PRACTICE MANUAL FOR PRO BONO ATTORNEYS REPRESENTING DETAINED CLIENTS WITH MENTAL DISABILITIES IN IMMIGRATION COURT

2009 Edition
For Washington, DC, Virginia and Maryland

1612 K Street, NW Suite 204
Washington, DC 20006
T (202) / 331-3320 ext. 20
F (202) / 331-3341

777 6th Street NW, Suite 1100
Washington, DC 20001
T (202) / 842-7800
F (202) / 842-7899

This manual is intended to provide practical and useful information for attorneys acting as pro bono counsel for detained immigrants. It is provided with the understanding that neither the CAIR Coalition nor Cooley Godward Kronish LLP is rendering legal or other professional advice to any person or entity. The manual shall not be deemed to create an attorney/client relationship with any reader. No reader may rely upon any of the statements contained herein for purposes of any specific matter. If legal advice is desired, the services of a competent professional should be engaged. Practitioners using these materials are advised that the authors have no obligation to update or amend these materials to account for developments in this area of law.

Acknowledgments

Both the CAIR Coalition team (composed of Liz McGrail and Vanessa Allyn) and the Cooley Godward Kronish LLP team (composed of Kristine Pirnia, Bonnie Weiss McLeod, Leigh Warren, Christi Novak, Christopher Kimball, Jill Parks, Bonnie Nelson and Erin Combs and former Cooley attorneys Blair Hedges and Noah Malgeri,) would like to thank the following individuals for their valuable contributions to this manual:

Greg Pleasants, Equal Justice Works Fellow at the Mental Health Advocacy Services, Inc. in Los Angeles, CA

Stacey Strongarone, Director, Legal Orientation Program, Vera Institute of Justice, New York, NY

Rose Holandez, Program Associate, Center on Immigration and Justice, Vera Institute of Justice, New York, NY

Maria Baldini-Potermin, Attorney, Maria Baldini-Potermin & Associates, PC, Chicago, IL

Maggie Donahue, Second year law student, Washington College of Law, American University, Washington, DC

Nicole Mailman, Third year law student, David A. Clarke School of Law, University of the District of Columbia, Washington, DC

Brittney Nystrom, former Legal Director of CAIR Coalition, Washington, DC

TABLE OF CONTENTS

PAGE

INTRODUCTION TO PRACTICE MANUAL 1
I. OVERVIEW: DETENTION AND IMMIGRATION COURTS 2
A. Detention Overview 2
B. Detention Standards of Care 3
C. Release from Detention 4
D. Immigration Court System 6
E. Post-Decision Options 12
II. OBTAINING MEDICAL CONSENT, RECORDS, AND TREATMENT 14
A. Introduction and Resources 14
B. Competency and Guardianship for Medical Purposes 15
C. Obtaining Medical Records 17
D. Medical Consent 27
E. Obtaining Medical Care While in Detention Facilities 30
III. LITIGATION STRATEGIES FOR MENTALLY INCOMPETENT CLIENT 33
A. Constitutional, Statutory, and Regulatory Framework 33
B. Approaches 39
IV. LEGAL RELIEF 44
A. Fear-Based Claims: Asylum, Withholding of Removal, and CAT Protection 44
B. Cancellation of Removal 56
V. CREATING THE RECORD TO WIN THE CLAIM 66
VI. POST-ADJUDICATION ISSUES 67
A. Mental Health Issues 67
B. Other Issues 87
ACRONYMS 115
APPENDIX 119

INTRODUCTION TO PRACTICE MANUAL

This Practice Manual is designed to help attorneys represent aliens who have mental health issues throughout the immigration detention and removal (deportation) process. In fiscal 2007, the U.S. Immigration and Customs Enforcement ("**ICE**") deported 276,912 illegal aliens from the United States. Most aliens are kept in custody (detention) during the removal proceedings — in 2007, ICE detained over 311,000 aliens.

Less than half of all aliens in removal proceedings have legal representation.[1] While aliens have a right to counsel in immigration cases, the government has no obligation to provide counsel (unlike criminal cases). Not surprisingly, legal representation makes an enormous difference in outcome: aliens represented by counsel are 50% more likely to avoid deportation.[2]

The inherent complexity of the immigration legal process and stress of detention presents problems to all detained aliens, but especially to those with mental health issues. Statistics are incomplete regarding the number of aliens who suffer from mental illness, but limited statistics and anecdotal evidence suggests that aliens face widespread mental health issues. A 2003 study found that out of seventy detained asylum seekers, symptoms of depression were present in 86%, anxiety was present in 77% and PTSD in 50%.[3]

Many attorneys providing representation do so on a pro bono basis without any immigration law experience. This manual attempts to provide a practical overview of the immigration detention and removal processes and the specific challenges facing aliens with mental health needs.

As this Practice Manual is designed as a practical guide for attorneys to navigate the labyrinthine immigration system, it is not exhaustive. Particularly on specific legal points, we urge practitioners to consult immigration attorneys and the supplemental materials referenced throughout the manual.

---

[1] From fiscal 2003-2007, only 35-48% of aliens had legal representation in removal proceedings. *See* http://www.usdoj.gov/eoir/statspub/fy07syb.pdf.

[2] *Id.*

[3] Statement on Immigration Detainee Health Care, Homer D. Venters, M.D., Attending Physician, Bellevue/NYU Program for Survivors of Torture Public Health Fellow, New York University, House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law Hearing on Problems with Immigration Detainee Medical Care, June 4, 2008. *See* http://www.aila.org/content/fileviewer.aspx?docid=25596&linkid=178624.

I. OVERVIEW: DETENTION AND IMMIGRATION COURTS

A. Detention Overview

Immigration and Customs Enforcement ("**ICE**") of the Department of Homeland Security ("**DHS**") places aliens in its custody at detention facilities pending their removal proceedings. The U.S. Government Accountability Office reported that in fiscal year 2007, ICE detained over 311,000 aliens, with an average daily population of over 30,000. Detainees' average length of stay is approximately thirty-seven days. Although 50% of detainees stay eighteen days or less, some stay over six months.[4] Immigration detainees are held in over three-hundred facilities across the country and sometimes are housed with criminal populations. Many of these facilities are privately-run jails that contract with ICE and are not specifically designed to hold detained aliens.

1. Routes for Entry into Detention

Aliens enter custody through a variety of routes.

- **Arrival at ports of entry at the borders of the United States without proper documentation, such as without a valid visa.** If the alien does not express fear of returning, then ICE returns the alien to his country of origin. If the alien expresses fear of return, then the alien is detained pending a hearing.

- **DHS immigration raids, border inspections.**

- **Transfers from mental health hospitals.**

- **Criminal custody.** Almost half (48%) of aliens were in criminal custody before local law enforcement transferred them to ICE for removal.[5] Oftentimes, local law enforcement will stop, arrest, and detain aliens in criminal custody for minor offenses, such as traffic violations, and then refer these aliens to ICE custody, even in cases where the original criminal charges are dropped.

