNY School of Medicine, 160 Convent Avenue, Harris Hall, Suite 113, New York, NY, 10031, USA

^f Women's Health Services, Gotham Health, Morrisania, 1225 Gerard Avenue, 3rd Floor, Bronx, NY, 10452, USA

^g Immigrant & Non-Citizen Rights Clinic, CUNY School of Law, Two Court Square, Long Island City, NY, 11101-4356, USA



ARTICLE INFO

Keywords:

Asylum
Forensic medical evaluation
Refugee health
Torture
Trauma
Immigration policy

ABSTRACT

The purpose of this study was to investigate the impact of forensic medical evaluations on grant rates for applicants seeking immigration relief in the United States (U.S.) and to identify significant correlates of grant success. We conducted a retrospective analysis of 2584 cases initiated by Physicians for Human Rights between 2008 and 2018 that included forensic medical evaluations, and found that 81.6% of applicants for various forms of immigration relief were granted relief, as compared to the national asylum grant rate of 42.4%. Among the study's cohort, the majority (73.7%) of positive outcomes were grants of asylum. A multivariable regression analysis revealed that age, continent of origin, history of sexual or gender-based violence, gang violence, LGB sexual orientation, and being detained by the U.S. government at the time of evaluation request were statistically associated with case outcomes. Forensic physical evaluation was more strongly associated with a positive outcome than forensic psychological evaluation. Our findings strengthen and expand prior evidence that forensic medical evaluations can have a substantial positive impact on an applicant's immigration relief claim. Given the growing applicant pool in the U.S., there is an urgent need for more trained clinicians to conduct forensic medical evaluations as well as to educate adjudicators, immigration lawyers, and policy makers about the traumatic nature of the life-altering events that applicants for immigration relief experience.

1. Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), by the end of 2020, an estimated 82.4 million people were forceable displaced worldwide—a record high—due to persecution, conflict, violence, human rights violations, or events that seriously disturbed the public order. Of these, about 48.0 million were internally displaced persons, 26.4 million were refugees, 4.1 million were asylum-seekers, and 3.9 million were Venezuelans displaced abroad.¹ Regarding the asylum-seekers, in 2020, they formally submitted 1.1 million new claims (down substantially from the 2 million new claims the year before because of the COVID-19 pandemic). The United States (U.S.) was the

world's leading recipient of new individual applications, receiving ~250,800 of them, followed by Germany (~102,600), Spain (~88,800), France (~87,700) and Peru (~52,600).² In fiscal year 2019 (the latest data), the U.S. granted asylum status to 46,508 individuals either affirmatively (27,643 people, 59%) or defensively (18,865 people, 41%).³ Since 2010, more than 275,000 asylum seekers have been granted asylum by the U.S. government.⁴

Under U.S. law, those seeking asylum in the United States must prove that they are unable or unwilling to return to their home country because of a "well-founded fear of persecution" on account of their race, religion, nationality, political group, or membership in a social group. Those applying for this status from outside the United States are

* Corresponding author.

E-mail addresses: hatkinson@med.cuny.edu (H.G. Atkinson), kwyka@sph.cuny.edu (K. Wyka), khampton@phr.org (K. Hampton), christian.seno@live.law.cuny.edu (C.L. Seno), eyim000@citymail.cuny.edu (E.T. Yim), deb@ottenheimerhealth.com (D. Ottenheimer), nermeen.arastu@law.cuny.edu (N.S. Arastu).

<https://doi.org/10.1016/j.jflm.2021.102272>

Received 11 August 2021; Received in revised form 16 October 2021; Accepted 25 October 2021

Available online 28 October 2021

1752-928X/© 2021 The Authors.

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screened by the UNHCR, U.S. Department of State and United States Citizenship and Immigration Services (USCIS) and, if granted status, enter the United States as “refugees.” Those seeking this status at the U.S. border or after entry into the United States enter either an affirmative or defensive asylum process. Where individuals have not yet been placed in removal proceedings, their cases are first adjudicated affirmatively by USCIS through a non-adversarial asylum interview. If asylum is denied at this juncture, the individual is referred to the Department of Justice’s Executive Office of Immigration Review (EOIR) where an immigration judge decides if they are eligible for asylum, statutory withholding of removal, protection under regulations implementing the “Convention Against Torture (CAT),” or other forms of relief as a “defense” to deportation. If an individual does not request asylum upon entering the U.S. and remains in the U.S. without status (e.g., enters “without inspection” or overstays a student or tourist visa), ICE may initiate removal proceedings against them and/or detain them. These individuals enter directly into a defensive adversarial asylum process. Through either process, affirmative or defensive, those who are granted asylum or enter the U.S. as refugees have undergone a multi-stage and lengthy screening process (see Fig. 1).

Many asylum seekers can offer only their personal testimony to substantiate their claims as they have fled their home countries fearing for their lives with little documentation in their hands. Though lacking court-appointed access to counsel, many applicants have not only sought out assistance from immigration attorneys to state their claims, but, over the previous 30 plus years, have also increasingly turned to clinicians acting in the capacity of forensic medical evaluators to document the physical and/or psychological sequelae of the various forms of harm they have suffered.³ Since 1986, Physicians for Human Rights (PHR), a Nobel Peace Prize-winning, non-governmental human rights organization, has utilized the tools of medicine and science to document severe human rights violations around the world and mobilized the uniquely credible voices of medical professionals to raise awareness and work for change. In particular, PHR’s Asylum Network, launched in 1989, is a nationwide initiative comprised of clinicians—physicians, psychologists, physician assistants, nurse practitioners, and social workers—who provide *pro bono* forensic medical evaluations for asylum seekers and advocate for human rights-based immigration policies. Immigration attorneys reach out to PHR to request forensic medical evaluations for their clients and PHR in turn reaches out to its Asylum Network to place cases with its volunteer clinician evaluators. Clinicians are trained to perform evaluations based on the Istanbul Protocol, a United Nations document that outlines international legal standards and sets out specific guidelines on how to conduct effective medical investigations into allegations of torture and ill treatment.⁶

Currently, the PHR Asylum Network comprises more than 2000 health professionals who conduct forensic medical evaluations to document evidence of torture, ill treatment, and/or abuse. Clinicians prepare affidavits that detail the applicant’s history of harm and any pertinent previous medical and/or psychological history; record evidence of physical findings and psychological sequelae of the harm; and comment on the degree of consistency between the clinical findings and the applicant’s narrative of abuse. In some situations, affidavits address the specialized medical or mental health treatment that a survivor may need to recover and maintain full functioning, as well as the adverse effects on the symptom burden of the applicant if returned to a country where they face a constant threat of harm and/or cannot access adequate medical treatment. These affidavits are useful in the legal process as they provide adjudicators with additional facts and evidence on which to base their decisions, often informing the adjudicator’s notion of the applicant’s credibility and influencing how they should exercise their discretion to grant relief.

In 2007, Lustig and colleagues published a seminal paper showing the significant difference in asylum grant rates between U.S. asylum seekers who received forensic medical evaluations compared to those applicants who did not undergo a forensic medical evaluation.⁵ The

Lustig study evaluated PHR data from 2000 to 2004 and found that 89% of cases in which asylum seekers received an evaluation from a clinician resulted in a grant of asylum, compared to the national average of 37.5% over the same four-year period. Lustig derived this national average from two sources: the average for affirmative cases (37.2%) adjudicated through USCIS and the average for defensive cases (37.9%) adjudicated through EOIR. (It should be noted that government reported averages are based on *all cases*, which includes cases with and without forensic medical evaluations, although the proportion of applicants for immigration relief who receive forensic medical evaluations is very small.) Even when accounting for representation and other qualities of the data set, medical evaluations made a difference in a considerable number of cases.^{7,8}

Since the publication of Lustig et al.’s findings, there have been three different administrations and, consequently, changes in immigration policies, practices, and grant rates. According to the Transactional Records Access Clearinghouse (TRAC) Immigration Project, over the years spanning 2008–2018 (the period of this study), the total number of asylum cases¹ completed by immigration judges was 262,877, with an average asylum grant rate of 45.6%, asylum denial rate of 52.4%, and ‘other relief’ granted rate of 2%.⁹ (Those who received ‘other relief’ were denied asylum but allowed to legally remain in the U.S. through an alternative form of temporary or permanent relief (i.e., withholding of removal, CAT). Over this period, positive outcomes for asylum claims ranged from a low of 33.7% (42,268 total cases, with 14,233 granted asylum) in 2018 to a high of 55.6% (21,535 total cases, with 11,962 granted asylum) in 2012. It should be noted that the TRAC data only capture asylum cases that are adjudicated before immigration judges within the EOIR, and *do not* include asylum applications that are initially submitted and approved through USCIS. Cases (which may include more than one individual, i.e., an applicant and a spouse and/or children) before USCIS were granted affirmatively at an estimated national average grant rate of 39.1% over the period from 2009–2018,² ranging from 28% to 46%.^{10,11} 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%.