2. Detention Facilities

DHS detains aliens in processing facilities and public and private detention facilities under contract with DHS. *See* 8 C.F.R. § 235.3(e). The Detention Watch Network tracks the location of immigration detention centers.[6]

---

[4] United States Gov't Accountability Office, Statement of Richard M. Stana, Director, Homeland Security and Justice Issues, Observations on the Adherence to ICE's Medical Standards in Detention Facilities, GAO-08-869T at 1, (June 4, 2008).

[5] CRS Report for Congress, Health Care for Noncitizens in Immigration Detention (June 27, 2008) (citing U.S. Immigration and Customs Enforcement, FY 2006 Detainees Not Seeking Asylum, Report Pursuant to § 904 of the Haitian Refugee Immigration Fairness Act (Pub.L. 105-277)).

[6] *See* http://www.detentionwatchnetwork.org/dwnmap.

Practitioner's Tip: DHS may transfer the client from one detention facility to another without notifying the attorney. Practitioners should communicate regularly with the client's case officer at the Detention & Removal Office (DRO) to remain apprised of the client's whereabouts. Although DHS must notify the Immigration Court when it has transferred a detainee, the practitioner should also file an Alien's Change of Address Form (Form EOIR-33/IC) with the Court when the practitioner knows that DHS has transferred his client.[7]

B. Detention Standards of Care

1. National Detention Standards and Lack of Enforcement

The existing standard governing administration of medical care at ICE detention facilities is the National Detention Standard issued in September 20, 2000, (*INS Detention Standard Medical Care* form attached in **Appendix 1**).[8] These standards apply to the following types of detention facilities: service processing centers ("**SPCs**"), contract detention facilities ("**CDFs**"), and state or local government facilities. It is important to note that ICE does not apply these standards to hospitals or critical care facilities where it may send detainees.

On December 2, 2008, ICE released a new set of detention procedures and service standards called the ICE Performance Based National Detention Standards (*ICE/DRO Detention Standard Medical Care, December 2, 2008)* attached in **Appendix 2**), which will go into effect in 2010, replacing the 2000 PBNDS.[9] One concern with the 2008 PBNDS is that it fails to provide meaningful enforcement; while it provides a grievance system, ultimately the facility itself, not an outside monitoring board, addresses grievances.

Further, the detention standards are not judicially enforceable, rendering them mere guidelines. Evidence suggests that facilities frequently do not follow the detention standards.[10] The Office of Inspector General of the DHS found that four of five detention facilities examined failed to provide adequate medical care to detainees.[11] Common problems include failures to perform mental health screening, track or transfer medical records, and provide medication.

---

[7] U.S. Dep't of Justice, EOIR, Office of the Chief Immigration Judge, Immigration Court Practice Manual, http://www.usdoj.gov/eoir/vll/OCIJPracManual/ocij_page1.htm, § 9.1, at 121.

[8] http://www.ice.gov/doclib/partners/dro/opsmanual/medical.pdf

[9] U.S. Immigration and Customs Enforcement, http://www.ice.gov/PBNDS/faq.htm.

[10] *See, e.g.*, One America and Seattle University School of Law, *Voices from Detention: A Report on Human Rights Violations at the Northwest Detention Center* (July 2008); Women's Commission for Refugee Women and Children and Lutheran Immigration and Refugee Service, *Locking up Family Values: the Detention of Immigrant Families* (2007); ACLU of New Jersey, *Behind Bars: The Failure of the Department of Homeland Security to Ensure Adequate Treatment of Immigration Detainees in New Jersey* (2007); *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*, Human Rights Watch (December 2007); Nina Bernstein, *Immigrants Challenge Federal Detention System*, N.Y. Times B3 (May 1, 2008); *Orantes-Hernandez v. Gonzales*, 504 F. Supp. 2d 825, 876 (C.D. Cal. 2007).

[11] Dep't of Homeland Sec., Office of Inspector General, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilitie*s, OIG-07-01 (December 2006), *available at* http://www.dhs.gov/xoig/assets/ mgmtrpts/ OIG_07-01_Dec06.pdf.

a. Mental Health Care

Listed below are general guidelines included in the 2000 detention standards. The 2008 PBNDS and the currently implemented 2000 standards are discussed in more detail in Section II of this manual.

- **Initial medical and mental health screening** by a health care provider or trained officer.

- **Mental health evaluation.** A detainee may request a mental health evaluation or be referred for one by a mental health provider (defined as a psychiatrist, physician, psychologist, clinical social worker, or other licensed independent mental health practitioner).

- **Comprehensive evaluation.** Any detainee referred for mental health treatment shall receive a comprehensive evaluation within fourteen days of referral. The provider shall develop a treatment or management plan for the detainee.

- **Medical isolation must be reassessed daily.** A clinical medical authority may place a detainee "who is at high risk for violent behavior because of a mental health condition" in isolation but must reassess daily the need for it.

- **Restraints.** Only the clinical medical authority may authorize restraints "after reaching the conclusion that less restrictive measures are not appropriate." The facility must have a written policy for the use of restraints.

- **Involuntary administration of psychotropic medications.** This is only allowed pursuant to "specific, written and detailed authorization of a physician." The prescribing physician must follow specific criteria set forth in the applicable detention standards

- **Suicide prevention.** ICE shall immediately refer any detainee identified as "at risk" for suicide to the mental health provider or other appropriately trained medical staff member for an evaluation, which must take place within twenty-four hours. Until this evaluation takes place, security staff will place the detainee in a secure environment on a constant one-to-one visual observation.

C. Release from Detention

1. DHS Initial Determination.

ICE may arrest an alien without a warrant and must determine within forty-eight hours after the arrest: (1) whether the alien will be continued in custody or released on bond or recognizance; and (2) whether to issue a notice to appear and an arrest warrant.[12]

[12] 8 C.F.R § 287.3(d).

2. Mandatory Detention

Detention is mandatory for inadmissible arriving noncitizens not subject to expedited removal,[13] for noncitizens convicted of certain criminal offenses,[14] for noncitizens with a final order of removal, and for suspected terrorists.[15]

3. Parole

Parole is a special form of release. To qualify for parole, an individual must demonstrate that he is not a flight risk and will appear at all future hearings before the Immigration Court, does not pose a threat to national security, and has significant ties to the community. To be eligible for parole, an individual must have a government-issued identity document (such as a student ID card from a public university, a birth certificate, or a passport) and somebody willing to serve as a sponsor who will provide him with room and board if he is released. This person must be a U.S. citizen or legal permanent resident.

The parole request must be in writing, and generally consists of a letter detailing the case for the release of the individual (he is not a flight risk, is not a danger to the community, is likely to win his asylum case, might be further traumatized by continued detention, etc.), and any necessary supporting documentation. The sponsor should also file a brief affidavit discussing his citizenship or immigration status, relationship to the client, and financial situation. Any other supporting letters attesting to the good character of the detainee and evidencing ties to the community are also helpful.

4. Bond

ICE makes a determination of whether to keep the detainee in custody and whether to set a bond. The detainee may challenge this initial determination before the Immigration Court.[16]

The request for a bond hearing may be written or oral.

The request may be submitted to:

(1) the Immigration Court with jurisdiction over the detention facility;

(2) the Immigration Court (if different) with jurisdiction over the removal case; or

(3) the Office of the Chief Immigration Judge for designation of an appropriate Immigration Court.

---

[13] INA § 235(b)(1)(B)(ii); 8 U.S.C. 1225(b)(1)(B)(ii) (2006). Expedited removal allows immigration officers to remove certain inadmissible noncitizens and prevent them from entering the United States. *See* INA § 235(b)(1)(A)(i); 8 U.S.C. § 1225(b)(1)(A)(i) (1996).

[14] INA §§ 212, 237; 8 U.S.C. §§ 1182, 1227 (2008) (aliens may not be released if they are removable on the following: multiple crimes of moral turpitude, aggravated felonies, controlled substance offenses, firearms offenses, "miscellaneous crimes," or single crimes on moral turpitude, in particular cases).

[15] INA § 236A, 8 U.S.C. § 1226(a) (2001).

[16] U.S. Dep't of Justice, Immigration Court Practice Manual, § 9.3, at 123-27; *see also* 8 C.F.R. §§ 1003.19, 1236.1.

The request should include:

(1) the alien's name and alien registration number ("**A Number**");

(2) the bond amount set by ICE, if one has been set;

(3) the reasons why client is eligible for and deserving of a bond (or lower bond, if one has been set by ICE);

(4) if relevant, the location of the detention facility.

At the hearing, the Immigration Judge determines whether: (1) the alien is eligible for a bond; (2) the alien's release would pose a danger to property or persons; (3) the alien is likely to appear for further immigration proceedings; and (4) the alien is a threat to national security. Both the alien and DHS may appeal the bond hearing ruling to the Board of Immigration Appeals ("**BIA**").

Practitioner's Tip: **Bond Funds**. The National Immigrant Bond Fund ("**NIBF**") provides access to bond funds for detainees. *See* www.immigrantbondfund.org

D. Immigration Court System

1. Immigration Courts

Immigration Courts are part of the Executive Office for Immigration Review ("**EOIR**") of the Department of Justice. These Courts are neither Article III courts nor administrative courts. There are more than two-hundred immigration judges in more than fifty U.S. Immigration Courts.[17]

a. Scope of Authority.

- Determining whether client is subject to removal;
- Reviewing reasonable fear denials by DHS;[18]
- Determining whether to grant relief from removal including, but not limited to, asylum, withholding of removal ("restriction on removal"), protection under the Convention Against Torture, cancellation of removal, adjustment of status, registry and certain waivers;
- Reviewing matters concerning custody and bond re-determination.[19]

---

[17] U.S. Dep't of Justice**,** http://www.usdoj.gov/eoir/.

[18] Terminology: "removal," "deportation," and "excludability" are functionally synonymous. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996 ("**IIRIRA**") introduced the term "removal" to replace the prior terms "deportation" and "exclusion." Although the current proper term is "removal," courts and immigration texts still also refer to "removal" and "deportation" interchangeably. *See Evangelista v. Ashcroft*, 359 F.3d 145, n.1 (2d Cir. 2004) (IIRIRA "realigned the vocabulary of immigration law, creating a new category of `removal' proceedings that largely replaces what were formerly exclusion proceedings and deportation proceedings." Gerald L. Neuman, *Habeas Corpus, Executive Detention, and the Removal of Aliens*, 98 Colum. L.Rev. 961, 966 (1998)).

b. Immigration Court Procedure.

> **Practitioner's Tip:** Always refer to the U.S. Dep't of Justice, Immigration Court Practice Manual.[20]

2. Notice to Appear, Form I-862- Charging Document

Removal proceedings begin when DHS serves a Notice to Appeal ("**NTA**") on an alien and files it with the Immigration Court.[21]

- **Contents:** The NTA contains the charges against the alien ("**Respondent**") and is functionally equivalent to a civil complaint or a criminal indictment.

- **Scheduling**: The NTA may contain the date, time, and location of the initial master calendar hearing, at which the Respondent must appear. If the NTA does not contain this information, DHS will mail it to the Respondent in a notice of hearing.

3. Notice of Entry of Appearance as an Attorney or Representative, Form EOIR-28.[22]

Attorneys must file this form when first appearing before the Court, at any time after the beginning of proceedings when there is a change in representation or contact information for the attorney, whenever a case is remanded to the Immigration Court, when filing motions, and upon reinstatement after an attorney's suspension or expulsion from practice.[23]

4. Master Calendar Hearing.

This is an initial, administrative hearing before an Immigration Judge regarding removal proceedings.[24]

- **Respondent Must Attend.** However, the Respondent can file a motion to waive this requirement. Such waivers are infrequently granted; however, grounds for such waivers include physical and mental illness[25] and cases where serious hardship will result to the Respondent. If the Respondent is detained, ICE will either arrange the detainee's appearance in person or via televideo conferencing ("***TVC***"). DHS is increasingly utilizing TVC "appearances" in certain jurisdictions to avoid bringing detained individuals to their hearings.

- **Raise Competency First.** Ask for a competency determination at or before the Master Calendar Hearing. If the Court has found the Respondent not competent, then argue that the Court must assign the Respondent to treatment and stay the

---

[19] 8 C.F.R. §§ 1240.1(a), 1240.31, 1240.41.
[20] U.S. Dep't of Justice, Immigration Court Practice Manual, http://www.usdoj.gov/eoir/vll/OCIJPracManual/ocij_page1.htm.
[21] U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.2(a), at 55-56; 8 C.F.R. §§ 1003.13, 1003.14.
[22] U.S. Dep't of Justice, http://www.usdoj.gov/eoir/eoirforms/instru28.htm.
[23] U.S. Dep't of Justice, Immigration Court Practice Manual, § 2.1 at 15-16.
[24] U.S. Dep't of Justice, Immigration Court Practice Manual, § 14.5, at 64-75.
[25] INA § 240(b)(3) says that if mental illness precludes a Respondent from attending his hearing, the AG shall prescribe safeguards to protect his rights and privileges.

removal process indefinitely. Please refer to Section III for expanded discussion regarding competency determination.

- **Pleading.** The Respondent shall plead to the charges contained in the Notice to Appear. Below is a checklist of pleading options.

Practitioner's Tip: If the practitioner has just been assigned to the case and has not had time to review the NTA charges with his client, he should ask the Court for a one week continuance to confer with his client. Most courts readily agree to such a request.