In this paper, we aim to update and broaden the scope of Lustig et al.’s findings, using 11 years of recent data from PHR’s Asylum Network. In cooperation with PHR, our investigation was a cross-disciplinary collaboration between the CUNY School of Medicine, CUNY School of Law, and CUNY School of Public Health: our multi-disciplinary team included experienced physicians, immigration attorneys, a biostatistician, and medical and law students. Our primary study objective was to determine the utility of medical evaluations and their impact on adjudication outcomes of asylum claims and other forms of

¹ As noted for the Lustig study averages, this figure, the total number of asylum cases over the 11-year period, includes cases with and without forensic medical evaluations. Government statistics are not available from either USCIS or EOIR as to the proportion of cases in their figures that included a forensic medical evaluation, however, the proportion is very small. Physicians for Human Rights, the organization that likely arranges for the largest number of forensic medical evaluations across the country for applicants seeking some form of immigration relief, had completed over the 11-year period of our study a total of 4464 evaluations. This is only 1.7% of the over one-quarter of a million asylum cases completed just by judges in EOIR during the same period.

² Sufficient USCIS data are not publicly available for 2008 to discern the positive grant rate for that year, therefore the period from 2009 to 2018 was used to determine the USCIS average asylum grant rate as the best estimate for the period of the study.

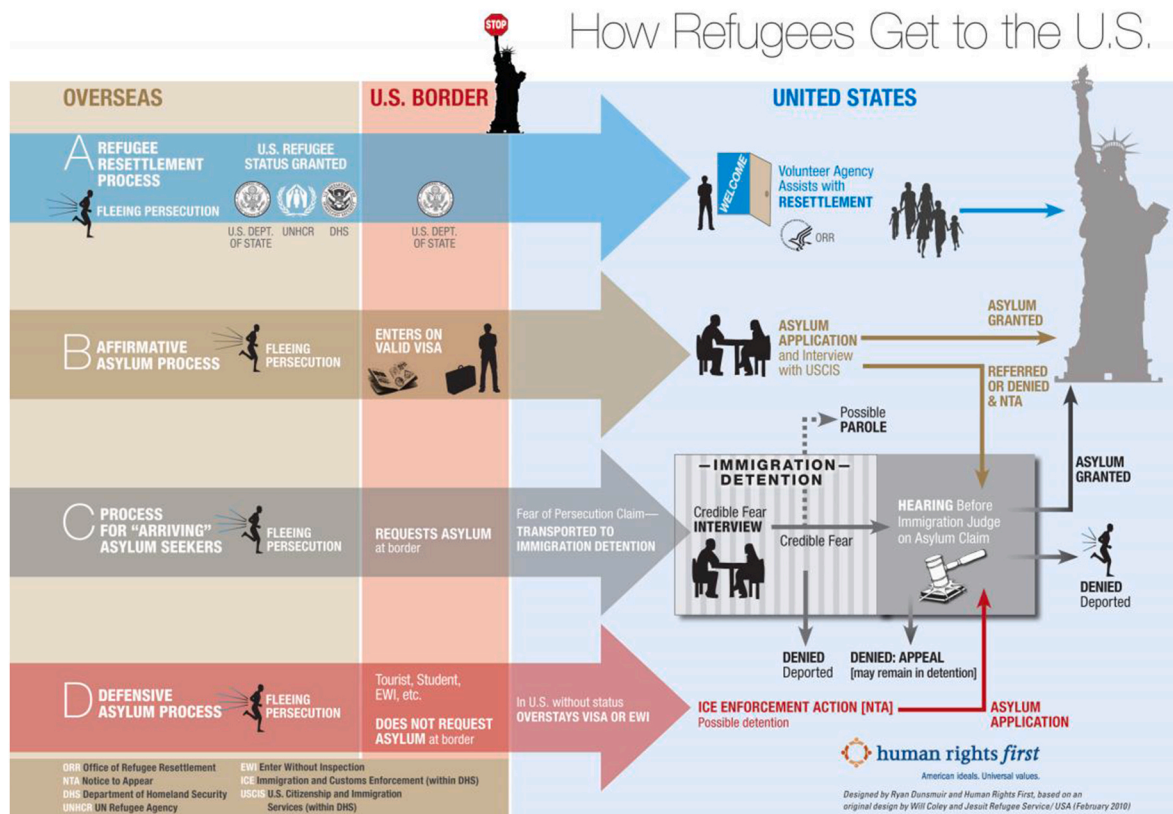


Fig. 1. Figure 1 shows an overview of the United States asylum process: A) represents the process of how refugees are resettled; B) represents the affirmative asylum process for those fleeing persecution who enter the U.S. on a valid visa; C) represents the potential process for asylum seekers who declare themselves at the U.S. border (note, as of publication, this process has been disrupted by government policies preventing asylum-seekers from applying for asylum at the border, i.e., Migrant Protection Protocols and Title 42); and D) represents the defensive asylum process for those fleeing persecution who are in the US without any legal status.

immigration relief by comparing the success rate among applicants receiving medical evaluations to the overall national asylum grant rate.³ Our secondary study objective was to determine which individual demographic and case characteristics were correlated with successful outcomes among applicants with forensic medical evaluations. Furthermore, in a sub-analysis of cases for which we had the accompanying medical affidavit and thus were able to determine the type of forensic medical evaluation conducted, we sought to assess the relative impact of psychological evaluation compared to physical evaluation on success rates. With our findings, we hope to inspire further interdisciplinary collaborations to strengthen legal arguments, educate adjudicators, support legal defense teams, and most importantly, provide trauma-informed support and care to asylum seekers and other immigrants seeking relief.

2. Methods

2.1. Study design and case selection

This study was a retrospective analysis of cases that PHR accepted between 1/2008 and 12/2018 for which it had received requests for forensic medical evaluations to be conducted by its Asylum Network clinicians to support applicants' claims for various forms of immigration relief. The research protocol was reviewed and approved by the Institutional Review Board, City College of New York. Criteria for inclusion

³ As a previous footnote explained, these national figures include all cases, both the very small minority of those for which a forensic medical evaluation was conducted and for the majority of those that did not have a forensic medical evaluation.

of a case in our analysis were: 1) the forensic medical evaluation was completed; 2) the resultant medical evaluator's affidavit was included in the applicant's application for immigration relief; and 3) the outcome of the adjudicated case was known by PHR. The total number of cases initiated by PHR during the 11-year study period was 5867 (see Fig. 2). Of the 5867 initiated cases, 2584 (44%) met the inclusion criteria.

A total of 3283 (56%) of the 5867 cases did not meet the inclusion criteria: 1310 cases were excluded because although the cases were initially taken on by PHR, the medical evaluations did not occur because the attorney, client, or clinician failed to schedule, attend, or complete the evaluation; the attorney found an evaluation elsewhere or withdrew the request; or the case was not placed with a volunteer clinician due to lack of PHR capacity in the area. Another 93 cases were excluded because, although the medical evaluation took place, the applicant's application was not filed or the evaluation was not used in the case. Another 1094 cases were excluded because the case outcome was unknown: although the forensic medical evaluation took place, PHR was not able to track the outcome because the attorney was not reachable, the attorney no longer represented the client, or the client could not be reached. In the remaining 786 cases, the final decisions by U.S. immigration officials are still pending.

2.2. Data collection

The data used to investigate the primary study objective was collected from the attorneys representing applicants seeking immigration relief at the time they referred the case to PHR. Only the sub-analysis of the association between the type of affidavit and case outcome used information gleaned from affidavits.