Issues for Master Calendar Hearing	Pleading Options
Competency	If an attorney has reason to believe the Respondent is not competent to understand the nature of the proceedings and charges against him, the attorney may ask for a continuance in order to obtain a medical competency report. Section IV provides a discussion of litigation strategies for representing clients who may be incompetent.
Was Notice to Appear served?	Concede or deny service.
Was the Notice to Appear formally read in court?	Request or waive a formal reading.
Has court explained the Respondent's rights in the removal proceedings?	Request or waive explanation of rights.
Answer allegations	Admit or deny the charges and factual allegations in the Notice to Appear.
Designate country of removal	Designate or decline to designate a country of removal. If contesting removal, then decline to designate country of removal.
What relief does Respondent intend to seek?	State what application(s) for relief from removal, if any, the Respondent intends to file.
Identify legal/factual issues	Identify legal and factual issues that the Court should consider.
Merits hearing length	Estimate the amount of time (in hours) needed to present the case at the individual calendar hearing, which typically last two to four hours.
Applications for relief deadlines	Request a date on which to file the application(s) for relief, if any, with the Immigration Court. Tell the Court that you are representing the detainee pro bono and ask court for extended time to respond.

Issues for Master Calendar Hearing	Pleading Options
	An extra 15-30 days should be acceptable to the Court.
Need interpreter?	Request interpreter for the Respondent and witnesses, if needed. The government will then provide the interpreter.

5. Pre-Hearing Conference.

A pre-hearing conference may be held between the parties and the Immigration Judge to narrow issues, negotiate stipulations to positions, and organize the proceedings.[26] The Respondent may file a "Motion for a Pre-Hearing Conference" either orally or in writing.

6. Motions and Discovery

- **Pre-Hearing Statement.** Unless ordered by the Immigration Judge, a pre-hearing statement is not required, though it may be helpful to narrow and reduce factual and legal issues in advance of the merits hearing.[27]

- **Pre-Hearing Briefs.** Unless ordered by the Immigration Judge, a pre-hearing brief is not required. However, we highly recommend that the practitioner submit a brief thoroughly explaining the legal and factual reasons in support of his client's application.[28]

- **Other Motions.** Some common motions are listed below.

Suggested Motions	Purpose of Motion and Notes
Motion for competency determination.	To answer a threshold question on the Respondent's competency before proceeding with any removal determinations.
Motion to continue. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 5.10(a), at 96-97.*	To delay a hearing to a later date. Should be in writing.
Motion to advance. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 5.10(b), at 96-97.*	To move the hearing to an earlier date. Generally disfavored.

[26] U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.18(a), at 78; 8 C.F.R. § 1003.21(a).
[27] U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.18(b), at 79.
[28] U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.19, at 79-81.

Suggested Motions	Purpose of Motion and Notes
Motion to change venue. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 5.10(c), at 97.*	To move the location of the hearing. Should be supported with documentary evidence explaining why a change in venue is warranted.
Motion for substitution/ withdrawal of counsel. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 2.3(i).*	To allow counsel to be substituted or withdrawn.
Motion for extension of a filing deadline. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 3.1(c)(iv).*	To give Respondent additional time to file a motion.
Motion to accept an untimely filing. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 3.1(d)(ii).*	To allow a filing after the deadline has passed.
Motion for closed hearing. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.9.*	To close the hearing because hearings are generally open to the public absent such request.
Motion to waive appearance from a master calendar hearing. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.15.*	To allow Respondent and/or his attorney to not appear at the master calendar hearing. Many courts routinely deny these motions.
Motion to permit telephonic appearance. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.15.*	To allow Respondent and/or his attorney to call the court for the hearing instead of appearing in person. Many courts routinely deny these motions.
Motion to request an interpreter. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.15.*	To provide (and pay for) an interpreter if requested.
Motion for video testimony. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.15.*	To allow video testimony.
Motion to present telephonic testimony. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.15.*	To allow telephonic testimony. Some judges simply do not allow telephonic testimony.
Motion for subpoena. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.20.*	To grant permission to issue a subpoena, either to compel attendance of a witness or to obtain documents in aide of defense.

Suggested Motions	Purpose of Motion and Notes
Motion for consolidation. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.21.*	To combine two or more cases into a single case.
Motion for severance. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.21.*	To divide one case with multiple Respondents into two or more separate cases.
Motion to stay removal or deportation. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 8.3(a), at 120.*	To delay removal or deportation which is otherwise imminent.
Motion to amend. *See U.S. Dep't of Justice, Immigration Court Practice Manual, § 5.10(u), at 99.*	To grant permission to amend a previous filing, usually to correct a mistake.

7. Individual Calendar Hearings (or "merits hearings")

- This is an evidentiary hearing to resolve disputed issues raised at the master calendar hearing.[29]
- **Filings before the hearing**. The parties should file all motions, applications for relief, proposed exhibits, and witness lists according to the deadlines provided by the Court presiding over the case.[30] Respondents with a criminal history should file a chart that includes the criminal records.[31]
- **Conduct of the hearing.** The Respondent should be prepared to:
  - make an opening statement;
  - raise any objections to the government's evidence;
  - present witnesses and evidence on all issues[32;]
  - cross-examine opposing witnesses and object to testimony, when appropriate; and
  - present a closing statement.[33]

[29] U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.16, at 75-78.
[30] U.S. Dep't of Justice, Immigration Court Practice Manual, § 3.1, at 31-39.
[31] U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.16(b), at 75-76.
[32] The Federal Rules of Evidence do not apply in immigration proceedings; however, Immigration Judges use these rules as guidelines.
[33] U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.16(d), at 76.

8. Immigration Judge's Ruling.

The Judge often issues an oral decision at the conclusion of the hearing but may instead issue a written ruling afterwards.[34]

E. Post-Decision Options

1. Motions to Immigration Court

- **Motion to Reconsider.** This motion either identifies an error in law or fact in the Immigration Judge's decision or identifies a change in law that affects a prior decision. With this motion, a Respondent may request that the Immigration Judge re-examine a prior ruling. A motion to reconsider is based on the existing record and does not seek to introduce new facts or evidence.[35]

  (i) **30 day deadline.** A motion to reconsider must be filed within thirty days of the immigration judge's final administrative order.[36]

  (ii) **Only 1 shot.** As a general rule, a party may file only one motion to reconsider.[37]

- **Motion to Reopen.** After an Immigration Judge has rendered a decision, he may grant a motion to reopen proceedings to consider new facts or evidence in the case.[38]

  (i) **90 day deadline.** As a general rule, a motion to reopen must be filed within ninety days of an Immigration Judge's final order, but there are limited exceptions.[39]

  (ii) **Only 1 shot.** A party is permitted only one motion to reopen.[40]

  (iii) **Does not stay appeal deadlines or removal orders.** A motion to reopen filed prior to the deadline for filing an appeal does not stay or extend the deadline for filing the appeal. The motion also does not automatically stay an order of removal or deportation.

2. Appeals Before the Board of Immigration Appeals

The Board of Immigration Appeals ("**BIA**") has jurisdiction to review decisions of Immigration Judges.[41] To appeal an Immigration Judge's decision, a party must file with the BIA

[34] U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.16(g), at 77.
[35] U.S. Dep't of Justice, Immigration Court Practice Manual, § 5.8, at 92-94.
[36] 8 C.F.R. § 1003.23(b)(1).
[37] 8 C.F.R. § 1003.23(b)(1).
[38] U.S. Dep't of Justice, Immigration Court Practice Manual, § 5.7, at 90-92.
[39] 8 C.F.R. § 1003.23(b)(1),(4).
[40] 8 C.F.R. § 1003.23(b)(1).
[41] 8 C.F.R. § 1003.1.

a properly completed and executed Notice of Appeal (Form EOIR-26), which must be received no later than thirty calendar days after the Immigration Judge rendered the oral decision or mailed a written decision.[42]

> **Practitioner's Tip: Do Not Waive Appeal.** The Respondent may be asked to waive any appeal. If the opportunity to appeal is knowingly and voluntarily waived, the decision of the Immigration Judge becomes final. *See* U.S. Dep't of Justice, Immigration Court Practice Manual, § 4.16(h), at 77; 8 C.F.R. § 1003.39.

3. **Appeal to Federal Courts of Appeals.** The Respondent may appeal a BIA decision to the Federal Circuit Court of Appeals. To appeal, a party must file a Petition for Review within 30 days of the final order of removal.[43] Unlike appeals to the BIA, once a party makes an appeal to the circuit court, there is no automatic stay of removal.[44] Therefore, the practitioner must file a Motion for Stay of Removal when making a federal appellate claim. The circuits are currently split regarding the standard of proof required for a Motion to Stay.

[42] 8 C.F.R. § 1003.
[43] INA § 242(b)(1). *See* § 242(c) for additional requirements for a Petition for Review.
[44] INA § 242(b)(3)(B).

II. OBTAINING MEDICAL CONSENT, RECORDS, AND TREATMENT

A. Introduction and Resources

1. The 2000 and 2008 Detention Standards on Medical Care

Existing Standard: The 2000 NDS. The existing standard governing administration of medical care at ICE detention facilities is the National Detention Standard issued in September 20, 2000, *INS Detention Standard Medical Care* form attached in **Appendix 1**). It is available online at http://www.ice.gov/doclib/partners/dro/opsmanual/medical.pdf.

The Detention Standard applies to the following types of facilities housing detainees: service processing centers ("**SPCs**"); contract detention facilities ("**CDFs**"); and state or local government facilities used by the Office of Detention and Removal ("**DRO**"), a division of ICE, through intergovernmental service agreements ("**IGSAs**") to hold detainees for more than seventy-two hours.

New Standard: 2008 PBNDS. The new Performance-Based ICE/DRO Detention Standard on Medical Care, published December 2, 2008, as part of the new ICE Performance-Based National Detention Standards (*ICE/DRO Detention Standard Medical Care, December 2, 2008)* attached in **Appendix 2** and together with the 2000 NDS, the "**NDS**"), will supersede the 2000 NDS.[45] The DRO is currently transitioning into these new standards over eighteen months. The 2008 PBNDS will take full effect in all facilities housing ICE detainees in January 2010. Until then, the 2000 NDS serves as the standard. The 2008 PBNDS resulted from lobbying efforts by detainee advocacy groups and introduces improved procedures for administering services (including medical care) to detainees. The explanations and tips that follow in this section note where the 2000 NDS and 2008 PBNDS differ significantly.

An attorney should not expect that the NDS will be enforced, or consider them enforceable. All facilities housing ICE detainees are contractually required to be in compliance with ICE's detention standards. However, the 2000 NDS does not have the force of law, which leaves little recourse to an affected detainee if a facility does not meet the standards. In fact, noncompliance with the 2000 NDS is prevalent, and facility staff is often unfamiliar with the NDS. The 2008 PBNDS likewise will not have the force of law, and practitioners should anticipate the same noncompliance issues.

Practitioner's Tip: While the detention standards are not fully enforced in practice, they are useful to attorneys for a number of reasons. For example, the enumerated detention standards:

- provide a basis to make a specific request on behalf of a detainee;
- provide support for pursuing a claim that a detainee is not receiving services to which he is entitled; and
- require that detention facilities document certain items, useful for attorneys who need to create a "paper trail" of documentation to support their clients' cases.

[45] The 2008 PBNDS encompasses forty-one standards, of which one addresses medical care.

2. Who's Who: ICE, INS, DHS and DIHS

The Immigration and Naturalization Service ("**INS**") was an agency within the Department of Justice. INS ceased to exist in March 2003 and was replaced by three new agencies under the DHS. ICE is one of those three new DHS agencies. The 2000 NDS was issued before the transition, so the 2000 NDS is entitled "**INS Detention Standard**," while the 2008 PBNDS is entitled "**ICE/DRO Detention Standard**" (emphases added). Thus, when practitioners refer to the 2000 NDS, they should mentally "replace" INS with ICE.

The Division of Immigration Health Services ("**DIHS**") is a division within DHS that provides or arranges for health care services for ICE detainees. While ICE and DIHS both fall under the umbrella of DHS, they are separate agencies and consist of very different personnel (DIHS employees are medical personnel). DIHS (not ICE) will have to approve non-routine health care services for detainees (*e.g.*, transfers of detainees to facilities better able to provide medical needs or out-of-facility medical visits[46]).

Despite the important role that DIHS plays, an attorney and the detainee do not have direct contact with DIHS. For the most part, an attorney can only advocate to representatives of the detainee's detention facility and the detainee's detention officer from ICE.

Practitioner's Tip: An attorney's points of contact in representing a detainee:

- **Detention Center Personnel** – day-to-day contact to make requests and inquiries;
- **ICE Detention Officer** – less frequent contact, serves as indirect contact with DIHS; and
- **DIHS** – no direct contact.

B. Competency and Guardianship for Medical Purposes

1. Personal Representatives and Guardianship

When a client lacks competence, he may not be able to legally sign an engagement letter, authorize the release of medical records, consent to medical treatment or sign a power of attorney. In such a case, an attorney will need to alter his representation strategy, because the client's ability to execute basic and preliminary documents for proper representation may be compromised. In some cases, requests for documentation and certain decisions may need to be made by a guardian.

- To obtain medical records for an incompetent detainee, an authorized request under the Health Insurance Portability and Accountability Act ("**HIPAA**") can be signed by a "personal representative." 45 C.F.R. § 64.502(g)(2). Although HIPAA is federal law, "personal representative" is defined by state law. In other words, a "covered entity" must honor requests for medical records by a personal representative; however only the state determines who is recognized as a valid personal representative. In Virginia, for example, personal representatives include parents, those with a health

[46] INS Detention Standard on Detainee Transfer § III(B) (to be superseded by ICE Detention Standard on Transfer of Detainees when it takes full effect in January 2010).

care power of attorney (but only medical records for current medical condition) and legal guardians (appointed by the state court). For more information on access to medical records in Virginia, see http://ihcrp.georgetown.edu/privacy/stateguides/va/va.pdf.