PHR collects data from the attorneys who are seeking a forensic medical evaluation for their clients and houses the data in a password-

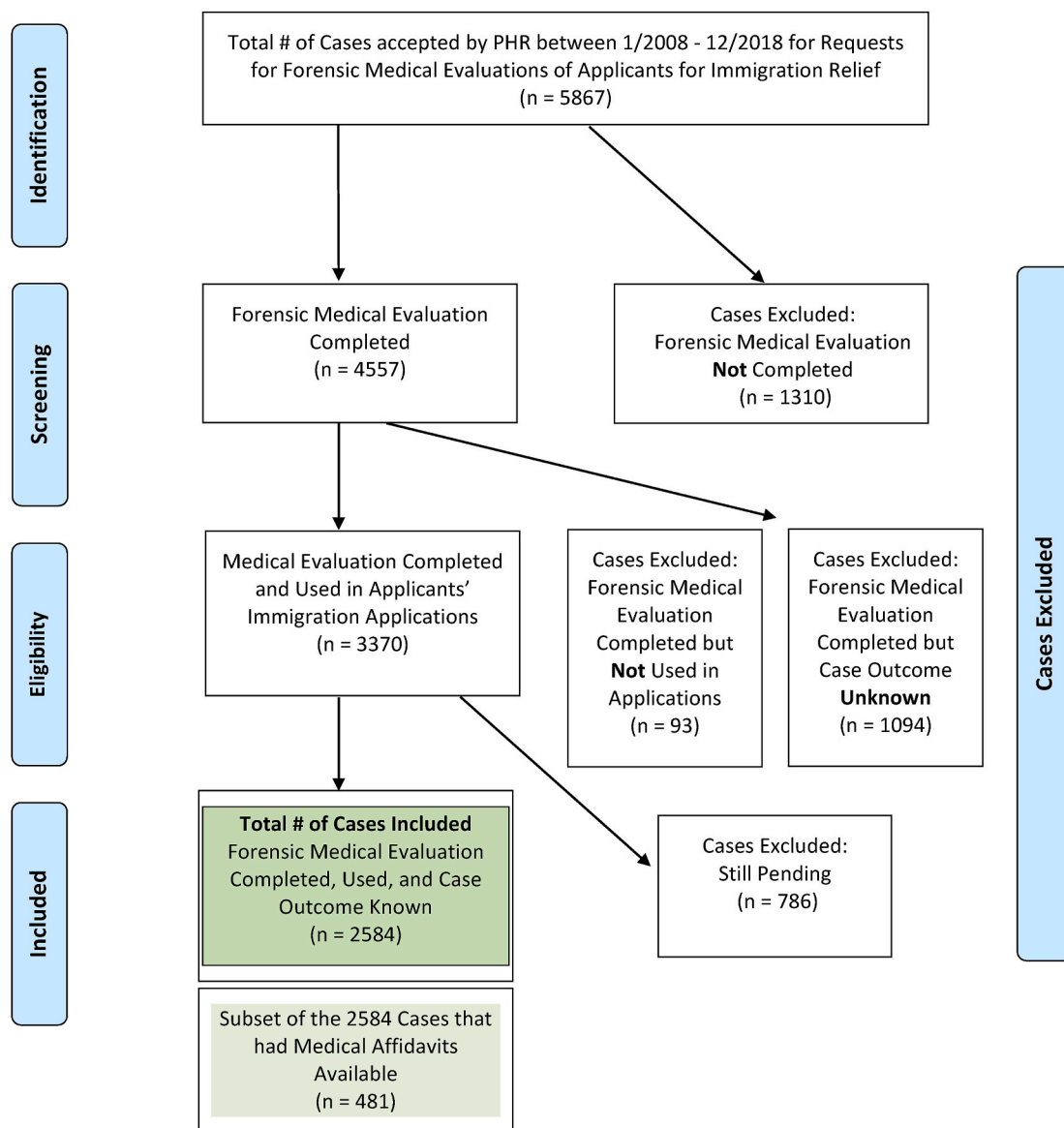


Fig. 2. Case selection.

protected, limited-access database. Attorneys complete a form that collects standardized information regarding the client’s demographic characteristics (e.g., age, sex, country of origin, language spoken) and information about the type of case (e.g., form of immigration relief being applied for, protected grounds, asylum reason(s), whether currently detained, hearing date, whether testimony by the evaluator is requested by the attorney). PHR’s form asks attorneys to verify client consent for PHR to use de-identified and aggregated data for the purposes of research and advocacy.

PHR staff follow up with attorneys by email for up to five years after the final hearing or interview date to obtain information regarding case outcome, and systematically log the results into the database. PHR’s case outcome process prompts the attorney to indicate specific consent for PHR to use the case outcome data. In cases where PHR has the client’s alien registration number, PHR staff also check for defensive case outcomes through the EOIR website or hotline if the attorney does not reply. PHR outcomes are measured primarily by whether: relief/applications were granted or denied; the case was terminated or administratively closed; and/or whether an individual was ordered deported. If outcomes cannot be obtained, the reasons why are recorded. PHR staff also ask the attorneys and forensic medical evaluators to provide

redacted copies of the expert medical affidavits whenever possible.

The research team exported the standardized attorney-reported data collected over the 11-year period from the PHR database into an Excel spreadsheet, which had a structured coding system built into it. No data regarding characteristics of the client, the legal case, or the case outcome were extracted from affidavits associated with the cases. The research team only accessed the medical affidavits to confirm the type of medical evaluation conducted for the associated case (see *Independent variables* below).

2.3. Outcome variable

The primary outcome of interest was case outcome. Each case in our study had one outcome associated with it, as reported by the applicant’s attorney through the process described above. Attorneys typically reported at the end of the process, and thus case outcomes do include some subsequent reversals in referred or appealed cases (e.g., cases that may have started out as affirmative cases before USCIS but then became defensive cases before EOIR).

The original variable comprised 19 categories, which were combined into a 3-level case outcome variable: ‘positive’ outcome, ‘negative’

outcome, and 'other' outcome (see Table 1). Positive outcome 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), released from U.S. detention, adjustment of status and termination of proceedings. Negative outcome included asylum denied, ordered deported, relief denied and application denied (no deportation order). Other outcome included administrative closure and other.

2.4. Independent variables

Individual demographic characteristics reported by attorneys via the PHR standardized form included age (in years), sex (female, male), continent of origin (135 countries categorized into regions: South America, Africa, Asia, Europe and Oceania) and primary language (59 languages categorized into English, Spanish, French and Other. All languages characterized as other had a prevalence of <1.6%).

Case characteristics reported by attorneys via the PHR standardized form included 1) asylum case basis, categorized into sexual/gender-based violence (SGBV) (violence against women (VAW), sexual violence, domestic violence, female genital cutting, one child policy), trafficking, kidnapping, gang violence, slavery, sensory deprivation, foreign detention,⁴ lesbian/gay/bisexual (LGB⁵), transgender, and other; 2) protected grounds reasons (race, religion, nationality, political opinion, membership in a particular social group); 3) subject to torture

Table 1
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
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
Other Outcome	n	%
Administrative Closure	156	96.3
Other	6	3.7
Total	162	100

⁴ Foreign detention refers to the asylum-seeker having been detained in the country in which they were persecuted, from where they were seeking asylum.

⁵ The term Lesbian/Gay/Bisexual (LGB) is used in this study, as it draws on PHR historical data. In the past, the PHR intake form separated applicants pursuing persecution claims related to sexual orientation (LGB) from those pursuing claims related to gender identity, transgender (T). The form has since been updated to group all sexual orientation and gender identity (SOGI) related claims together as LGBT, however the term LGB as a separate term from transgender in this paper reflects the historical version of PHR's form that was used during the period of study.

(yes, no); 4) currently in a U.S. detention center (yes, no); 5) whether evaluation was sought elsewhere (yes, no); 6) whether testimony was requested (yes, no); 7) whether telephonic testimony was allowed (yes, no); and 8) evaluator gender preference (female, male, no preference). Asylum case and protected ground reasons were also considered with respect to the number of protected grounds alleged (1, 2, 3+ reasons). The circuit court was categorized based on the state in which the case was adjudicated, and further analyzed by region: Mid-Atlantic and South (Fourth, Fifth, Eleventh, and DC Circuits), North-Central and South-West (Eighth and Tenth Circuits), Mid-West (Sixth and Seventh Circuits), West-Coast (Ninth Circuit) and Northeast plus Caribbean (First, Second and Third Circuits).

Type of forensic medical evaluation was gleaned from affidavits that accompanied a subset of cases (n = 481, 18.6% of 2584). All of these affidavits were for cases that originated in Africa and South America; affidavits (n = 90) for cases from Europe, Asia, and Oceania were not considered due to insufficient sample sizes for the analysis. Each medical affidavit is routinely type-labeled as physical, psychological, and/or gynecologic by PHR staff when it is obtained from either the applicant's attorney or forensic medical evaluator and entered in the database. Some of the 481 cases had more than one affidavit associated with it, for example, 29 cases (6%) had affidavits for both a physical and psychological evaluation. A member of our research team examined each of the available affidavits to verify the type was correct. Type was determined based on the purpose of the evaluation, which PHR stipulates in its original request for evaluation to the forensic medical evaluator, and on the overall content of the affidavit, e.g., recorded findings by the evaluator of a physical, psychological, and/or gynecological evaluation. For our sub-analysis, we had a total of 505 affidavits for the 481 cases; 349 were psychological evaluations and 156 were physical evaluations. Gynecologic evaluations as a type were ultimately not considered in this study due to extremely rare occurrence (n = 8). Cases with available affidavits and without available affidavits were similar in terms of case outcomes, and individual and cases characteristics (standardized difference in proportions <0.20) (see Supplemental Table 1).