- Personal representatives/legal guardians can also sign medical consent forms for incompetent detainees. The health care provider must still disclose all the information and risks associated with the medical treatment and its alternatives in order for the consent to be legally valid.
- Even if a client is competent at the start of the attorney-client relationship, the client's mental health status may decline such that he becomes incompetent during the course of representation. This is a particular hazard for clients in detention because of mediocre medical care as well as the emotional strain of detention. If an attorney anticipates future incompetence of a currently competent detainee (for example, because of history of mental illness) the attorney should consider having the detainee sign a psychiatric advance directive (discussed below) or a health care power of attorney appointing a proxy to make health care decisions. If no such preemptive measures are taken before the detainee is officially declared incompetent, an attorney may have to go to state court to get a legal guardian appointed.

2. Psychiatric Advanced Directives

Psychiatric advance directives ("**PADs**") are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment in the event he becomes mentally incompetent. The PAD is an ideal tool used in preparation for the possibility that a person may lose the capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

Almost all states permit some type of legal advance directive for health care, which can be used to direct at least certain forms of psychiatric treatment. In the past decade, twenty-five states have adopted specific PAD statutes. Moreover, in most states, a competent person can provide legal advance instructions for future mental health treatment and the appointment of an agent to make decisions about his psychiatric treatment if he becomes incompetent. Such a directive would become enforceable without the need for court intervention. Most states also provide that the PAD can take effect without a court determination of incompetence. State-specific information on PADs is available on the website for the National Resource Center for Psychiatric Advance Directives, http://www.nrc-pad.org.

A PAD may be a particularly valuable preemptive measure for a detained client who will be released from jail during deportation proceedings. The detainee may be competent while on medication regularly administered in the detention facility, but he may neglect to take the medication regularly outside the structured environment. Thus, it may be advisable to secure a PAD before the competent detainee leaves the detention facility (if representation is still ongoing) so that medical consent issues will not later arise.

C. Obtaining Medical Records

An attorney may wish to access the detained client's medical records for a number of reasons early in his representation of a detainee; for example:

- to obtain the appropriate documentation to support a defense of fear-based persecution of the mentally ill in the detainee's home country;
- to obtain evidence for a mental competency hearing;
- to ensure the detainee's mental status will enable him to understand or participate meaningfully in his representation; and
- to ensure that the detainee receives appropriate medication(s) in the appropriate amounts.

1. Authorized Request for Medical Records by Detainee

Obtaining the medical records of a detainee requires compliance with federal law; namely the Health Insurance Portability and Accountability Act ("**HIPAA**"), the federal agency rules promulgated under HIPAA (the "**HIPAA Privacy Rules**"), any state law setting stricter standards for release of medical records, and the relevant forms for requesting medical records from an ICE detention center.

HIPAA was passed to improve the efficiency and effectiveness of the health care system and includes provisions mandating the adoption of Federal privacy protections for individually identifiable health information. Acting under that mandate, DHS issued the HIPAA Privacy Rules (45 C.F.R. Parts 160, 162 and 164) that govern the release of medical records by health care institutions qualifying as "covered entities" (as defined in the HIPAA Privacy Rules). Generally, the institutions holding a detainee's medical records (*e.g.*, ICE detention centers, hospitals, mental health centers and criminal justice facilities) are considered covered entities under HIPAA. A detainee's request to release medical records must, at a minimum, comply with the HIPAA Privacy Rules. (*see* **Appendix 3 - Appendix 7** for sample requests of medical and mental health records).

State laws that require stricter privacy standards are not preempted by HIPAA, so a detainee may have to comply with additional rules to obtain his medical records in those states. Furthermore, ICE detention centers prefer requests made through particular forms.

Depending on the detainee's medical history, release of his medical records to an attorney may be easy or challenging. On the one hand, it may be relatively easy to obtain a detainee's medical records when he has received medical care at identified facilities and the detainee is unquestionably legally competent to authorize release of those records. However, when a detainee has no documented medical treatment before arriving at the detention center (thus, no medical record to obtain), then it can be a challenge to get meaningful mental health evaluation and documentation from the detention center's health facility.

a. Requests under NDS, HIPAA and State Law

Regardless of a detainee's medical history or mental health status, the likely place for an attorney to first obtain medical records is from the detainee's current detention facility. ICE facilities prefer particular forms for detainee's requests for medical records, and these forms comply with HIPAA requirements as well (described more fully below). The 2000 NDS

recommends Form I-813 (2000 NDS § III(M)), while the 2008 PBNDS specifies only "the appropriate request form" be provided to the detainee for such requests (2008 PBNDS § V(U)(2)). Copies of *INS Healthcare Program Authorization for Disclosure of Information* (Form I-813) attached in **Appendix 8** and *Division of Immigration Health Services Authorization for Release of Confidential Health Information (Form DIHS-003)* attached in **Appendix 9.** Requests must be directed to the "facility health care provider" (2000 NDS § III(M)) or "administrative health authority" (2008 PBNDS § V(U)(2)). Practitioners should contact the facility directly to request the name and contact information for its designated health care provider. The 2000 and 2008 NDS provide that a detainee can release his medical records directly to the detainee's designee. 2000 § III(M); 2008 PBNDS § V(U)(2).

> **Practitioner's Tip:** The 2008 PBNDS provides that copies of medical records will be released at no cost to the detainee. 2008 PBNDS § V(U)(2). Currently, however, some facilities require a small fee (approximately $20). The HIPAA Privacy Rules allows covered entities to charge a "reasonable fee." *See* 45 C.F.R. § 164.524(c)(3).

In lieu of a form, detainees may submit written authorization that complies with the HIPAA Privacy Rules[47] to obtain copies of their medical records from a detention facility. According to the NDS, such written authorization must include the:

- address of the facility to release the information;
- name of the individual or institution to receive the information;
- detainee's full name, alien number (the "**A number**"), date of birth and nationality;
- purpose or need for the information to be released (2000 NDS only; not required in the 2008 PBNDS);
- specific information to be released with inclusive dates of treatment; and
- detainee's signature and date. *See* 2000 NDS § III(N); 2008 PBNDS § V(U)(2).

A detainee would make a similar written request of other health care facilities where he received medical care. CAIR Coalition recommends using a HIPAA release authorization form as a template for written authorization to release medical records. An example can be found online at http://members.mobar.org/pdfs/publications/public/HIPAA.pdf (also found in **Appendix 10**).

[47] HIPAA guarantees consumers the right to inspect and obtain a copy of their own medical records and also restricts access of other entities to those medical records.