2.5. Analytic approach

Descriptive statistics were used to summarize the data (2008–2018). The success rate among applicants receiving medical evaluations was compared to the national asylum grant rate of 42.4% during the same period using a chi-squared test.

Multivariable multinomial regressions were used to assess which individual demographic and case characteristics were correlated with successful case outcomes (positive outcome and 'other' outcomes). Negative case outcome was set as a comparison category. Independent variables included individual and case characteristics associated with case outcomes in bivariate analyses (p < .05).

In a sub-analysis of the study, we determined the relative impact of the type of forensic medical evaluation on case outcomes among applicants with available affidavits. (Note: We did not retrieve any data from within the affidavits themselves, for example, data regarding mental health diagnoses, such as major depression, generalized anxiety disorder, or post-traumatic stress disorder, to determine their impact on case outcomes.) Because there were so few gynecological evaluations, the affidavit sub-analysis compared only psychological to physical evaluations. Independent variables included type of forensic medical evaluation (physical, psychological) and all other variables associated with case outcomes.

IBM SPSS Statistics for Windows, version 25.0 was used to perform the statistical analyses.

3. Results

3.1. Individual and case characteristics

Table 2 shows case outcomes as well as individual and case characteristics for this cohort of applicants ($n = 2584$) receiving forensic medical evaluations. Applicants were equally frequently females and males (51.7% and 48.3%, respectively) with a mean age of 30.76 years ($SD = 11.49$). Continent of origin was South America (48.2%), Africa (35.7%), Asia (12.8%), Europe (2.2%) and Oceania (1.2%). Spoken languages included English (38.2%), Spanish (38.5%), French (8%) and Other (15.3%). Most common asylum reasons were SGBV (58.7%), gang violence (21.8%), foreign detention (17.7%) and LGB (14.4%). Most common protected grounds were membership in a particular social group (78.2%) and political opinion (43.2%). Two-thirds of cases indicated one reason for asylum and protected ground. Torture was indicated in 43.1% of cases, and 7.7% of applicants were detained by the U.S. Government at the time of the evaluation request. An evaluation outside of PHR was also sought in 14.4% of cases. Testimony by the evaluator was requested in 46.2% of cases, and telephonic testimony by the evaluator was allowed in 18.5% of cases (there is no data on how often such a request for testimony was made). Evaluator gender preference was as follows: no preference (63.4%), female (31.5%), and male (5.2%). The majority of cases (59.5%) were adjudicated in the Northeast (First, Second, and Third Circuits (which includes Puerto Rico)) and almost a quarter (24.6%) were adjudicated in the Mid-Atlantic and South (Fourth, Fifth, Eleventh, and DC Circuits). Circuits in the North-Central and South-West regions (Eight and Tenth Circuits) had the smallest percentage of cases (1.2% combined).

3.2. Immigration relief grant rates

From 2008 to 2018, 81.6% ($n = 2109$) of case outcomes were positive, 12.1% ($n = 313$) were negative and 6.3% ($n = 162$) were adjudicated as 'other' outcomes. This rate of positive case outcomes differed significantly ($p < .001$) from the national asylum grant rate of 42.4%. Of the 2584 applicants, 67.1% ($n = 1735$) had a known adjudicated asylum claim, and of this group, 89.6% ($n = 1555$) were granted asylum, a significant difference from the national asylum grant rate of 42.4%. Asylum grants made up the largest bulk (76.6%) of positive outcomes in our cohort.

3.3. Correlates of case outcomes

In bivariate analyses, individual demographic characteristics associated with the case outcome were age, gender, primary language and continent of origin. Case characteristics associated with the case outcome (either positive or negative) were asylum reason of SGBV, gang violence, foreign detention, and LGB; being in a U.S. detention center at the time of evaluation request; and requesting testimony from medical evaluator ($p < .05$) (see Table 2).

In multivariable analyses, age, continent of origin, SGBV, gang violence, LGB, and being in a U.S. detention center at the time of evaluation request remained statistically significant correlates of case outcomes. Specifically, compared to negative outcome, younger age was associated with positive outcome ($aOR = 0.97$, 95%CI[0.96-0.98]) and 'other' outcome ($aOR = 0.96$, 95%CI[0.94-0.98]). Positive outcome was more likely among Africans ($aOR = 1.96$, 95%CI[1.13-3.40]), compared to South Americans. SGBV was associated with positive outcome ($aOR = 1.80$, 95%CI[1.22-2.66]) but this association, while in the same direction, was not statistically significant for 'other' outcome ($aOR = 1.47$, 95%CI[0.80-2.70]). Lesbian/Gay/Bisexual was associated with positive outcome ($aOR = 2.11$, 95%CI[1.26-3.52]), however 'other' outcome was less likely ($aOR = 0.33$, 95%CI[0.10-1.06]). Finally, fleeing gang violence and being detained in the U.S. were associated with decreased odds of positive outcome ($aOR = 0.54$, 95%CI[0.37-0.78]) and ($aOR =$

0.48, 95%CI[0.30-0.77]), respectively). Being in a U.S. detention center at the time of the evaluation request also decreased odds of 'other' outcome ($aOR = 0.13$, 95%CI[0.03-0.54]) (see Table 3).

Among the 481 cases with 505 affidavits, physical and psychological evaluations were conducted in 32.4% and 72.6% of cases, respectively. 87.8% of cases with physical evaluation had a positive outcome, compared to 79.7% without physical evaluation, while 80.8% of cases with psychological evaluation had a positive outcome, compared to 86.4% without psychological evaluation (where they only received a physical evaluation). In multivariable analyses, physical evaluation was associated with positive outcome ($aOR = 7.04$, 95%CI[1.12-44.40]), and psychological evaluation was marginally associated with positive outcome ($aOR = 4.91$, 95%CI[0.78-30.84]). A similar trend was present for 'other' outcome, however the association was not statistically significant ($aOR = 3.08$, 95%CI[0.31-31.16]) and ($aOR = 2.87$, 95%CI[0.27-30.11]), respectively) (see Supplemental Table 1).

4. Discussion

4.1. Interpretation of findings

The purpose of our investigation was to determine grant rates and evaluate correlates of grant status among applicants seeking various forms of immigrant relief who underwent forensic medical (physical and/or psychological) evaluations. Overall, we found that of the 2584 applicants who received forensic medical evaluations through PHR between 2008 and 2018, 81.6% of applicants' cases resulted in positive outcomes, compared to the national asylum grant rate of 42.4% during the studied period. The majority of positive outcomes were asylum grants (1555 applicants) compared to other forms of immigration relief (see Table 1). Our sample size of 2584 cases allowed us to conduct a multivariable regression analysis, which revealed that age, continent of origin, fleeing from SGBV, gang violence, and LGB-based persecution, and being detained in the U.S. at the time of the evaluation request were statistically significant correlates of case outcomes.

Younger age was associated with a positive or 'other' outcome versus a negative outcome. Why this is the case is not clear, however, several factors may play a role: immigration officials may be more sympathetic to younger victims of persecution or respond differently to the various harms that younger individuals may experience. Among our cohort, for example, younger age was associated with SGBV as a reason for asylum ($M = 29.17$ ($SD = 11.08$) vs. 31.19 ($SD = 11.27$), $p < .05$) and SGBV was a positive factor for being granted relief. Officials may also perceive younger individuals to be potentially more productive members of society and more employable in the labor market and thus not as great a potential burden on the state as older individuals; or they may recognize children as especially vulnerable to harms that rise to the level of persecution, as well as being entitled to certain procedural protections as minors.

Regarding continent of origin, in our study, a positive outcome was more likely among Africans compared to South Americans. At the surface, this finding contrasts with what is well documented: that black asylum seekers and immigrants face unique challenges due to systemic racism in the U.S. immigration system.^{12,13} These include higher denial rates (during a similar period, 2012-2017, of our study) of applicants from certain countries, such as Haiti and Somalia; higher rates of arrest and detention, which decreases the likelihood of securing counsel and forensic medical evaluations; and higher rates of deportation, which essentially foreclose the possibility of applying for immigration relief in the first place.^{14,15,16} Yet implicitly, our findings reflect how adjudicators do not find black asylum seekers credible unless they obtain hard-to-get supporting documentation like forensic medical evaluations to corroborate their narratives. For those African asylum seekers in our data set, all of whom were able to get access to forensic evaluations, their grant rates went up exponentially, underscoring the egregiousness of the harms they faced that would otherwise likely have been discounted and

Table 2
Individual and case characteristics and case outcomes (n = 2584).

	Total		Positive outcome		Negative outcome		Other outcome		p-val ^a
	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	
Age	2503	30.76 (11.49)	2046	30.82 (11.37)	299	32.41 (10.83)	158	26.84 (13.26)	<.001
	n	%	n	%	n	%	n	%	p-val ^b
Gender									
Female	1333	51.7	1106	83.0	140	10.5	87	6.5	0.030
Male	1245	48.3	997	80.1	173	13.9	75	6.0	
Primary language									
English	967	38.2	827	85.5	103	10.7	37	3.8	<.001
Spanish	975	38.5	725	74.4	154	15.8	96	9.8	
Other	386	15.3	327	84.7	38	9.8	21	5.4	
French	203	8.0	185	91.1	12	5.9	6	3.0	
Continent of origin									
South America	1244	48.2	926	74.4	193	15.5	125	10.0	<.001
Africa	920	35.7	833	90.5	71	7.7	16	1.7	
Asia	329	12.8	282	85.7	33	10.0	14	4.3	
Europe	56	2.2	43	76.8	10	17.9	3	5.4	
Oceania	31	1.2	22	71.0	5	16.1	4	12.9	
Circuit region									
Mid-Atlantic & South (Fourth, Fifth, Eleventh, and DC Circuits)	634	24.6	526	83.0	78	12.3	30	4.7	0.071
North-Central & South-West (Eighth and Tenth Circuits)	31	1.2	20	64.5	5	16.1	6	19.4	
Mid-West (Sixth and Seventh Circuits)	126	4.9	98	77.8	18	14.3	10	7.9	
West-Coast (Ninth Circuit)	253	9.8	210	83.0	27	10.7	16	6.3	
Northeast + Caribbean (First, Second, and Third Circuits)	1533	59.5	1251	81.6	184	12.0	98	6.4	
Asylum case type: number of reasons									
1 reason	1349	64.1	1096	81.2	164	12.2	89	6.6	0.193
2 reasons	526	25.0	431	81.9	62	11.8	33	6.3	
3 reasons or more	231	11.0	203	87.9	17	7.4	11	4.8	
Asylum case type: reasons									
No sexual/gender-based violence	870	41.3	665	76.4	129	14.8	76	8.7	<.001
Sexual/gender-based violence	1236	58.7	992	80.3	114	9.2	130	10.5	
No Kidnapping	1887	89.6	1542	81.7	222	11.8	123	6.5	0.302
Kidnapping	219	10.4	188	85.8	21	9.6	10	4.6	
No Gang Violence	1647	78.2	1425	86.5	145	8.8	77	4.7	<.001
Gang Violence	459	21.8	305	66.4	98	21.4	56	12.2	
No Trafficking	2071	98.3	1631	78.8	240	11.6	200	9.7	.321
Trafficking	35	1.7	26	74.3	3	8.6	6	17.1	
No Slavery	2090	99.2	1715	82.1	243	11.6	132	6.3	0.346
Slavery	16	0.8	15	93.8	0	0.0	1	6.3	
No Sensory Deprivation	2049	97.3	1681	82.0	238	11.6	130	6.3	0.743
Sensory Deprivation	57	2.7	49	86.0	5	8.8	3	5.3	
No Foreign Detention	1734	82.3	1403	80.9	210	12.1	121	7.0	0.003
Foreign Detention	372	17.7	327	87.9	33	8.9	12	3.2	
No LGB	1803	85.6	1455	80.7	219	12.1	129	7.2	<.001
LGB	303	14.4	275	90.8	24	7.9	4	1.3	
No Transgender	2105	100	1729	82.1	243	11.5	133	6.3	0.897
Transgender	1	0	1	100	0	0	0	0	
No Other	2058	97.7	1693	82.3	233	11.3	132	6.4	0.073
Other	48	2.3	37	77.1	10	20.8	1	2.1	
Protected ground: number of reasons									
1 reason	1581	66.6	1288	81.5	186	11.8	107	6.8	0.29
2 reasons	555	23.4	449	80.9	74	13.3	32	5.8	
3 reasons or more	239	10.1	206	86.2	22	9.2	11	4.6	
Protected ground: reasons									
No Religion	2113	89.0	1718	81.3	255	12.1	140	6.6	0.128
Religion	262	11.0	225	85.9	27	10.3	10	3.8	
No Membership in Social Group	518	21.8	435	84.0	57	11.0	26	5.0	0.277
Membership in Social Group	1857	78.2	1508	81.2	225	12.1	124	6.7	
No Political Opinion	1349	56.8	1088	80.7	162	12.0	99	7.3	0.057
Political Opinion	1026	43.2	855	83.3	120	11.7	51	5.0	
No Nationality	2259	95.1	1843	81.6	274	12.1	142	6.3	0.235
Nationality	116	4.9	100	86.2	8	6.9	8	6.9	
No Race	2193	82.3	1793	81.8	262	11.9	138	6.3	0.922
Race	182	7.7	150	82.4	20	11.0	12	6.6	
Subject to Torture									
No	1471	56.9	1191	81.0	177	12.0	103	7.0	0.21
Yes	1113	43.1	918	82.5	136	12.2	59	5.3	
Seeking Evaluation Elsewhere									
No	2212	85.6	1803	81.5	270	12.2	139	6.2	0.934
Yes	372	14.4	306	82.3	43	11.6	23	6.3	
Detention Center									
No	2386	92.3	1965	82.4	262	11.0	159	6.7	<.001
Yes	198	7.7	144	72.7	51	25.8	3	1.5	
Evaluator gender preference									
No Preference	1636	63.4	1303	79.6	237	14.5	96	5.9	<.001

(continued on next page)

Table 2 (continued)

	Total		Positive outcome		Negative outcome		Other outcome		p-val ^a
	n	M (SD)	n	M (SD)	n	M (SD)	n	M (SD)	
Female	812	31.5	684	84.2	71	8.7	57	7.0	
Male	133	5.2	119	89.5	5	3.8	9	6.8	
Request Testimony									
No	1391	53.8	1172	84.3	150	10.8	69	5.0	0.001
Yes	1193	46.2	937	78.5	163	13.7	93	7.8	
Telephonic Testimony Allowed									
No	972	81.5	752	77.4	132	13.6	88	9.1	0.569
Yes	221	18.5	185	83.7	31	14.0	5	2.3	
Evaluation Type (n=481)									
No Psychological	132	27.4	114	86.4	11	8.3	7	5.3	0.280
Psychological	349	72.6	282	80.8	34	9.7	33	9.5	
No Physical	325	67.6	259	79.7	34	10.5	32	9.8	0.083
Physical	156	32.4	137	87.8	11	7.1	8	5.1	

Note. Sample sizes vary due to missing data in some variables (% missing: age-3.1%, gender- 0.2%, primary language-2.1%, continent of origin-0.2%, circuit region-0.3%, asylum case type-18.5%, protected grounds-8.1%).

^a p-value is based on ANOVA test.

^b p-value is based on chi-squared test.

Table 3

Multivariable correlates of case outcomes.

	Comparison: Positive vs. Negative Case Outcome			Comparison: Other vs. Negative Case Outcome				
	aOR	95% CI	p-val	aOR	95% CI	p-val		
Full sample (n = 2584)								
Age	0.97	0.96	0.98	<.001	0.96	0.94	0.98	<.001
Female	0.95	0.66	1.38	0.798	0.83	0.48	1.45	0.518
Spanish	0.96	0.59	1.54	0.852	0.80	0.40	1.62	0.542
Other	1.94	0.85	4.46	0.116	2.26	0.56	9.04	0.251
French	1.92	1.05	3.54	0.035	2.28	0.89	5.86	0.088
Africa	1.96	1.13	3.40	0.017	0.31	0.12	0.81	0.017
Asia	1.79	0.87	3.68	0.113	0.78	0.26	2.37	0.658
Europe	1.08	0.34	3.41	0.902	0.39	0.04	4.01	0.432
Oceania	1.83	0.39	8.65	0.448	-	-	-	-
Detention center at time of evaluation	0.48	0.30	0.77	0.002	0.13	0.03	0.54	0.006
Sexual/gender-based violence	1.80	1.22	2.66	0.003	1.47	0.80	2.70	0.221
Gang violence	0.54	0.37	0.78	0.001	0.80	0.45	1.42	0.441
Foreign detention	1.17	0.71	1.95	0.536	1.18	0.48	2.90	0.721
LGB	2.11	1.26	3.52	0.005	0.33	0.10	1.06	0.062
Sub-sample of cases (n = 481) ^a with affidavits (n = 505)								
Psychological evaluation	4.91	.78	30.84	.090	2.87	.27	30.11	.379
Physical evaluation	7.04	1.12	44.40	.038	3.08	.31	31.16	.340

Note. aOR is adjusted odds ratio, CI is Confidence Interval. Oceania was excluded from the analysis comparing other vs. negative case outcomes due to insufficient cell size.