Practitioner's Tip for obtaining medical records under a HIPAA release request:

- although the practitioner will want to be as inclusive as possible in his request for medical records, he should be careful not to be too broad. Psychotherapy notes[48] are given greater protection under HIPAA and therefore cannot be aggregated with a request for other medical records. 45 C.F.R. § 164.508(b)(3). The covered entity (detention center) does not have to give the patient or his designee access to these psychotherapy records in response to general requests for medical records. Therefore, the practitioner should specifically request the psychotherapy records, describe the purpose of the request and explain the records' relevance to the purpose; and

- if using a form that specifies an expiration date or event for the authorization, the detainee should indicate that authorization is effective until after appeal.

The HIPAA Privacy Rules establish a floor for protecting patients' privacy. State laws that have more stringent standards protecting patients' privacy rights are not preempted by HIPAA. Therefore, an attorney requesting a patient's medical records must also consult applicable state law to determine whether more onerous standards apply. Health care providers are also obligated to comply with the HIPAA Privacy Rules and state law. If a state law conflicts with the HIPAA Privacy Rules, the health care provider must follow the authority that is most protective of the patient's rights. In addition, some jurisdictions have laws specifically governing access to mental health records (*e.g.*, the District of Columbia and Maryland). For a review of state law regarding access to medical to medical records, see Paul V. Sterns, "Access to and Cost of Reproduction of Medical Records: A Comparison of State Laws," Journal of Legal Medicine (March 2000). For a compilation of state-specific guides on laws applicable to patients' access to medical records, see the Web site of Georgetown University's Center on Medical Records Rights and Privacy and Rights, at http://ihcrp.georgetown.edu/privacy/records.html.

2. Obtaining Records of Medical Screening by Detention Facility

According to the NDS, detention facilities must conduct an initial medical screening, a comprehensive health appraisal and, in some cases, a mental health evaluation. Each stage addresses mental health issues (in theory), specified time frames for performing them, and requires documentation, thereby allowing an attorney to request something specific at a certain time to gather evidence of a detainee's mental health status. These three screening/evaluation stages are discussed in greater detail below.

[48] The HIPAA Privacy Rules define psychotherapy notes as "notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record." 45 C.F.R. § 164.501.

a. Initial Medical Screening of New Arrivals

While initial medical screening and follow-up health appraisal are required by the NDS, the timing and documentation differ for the 2000 NDS and 2008 PBNDS:

2000 NDS § III(D)	2008 PBNDS § V(K)(1)
Medical and mental health screening must be done "immediately" after the detainee's arrival in the detention facility.	Medical, dental, and mental health screening must be done within twelve hours after the detainee's arrival.
Documentation of intake screening: Form I-794 (or equivalent, if facility uses substitute).	Documentation of intake screening: Form I-795A (or equivalent, if facility uses substitute).

Thus, documentation of initial screening (including mental health issues) exists shortly after the detainee's arrival at the detention facility. An attorney with authorization to access a detainee's medical records should be able to get copies of the intake screening form.

Under the NDS, intake screening must include observations and an interview that addresses mental health issues. The 2000 NDS is vague on this point, stating only that "[t]his screening shall include observation and interview items related to the detainee's potential suicide risk and possible mental disabilities, including mental illness and mental retardation." 2000 NDS § III(D). The 2008 PBNDS is more specific, requiring that the medical screening "shall" include, inter alia "[o]bservation of behavior, including state of consciousness, mental status, appearance, conduct, tremor, sweating; [inquiry into] [h]istory of suicide attempts or current suicidal/homicidal ideation or intent." In addition, "[s]creening shall include observation and interview items related to the detainee's potential suicide risk and possible mental disabilities, including mental illness." 2008 PBNDS § V(I)(1). In addition, "[m]ental health screening should include prior history [of] physical, sexual or emotional abuse…" 2008 PBNDS § K(3).

Under the NDS, the initial medical screening is performed by a health care provider or a "trained" detention officer. 2000 NDS § III(D); 2008 PBNDS § V(K)(1). In CAIR Coalition's experience, the screening has been done by detention officers. It is very unlikely that a detainee will see a health care provider at this stage. Practitioners should bear in mind that detention officers must perform comprehensive screenings, touching on many medical and dental issues, and mental health is a small component of that screening.

Practitioners should also bear in mind that "mental health" has a broad meaning as defined in the detention standards, including substance abuse, mental illness, mental disabilities, mental retardation and suicide risk. Thus, a detention facility's mental health program attempts to address all of these issues, some of which are more objectively identified or diagnosed than others. Realistically, detention officers performing the initial screening will only spot the most egregious of mental health issues. More comprehensive evaluation allowing for more thorough review of mental health issues will occur in the health appraisal, described below.

b. Comprehensive Health Appraisal

Following the initial intake screening, a follow-up, comprehensive health appraisal must occur within fourteen days of the detainee's arrival. The health appraisal must be conducted by a health care provider, rather than a detention officer. Like the intake screening, the health appraisal addresses a broad set of medical issues. It is a basic "physical exam" and mental health is generally a small part of the evaluation, if addressed at all. However, because the appraisal must be performed by a health care provider, mental health issues are more likely to be spotted at this stage. 2000 NDS § III(D); 2008 PBNDS § V(J).

The NDS provides that health appraisals may be required earlier than fourteen days or not at all, though these exceptions differ under the 2000 NDS and 2008 PBNDS. This would allow an attorney to advocate for faster health appraisal or a health appraisal where the health care provider has determined that it is not otherwise required.

- **Expedited health appraisal**: "Each facility's health care provider shall conduct a health appraisal including a physical examination on each detainee within fourteen days of the detainee's arrival *unless more immediate attention is required due to an acute or identifiable chronic condition*, in accordance with the most recent ACA Adult Local Detention Facility Standards for Health Appraisals.[49] 2008 PBNDS § V(J) (emphasis added). "The clinical medical authority shall be responsible for review of all health screening forms within twenty-four hours or next business day to assess the priority for treatment (for example, urgent, today or routine)." 2008 PBNDS § V(I)(1). There are no corresponding provisions in the 2000 NDS.

- **No health appraisal**: If there is documented evidence of a health appraisal within the previous ninety days, the facility health care provider may determine that a new appraisal is not required. 2000 NDS § III(D); 2008 PBNDS §V(J).

Notes of the health care provider's health appraisal should be included in the detainee's medical records and should therefore be available to an attorney with authorized access to the detainee's medical records within fourteen days of the detainee's arrival to the facility. Unlike the intake screening, the health appraisal is not recorded on a specific ICE form.

c. Mental Health Evaluation

The possibility of obtaining a mental health evaluation after the health appraisal differs under the 2000 NDS and the 2008 PBNDS. The 2000 NDS has no provisions for a mental health evaluation or a mental health program. The only related provisions are "special needs," which provide that "[t]he medical care provider for each facility will notify the Officer in Charge ("**OIC**") in writing when a detainee has been diagnosed as having a medical or psychiatric condition requiring special attention (*e.g.*, pregnancy, special diet, medical isolation, AIDS, etc.)"[50] and the requirement that a detention officer contact a health care provider if a detainee requires emergency medical care.[51]

[49] The American Correction Association ("ACA") publishes a standards manual, available by order (online at http://www.aca.org/standards/healthcare/Standards.asp), or by mail, which is referenced by the 2008 PBNDS.
[50] 2000 NDS § III(J)
[51] 2000 NDS § III(D).