^a Analyses adjusted for variables in the full sample analysis except for detention center due to insufficient cell size.

questioned due to their race. Further, in our study, statistically significant differences ($p < .05$) were found between the reasons that Africans and South Americans applied for asylum (SGBV 57.2% vs. 65.4% respectively; gang violence 3.3% vs. 37.8%; foreign detention 35.3% vs. 2.9%; LGB 11.3% vs. 14.2%) as well as the protected grounds under which they applied for asylum (religion 12.8% vs. 3.3%; membership in a social group 67% vs. 93.5%; political opinion 55.8% vs. 30.4%; nationality 6.9% vs. 1.3%; and race 10.2% vs. 5.2%). Thus, the difference in outcomes between those from different continents and regions may also be influenced by the underlying reasons they are seeking asylum (e. g., gang-based persecution may have lower grant rates as compared to those fleeing SGBV).

Sexual/gender-based violence was correlated with a positive outcome but this association, while positive, was not statistically significant for ‘other’ outcome. This positive finding is not surprising given that the doors were widening for gender-based claims immediately before and during the 10-year period of our study due to the concerted efforts of various advocacy groups who were pressing for change. For example, in *Matter of Kasinga*, a Board of Immigration Appeals (BIA) case decided in 1996, the Department of Justice recognized female genital mutilation (included in our study as a form of SGBV) as a form of persecution, making an applicant eligible for asylum.¹⁷ Advocacy

initiatives also influenced the *Matter of A-R-C-G* decision in 2014, which recognized that serious physical harm caused by domestic violence could constitute persecution where there was no state protection.¹⁸ The decision paved the way for expanded claims based on gender-based violence. However, in June 2018, as our study period was ending, the then-Attorney General Jeffrey Sessions attempted to weaken the legitimacy of such grounds with the *Matter of A-B* decision.¹⁹ At the time of this writing, *Matter of A-B* has been vacated by current Attorney General Merrick Garland, once again, opening the doors to further SGBV claims.²⁰ Likewise, U.S. law was amended in 1996 to explicitly include individuals affected by forced sterilization, which increased asylum rates particularly for Chinese asylum seekers, although other vulnerable populations, such as HIV-positive women, around the world still experience forced sterilization.²¹

LGB sexual orientation was associated with a positive outcome, however ‘other’ outcome was less likely. This finding, too, may be due to case law development. Over the 11-year period of our study, doors were opening to asylum claims based on sexual orientation and gender identity perhaps reflecting the substantial impact that large social movements and activism have been making on domestic policy. These observations match data from similar time periods that showed that asylum seekers with persecution claims relating to sexual orientation or

gender identity overwhelmingly passed initial U.S. screenings regarding their fear of returning to their home country.²² Yet even with these successful outcomes, scholars and researchers note that such positive correlations may have limitations as these numbers only capture those applicants who disclose their sexual identity or who visually conform to stereotypic impressions.²³

A history of having fled gang violence and or being in a U.S. detention center at the time of evaluation request were associated with decreased odds of a positive outcome. Those who flee gang violence have long had trouble prevailing on fear-based claims. Applicants must show that they were persecuted on a basis of one of five protected grounds, with those fleeing gang violence often articulating their claim based on political opinion (arguing their refusal to join a gang as a political statement) and membership in a particular social group (arguing they are part of a faction of society especially targeted by gangs). In several published BIA decisions,²⁴ claims based on such arguments have been denied; some courts have also cited governmental efforts to curb gang violence to undermine claims. This difficult terrain for those seeking gang violence is consistent with our findings.

The Department of Homeland Security detains many immigrants at its own discretion, some of whom may be released on bond and others who may be subject to mandatory detention indefinitely. It is well established that detained immigrants have the lowest chances of prevailing within the immigration system.^{9,25} With no access to counsel, detained immigrants have an even lower chance of securing counsel than the average immigrant, the single biggest factor influencing positive outcomes.²⁶ In turn, they may have difficulty accessing the evidence needed to successfully litigate their case and identifying and pursuing relief for which they are eligible. Further, those in detention are more likely to have interactions with the criminal system that further lowers their chances of success when seeking relief. Nevertheless, while we found that those in our cohort who were in detention at the time of requested evaluation had lower odds of a positive outcomes, when comparing their success rates with the national asylum grant average (72.7% versus 42.4%, respectively), those detained applicants who had a forensic medical evaluation still fared better.

Regarding the type of forensic evaluation conducted by the clinical evaluator, physical evaluations were conducted in 32.4% of the cases, while psychological evaluations were conducted in 72.6% of cases. Some cases had both psychological and physical evaluations (6%). In cases with a physical evaluation, 85.3% had a positive outcome, compared to 74.5% without physical evaluation. In cases with a psychological evaluation, 75.4% had a positive outcome, compared to 84.8% without psychological evaluation. In adjusted analyses, physical evaluation was associated with positive outcome, and psychological evaluation was marginally associated with positive outcome. The difference in impact of having an affidavit based on a physical versus psychological evaluation might be explained by a negative bias held by adjudicators toward psychological symptoms, i.e. believing that physical evidence of persecution is more trustworthy or evidential of severe harm than are psychological symptoms and/or a psychiatric diagnosis, such as post-traumatic stress disorder or clinical depression. If an applicant is suffering from only psychological sequelae, it may be harder for them to pass a credibility test. These affidavit findings may also point to the fact that cases involving applicants with psychological symptomatology may be more difficult cases to adjudicate, involving, for example, issues related to the one-year filing deadline, or problems with memory and/or inconsistency in testimonies. It should be pointed out however, that even though applicants with psychological evaluations had worse outcomes than those with physical evaluations, overall, those applicants with psychological evaluations still had significantly more positive outcomes, 75.4%, compared with the national asylum grant rate of 42.4%.

4.2. The value of the forensic medical evaluation and the trauma-informed approach

Our findings corroborate the findings of Lustig et al., reaffirming the value of forensic medical evaluations in support of applicants who are seeking various forms of immigration relief, particularly asylum. What the forensic medical evaluation brings to an applicant's case is significant: a trauma-informed approach by which to understand the harmful experiences that applicants have undergone and detailed documentation of the physical and/or psychological evidence of the trauma they have endured. Trauma results from an "event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."²⁷ Advances in the field of trauma and trauma-informed care, particularly with respect to victims of torture, persecution and other ill treatment, have given us important insights on the adverse effects that trauma can have on a survivor's functioning and mental health.²⁸ For example, we now understand that memory lapses and/or inconsistency in a survivor's narrative of traumatic events are very common sequelae of trauma, and can be considered symptoms of it.²⁹ And yet too often, adjudicators point to such memory lapses or testimonial inconsistencies as indications of malingerer, often denying claims because of them.³⁰

Most applicants engaging with our immigration system still do not have access to a forensic medical evaluation; relatively speaking, only a select minority do. Although the pool of trained clinicians and number of medical school asylum clinics are growing, currently Physicians for Human Rights is the largest referral source for *pro bono* evaluations in the United States, arranging approximately 700 evaluations per year, a small number compared to the tens of thousands of applications submitted each year. The fact that so few applicants undergo a forensic medical evaluation, which makes a significant contribution to a successful claim, raises the critical issue of how to expand access. Lustig et al. addressed this issue in their paper: they wrote, "*It raises the question of whether medical evaluations should be standard, or if all asylum seekers should have the right to a medical evaluation during the adjudication process. The improved grant rate among recipients of evaluations also raises the question about whether the standard of proof will change if medical evaluations become more commonplace, i.e. will immigration officials come to expect medical and psychological evaluations, without which legal defenses will be perceived as less compelling.*"⁵

The concern Lustig and colleagues raised about changing the standard of proof is a valid one. Given the wide latitude adjudicators are given to make credibility assessments, the limited access to legal counsel of those seeking asylum, and the convoluted and narrow criteria to qualify for relief, it has become increasingly difficult under the REAL ID Act passed by the U.S. Congress in 2005 for applicants to meet the evidentiary threshold.³¹ Forensic medical evaluators not only document symptoms and signs consistent with sequelae of mistreatment, write affidavits, and serve as expert witnesses, they also elucidate details of trauma beyond what asylum seekers state in their personal affidavits.³² Photographic documentation of scars is now being used as "a virtual fingerprint of the initial trauma."³¹ Further, they educate adjudicators regarding the difficulty applicants often experience in recalling specific details or dates, providing cohesive narratives, and expressing emotion when recounting their narratives of abuse, all of which contribute to an assessment of the credibility of the applicant.^{33,34,35} Thus, in the context of supporting asylum and, increasingly, other immigration-relief—such as VAWA, U-Visa and T-Visa claims³⁶—the forensic medical evaluation based on a trauma-informed approach has played a critical role. As immigration reform is considered in the United States, a trauma-informed approach, which considers the past harms and future vulnerabilities of immigrants, may become even *more* important to the legal process. However, that wider access to such evaluations might actually *inflate* evidentiary standards and *raise* adjudicators'

expectations regarding corroboration of applicants claims of harm, and thus further disadvantaging those who cannot gain access to such evaluations would be deeply ironic. While it is beyond the scope of this paper to explore this concern in further detail, such an inadvertent effect of broadening access to forensic medical evaluations would be tragic. (For further discussion, see our accompanying legal review, "Access to Justice: How Corroborating Evidence from Medical Forensic Evaluations Affects Immigration Outcomes" by Nermeen Arastu.)³⁷

4.2.1. Expansion of medico-legal partnerships

Still, enhanced medico-legal partnerships can further assist attorneys in effectively demonstrating the consistency of clients' testimonies with psychological and physical evidence provided by medical evaluators.^{38,39,40} Perhaps a salient model for such enhanced partnerships is the New York Immigrant Family Unity Project (NYIFUP). Funded by the New York City Council, NYIFUP provides free, universal, high-quality legal representation for detained indigent immigrants in deportation proceedings in the Varick Street Court in New York City. The Vera Institute of Justice (Vera) investigated NYIFUP's impact on immigration outcomes by analyzing EOIR data and conducting focus groups with NYIFUP attorneys. In its 2017 publication, *Evaluation of the New York Immigrant Family Unity Project*, Vera reported that "NYIFUP has significantly improved the chances that low-income non-citizens will receive successful immigration court outcomes permitting them to remain in the United States legally."²⁵ Vera has estimated, analyzing data from cases already completed and using advanced statistical modeling that predicts outcome for pending cases, that 48% of cases will end successfully for NYIFUP clients, a 1100% increase from the observed 4% success rate for unrepresented cases at Varick Street before NYIFUP. Of note, Vera concluded that NYIFUP's holistic model "has brought fairness and due process to immigration proceedings, ensuring all persons facing deportation have equal access to the defenses and protections available under the law." Vera reported an important part of this holistic model is NYIFUP attorneys' use of outside experts to enhance their legal arguments: one attorney said, "[W]e work with experts all the time and they're great ... subject matter experts, medical experts, forensic experts, all kinds of experts."²⁵

Further expansion of the NYIFUP model could include the assignment of a forensic medical evaluator to every case where the individual has sequelae to document. Medical evaluators can play an expanded role to a larger pool of applicants—providing evidence and testimony to enhance legal arguments related to harm-related assessments, credibility, discretion, and competency as well as to connect applicants with other holistic services, such as diagnostic and therapeutic medical care. However, the major challenge—and it is a significant one—to this approach is the limitation of an adequate number of available, skilled forensic medical evaluators. Evaluators are individuals who self-select to undergo specific training in this highly specialized area and, for the most part, conduct evaluations on a *pro-bono* basis. Forensic training is not part of the core medical education, nor is it part of regular medical practice. While the evaluator pool has been expanding over the years, and there are now many "asylum clinics" associated with medical schools that are training medical students, the physicians of tomorrow, the pool of volunteer experts is still far too small to accommodate the majority of applicants. Expanding the evaluator pool will take many years—ranging from changing undergraduate and graduate medical education as well as how medico-legal partnerships are currently funded and construed. Evaluators often find it difficult to fit these evaluations into their demanding schedules, and struggle with accommodating short turnaround times, sometimes as short as two weeks. The available pool of evaluators might well expand dramatically if clinicians could be compensated for their time. However, such remuneration may be considered by adjudicators when evaluating the forensic medical evidence (In *Matter of M-*, the BIA held that the fact an expert has appeared in many cases and has been paid a fee is a valid consideration in evaluating the evidence but does not conclusively show bias.⁴¹). In addition,

objective and trauma-informed forensic medical evaluation of asylum seekers requires a high level of cultural competence, and sensitivity to and knowledge of the health consequences of racism, sexism, homophobia, and other discriminatory attitudes. Numerous studies have established that biases against, for example, people of color,⁴² sexual and gender minorities (SGMs),⁴³ or those with disabilities,⁴⁴ are endemic to the medical field and we must be wary of infusing further such biases into immigration cases.

4.3. Harm is not enough

Even if we were able to sufficiently expand the pool of skilled evaluators to grant access to all who needed forensic medical evaluations, there is the reality that current immigration system will not always recognize the contributions these evaluations can and should make. Legal scholars in the U.S. have noted how both immigration judges and adjudicating officers discount forensic medical reports in certain contexts. For example, Wiebe and Brenes found that the Administrative Appeals Office often gives a short shrift to standalone evaluations, such as those offered by PHR Asylum Network's medical evaluators, because they are created for the purposes of litigation.⁴⁵ International studies also have documented that adjudicators often do not appropriately utilize the medical expertise that is presented. Tay et al. examined the use of psychological evidence among asylum-decision makers in New South Wales, Australia, drawing on the archives of a representative cohort of 52 asylum seekers.⁴⁶ They found that adjudicators often do not refer to psychological evidence in their decision records. In those cases in which evidence was cited, particularly in the context of negative decisions, the adjudicators challenged the expert findings and rejected the value of such evidence. A 2016 study involving a systematic review of 50 asylum cases by Freedom from Torture, a UK-based human rights organization, demonstrated that recurring and systematic errors in the handling of expert medical evidence of torture, resulted "in a very high rate of decisions overturned on appeal, with the claimant eventually being granted asylum."⁴⁷ In 74% of the cases Freedom from Torture reviewed as part of its study, asylum-case workers substituted their own opinion for that of the clinician who conducted a forensic evaluation on the likely causes of different types of scars or psychological symptoms.

Of note, our cohort was a very homogenous group: all had legal representation, all had a relatively severe symptom burden, and all had the benefit of a forensic medical evaluation and yet, *some did not prevail*. Even the advantageous combination of having an attorney and a clinician working together to document severe harm and establish credibility was not enough; if as an applicant, one finds oneself in certain categories (e.g., detained, a victim of a "personal crime," a history of gang membership), they will likely find themselves significantly disadvantaged in our immigration system. Harm—even severe harm—is not enough. To qualify for relief under U.S. law, harm must be furthered on account of the applicant's protected identity and the applicant must prove that the state cannot or will not protect them. Thus, even cases involving severe documented harm may not lead to immigration relief. Such cases highlight the fact that the current U.S. immigration system does not offer sufficient protection for people fleeing severe forms of harm because of overly restrictive definitions. The United States still deports people who will be killed in their countries of origin because of narrow definitions under current law. As of the writing of this article, immigration restrictions passed in the name of "public health" have essentially foreclosed asylum altogether. U.S. Border officials continue to use a late 19th-century public health authority, Title 42, to order summary expulsions of immigrants at the Southern Border, many of whom are fleeing persecution.⁴⁸ Given narrow interpretations of asylum eligibility and broad-based exclusionary policies, there is an urgent need for concerned stakeholders to engage in a widespread initiative to strengthen critical legal arguments, raise due process protections, and advance case law related to "persecution," "hardship," "credibility," and "substantial harm" in defense of applicants seeking various forms of immigration

relief.

4.4. Transformative cooperative initiatives

The impact of not only the forensic medical evaluation in particular but forensic medical knowledge in general could be substantially enhanced through cooperative initiatives. For example, allowing physicians and other clinicians to have regular and expanded access to immigration proceedings would surely expand what we know about what persecution is and how it manifests. If we reformed the immigration process to truly incorporate the significant and ongoing advances made in understanding the nature and consequences of trauma, we would not need an evaluation to validate and certify for every single applicant that, for example, memory problems or inconsistent testimony are symptoms of harm and suffering. We need greater education of adjudicators across the board to understand how illness impacts memory and credibility. If every immigration judge and official were cognizant of trauma-informed best practices, we could radically change outcomes for thousands of traumatized individuals. The current time-consuming process focused on the applicant may not be the best way to utilize medical expertise. Could medical evidence be brought into the system in other ways that would profoundly broaden the access immigrants had to it? How can forensic medical evaluators act in a capacity broader than providing just direct services to individuals? We need to build a greater understanding of the medical needs of immigrants and allow for health-informed recommendations of how the court and legal defense bar could better function. Perhaps a more impactful approach would be for medical experts to become more integrated than they already are in close medical-legal partnerships to educate adjudicators and the bar, aid in changing case law, help establish better norms, and assist in ensuring due process. In addition, clinicians need to continue to work at connecting immigrants who are shut out of receiving medical care due to a host of issues (e.g., immigrant status, lack of insurance and financial resources) to services that address their unmet health needs and other social hardships.

In keeping with this vision, we offer the following recommendations: 1) conduct research to determine the current role forensic evidence plays in the decision making processes of adjudicators and study the variability of grant rates, with particular consideration given to analysing the data to investigate discriminatory bias against particular groups (e.g., racial/ethnic minorities, women, SGMs and individuals with disability); 2) identify ongoing barriers to receiving forensic medical evaluations and successful strategies to improve access; 3) develop guidelines for the consistent use of forensic evidence in immigration cases; 4) ensure training for adjudicators in trauma-informed approaches; 5) fund access to representation in immigration cases, with some funding dedicated to forensic medical evaluations; and 6) reform the U.S. immigration system to ensure international protection for those fleeing severe harm, even for those who do not meet all of the strict criteria to qualify for asylum.

4.5. Study strengths and limitations

Our study has important strengths. First, we were able to analyse 11 years of accumulated data. The total number of cases ($n = 2584$) provided a sufficient sample size that allowed us to conduct a multivariable multinomial regression analysis. PHR was able to obtain outcomes in 76.7% (2584 of 3370, see Fig. 2) of cases that were initiated during the study period, received a forensic medical evaluation, the medical affidavit was used in the case, and had been adjudicated at the time of our study. Second, within our cohort, we were also able to identify 481 case outcomes that had accompanying affidavits, allowing us to explore the association of different types of medical evaluations (physical, psychology, or both) with case outcomes. Lustig et al. was not able to perform either of these analyses, as their case number ($n = 746$) was too small.

Our investigation also has limitations. The group of 2584 applicants comprising our data pool was not a randomly selected group of individuals from all applicants across the U.S. They were a select group of individuals in several important ways: first, all applicants had legal representation, a factor which is intrinsically linked to having access to a forensic medical evaluation and has been shown to increase the odds of being granted relief. Syracuse University's TRAC ("Transactional Records Access Clearinghouse") analysis of the Executive Office for Immigration Review's annual statistics has shown that during the 11-year study period of 2008–2018, 81% of asylum seekers had legal representation (although, we do not know how many of these applicants underwent a forensic medical evaluation); of these, 54% were granted asylum while 44% were denied asylum. In contrast, of the 19% who were not represented, only 10% were granted asylum, while 88% were denied it.⁹ (Note: A small percentage of cases—1.99% and 2.21%, respectively, for both represented and not represented applicants—were granted other forms of relief, in which the applicant was denied asylum but was allowed to legally remain in the U.S. through another form of permanent or temporary relief.) Second, PHR screens cases; it attempts to place only those applicants who appear to have indications of either physical and/or psychological sequelae and thus would likely benefit from a forensic medical evaluation. This selection process results in a pool of applicants who, for the most part, have experienced *considerable* harm and have a large symptom burden. It does not include those survivors of torture, persecution, and other ill treatment who do not have physical sequelae or who are very resilient, without psychological symptoms.

Third, three-quarters of the applicants who comprised our data pool had their cases adjudicated in the Circuits covering the Northeast and Mid-Atlantic regions, with the fewest being adjudicated in Circuits covering the North-Central and South-West regions. These data reflective the fact that the PHR Asylum Network comprises clinician evaluators who are located primarily on the eastern seaboard, with some located in California, and thus take on cases that are adjudicated in Circuits that have been historically more favorable to immigrants.^{49,50} While our statistical analysis did not reveal a significant difference in outcomes based on the geography of the courts, our sample size was small particularly in the Sixth and Seventh Circuits ($n = 126$ cases in total) and the Eighth and Tenth Circuits ($n = 31$ cases in total).

Fourth, the vast majority of those in our data set, 92.3%, were not subject to immigration detention at the time of the evaluation request. Like representation, freedom from detention also has a strong correlation with increased positive outcomes. Even with these factors in mind, those who had access to a medical evaluation still fared significantly better than similarly situated immigrants who were represented and not detained. For example, those within our cohort who applied for asylum were denied only 6.9% of the time compared to 44.1% of *represented* and *non-detained* asylum seekers who were denied asylum in the national EOIR asylum group.⁶

Another limitation of our study is that we were not able to determine case outcomes based on type of case, affirmative versus defensive, as PHR aggregates its data across case type. US government data is disaggregated by immigration proceedings under the Department of Justice and the Department of Homeland Security, and it would be interesting to compare case outcomes based upon an affirmative versus a defensive proceeding.

Finally, another limitation of our study is that although all the applicants in our cohort underwent a forensic medical evaluation, we do not know how the evaluation was used in the legal process by the applicant's attorney or by the adjudicating official, and thus we cannot determine the actual role it played in the decision regarding case outcome. We do not know whether medical affidavits tend to turn very difficult cases into a big wins or have minimal impact on the ultimate outcomes. We also do not know whether the quality of the medical affidavits impacts case outcome; affidavit quality might vary considerably. The precise role of the medical affidavit and its quality are aspects of the

immigration process that need further investigation.

5. Conclusions

In our analysis of 2584 cases initiated by PHR between 2008 and 2018 with forensic medical evaluations and known outcomes, we found that 81.6% of applicants seeking various forms of immigrant relief were granted relief compared to the national asylum grant rate of 42.4%. Almost three-quarters of positive outcomes were asylum grants. Our findings strengthen and expand prior evidence that forensic medical evaluations are an important component in scientifically documenting evidence of persecution and harm, which can significantly bolster an applicant's immigration relief claim. Due to the unprecedented rise in applications and the failure of the current immigration system to adequately address the issues facing traumatized applicants seeking immigration relief in the U.S., there is an urgent need for more trained clinicians to provide trauma-informed forensic medical evaluations and subsequent care to these individuals as well as to further educate adjudicators and lawyers about the life-altering events applicants have experienced. The U.S. immigration system needs to move toward one in which people are treated humanely throughout the entire process and their claims are adjudicated according to an objective process that relies on scientific evidence, grounded in a trauma-informed approach.

CRedit authorship contribution statement

Holly G. Atkinson: Conceptualization, Methodology, Formal analysis, Resources, Writing – original draft, Writing – review & editing, Visualization, Supervision, Project administration. **Katarzyna Wyka:** Methodology, Validation, Formal analysis, Writing – original draft, Writing – review & editing, Visualization. **Kathryn Hampton:** Conceptualization, Investigation, Resources, Data curation, Writing – review & editing. **Christian L. Seno:** Investigation, Data curation, Writing – review & editing. **Elizabeth T. Yim:** Data curation, Writing – original draft. **Deborah Ottenheimer:** Conceptualization, Resources, Writing – review & editing. **Nermeen S. Arastu:** Conceptualization, Investigation, Resources, Data curation, Writing – original draft, Writing – review & editing, Supervision, Project administration.

Declaration of competing interest

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. We have no conflicts of interest or disclosures to make.

Acknowledgements

The authors would like to acknowledge Hajar Habbach, who tracked a great many of the PHR case outcomes that made this project possible, as well as provided input in the early stages of the project. In addition, sincere thanks to the many PHR Asylum Network members who volunteered to conduct these forensic medical evaluations. We would also like to thank Human Rights First for granting us permission to include its graphic of the overview of the U.S. asylum process as Fig. 1. Finally, we would like to extend our gratitude to Ranit Mishori, M.D., Senior Medical Advisor, Physicians for Human Rights, and the anonymous reviewers for reviewing the manuscript.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.jflm.2021.102272>.

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