In contrast to the 2000 NDS, the 2008 PBNDS describes a mental health program, which includes a mental health evaluation. Whether a detainee receives a mental health evaluation depends on whether the intake screening officer or health care provider conducting the health appraisal finds a need for it and if so the administrative health authority issues a referral.

- **Trigger for mental health evaluation**. "If at any time during the screening process there is an indication of need, or request for, mental health services, the mental health authority must be notified within twenty-four hours. The clinical medical authority will ensure a full evaluation if indicated." 2008 PBNDS § V(K)(3). "Based on intake screening, medical documentation or subsequent observations by detention staff or medical personnel, the administrative health authority shall immediately refer any detainee with mental health needs to a mental health provider for a mental health evaluation." 2008 PBNDS § V(L).

- **Possibility of mental health evaluation**. "The clinical medical authority shall be responsible for review of all health appraisals to assess the priority of treatment." 2008 PBNDS § V(J).

- **A mental health provider performs the evaluation**.

- **What's covered?** In the mental health evaluation, the mental health provider must include:

  - reason for referral;
  - history of any mental health treatment or evaluation;
  - history of illicit drug/alcohol use or abuse or treatment for such;
  - history of suicide attempts;
  - current suicidal/homicidal ideation or intent;
  - current use of any medication;
  - estimate of current intellectual function;
  - prior history physical, sexual, or emotional abuse;
  - impact of any pertinent physical condition, such as head trauma;
  - recommendation for appropriate treatment (including remaining in the general population with psychotropic medication and counseling, "short-stay" unit or infirmary, special management unit, or community hospitalization); and
  - recommendation and/or implementation of a treatment plan, including recommendations concerning transfer, housing, voluntary work, and other program participation. *See* 2008 PBNDS § V(K)(3).

Practitioner's Tip: If a detainee has gone through the health appraisal process and is not recommended for a mental health evaluation, the attorney should submit a written request to the Field Office Director for an independent examination (2008 PBNDS § V(Y)) or seek an independent health care practitioner. *See* Section V for a list of possible resources.

To summarize the three screening/evaluation stages within the detention facility:

Stage	Details
Initial Medical Screening	**Timing:** Immediately or within twelve hours of the detainee's arrival **By whom:** Detention officer **Documentation:** Form I-794 or Form I-795A **Requirement to get to next stage:** None. Health appraisal will be conducted unless there has been an appraisal within the previous ninety days and another appraisal is deemed unnecessary.
Comprehensive Health Appraisal	**Timing:** Within fourteen days of the detainee's arrival **By whom:** Health care provider **Documentation:** Recorded in medical records **Requirement to get to next stage:** (i) Recommendation to administrative health authority; then referral by administrative health authority for mental health evaluation; or (ii) Request for mental health services, notification to health authority, and referral by administrative health authority. (applies as of Jan. 2010, only in 2008 PBNDS
Mental Health Evaluation within Facility's Mental Health Program (*applies as of Jan. 2010, only in 2008 PBNDS*)	**Timing:** Within fourteen days of referral by administrative health authority (if referred) **By whom:** Mental health provider **Documentation:** Recorded in medical records

The table below presents a key to who's who under the 2008 PBNDS mental health program. Practitioners should be aware, however, that these programs will be newly established in 2010, and detention facilities may have their own organization of personnel. The titles listed below may not exactly coincide with those used by the particular detention facility.

Detention Facility Personnel	Role in Mental Health Screening or Evaluation
Administrative Health Authority	a physician, health services administrator, or health agency with overall responsibility for health care services; authorized and responsible for making decisions about the deployment of health resources and the day-to-day operations of the health services program
Clinical Medical Authority	a physician, licensed independent practitioner or other clinically trained professional designated by a physician to have final medical decision-making authority with responsibility for medical clinical care
Joint: Administrative Health Authority and Clinical Medical Authority	administrative officials who establish processes and procedures necessary to meet medical standards set forth in the NDS; ensure due process in compliance with applicable laws
Facility Administrator	an administrative official who negotiates and maintains arrangements with nearby medical facilities or health care providers; identifies custodial officers to transport and accompany detainees for off-site treatment
Health Care Personnel	perform duties for which they are credentialed through training, licensure, certification, job descriptions, and/or written standing; or credentialed through direct orders by personnel legally authorized to give such orders
Mental Health Provider	a psychiatrist, physician, psychologist, clinical social worker or other appropriately licensed independent mental health practitioner; develops treatment/management plans that may include transfer.

See "Designation of Authority," 2008 PBNDS § V(B).

3. Obtaining Medical Records of a Transferred Detainee

Detainees may be transferred from one detention facility to another. We have observed that transfers are more common for detainees with mental health issues. The 2000 NDS allows transfers of a detainee in need of specialized or long-term medical care to a facility that can

meet those needs. ICE Detention Standard on Detainee Transfer (2004) § III(B).[52] What is special about transferred detainees is that the transfer generates specific documentation that can contain information about mental health issues. Practitioners should therefore be prepared to request certain documentation particular to transferred detainees to obtain all relevant medical information.

In theory, all relevant medical records should accompany the transferred detainee in a medical care summary marked "CONFIDENTIAL MEDICAL RECORDS." 2000 NDS § III(N); 2008 PBNDS §§ V(R) and V(U)(4)(b); 2004 ICE Detention Standard on Detainee Transfer § III(D)(6); 2008 ICE Detention Standard on Transfer of Detainees § V(D)(1). An attorney should ask for all medical records from the transferee's current detention center, but we have frequently observed that medical records often do not accompany transferees. An attorney should thus plan to request medical records from the transferee's prior detention facility as well.

Practitioner's Tip: Although detainees should be accompanied by their complete medical records upon transfer, this often does not happen in practice. An attorney will likely have to request medical records individually from each facility where the detainee resided (*e.g.*, prior detention facilities, mental health institutions, criminal justice facilities, etc.).

In particular, an attorney representing a transferred detainee should request the following forms held by ICE. He should make the request directly with the client's assigned case officer at ICE's local Detention & Removal Office. The following forms are in ICE's custody, not the detention center's, so requests must be directed to the client's case officer:

- **Form I-216:** Record of Property Transferred. The form must clearly note any medical/mental problems or medications. 2004 ICE Detention Standard on Detainee Transfer § III(C)(1); 2008 ICE Detention Standard on Transfer of Detainees §§ V(C) and V(D).

- **Form USM-553 or Form I-794:** In-Processing Health Screening Form. If Form I-216 indicates medical/mental problems or medications, then it must be accompanied by either JPATS[53] Form USM-553 or Form I-794. Form USM-553 must show current mental and physical health status, including all significant health issues and current medications. 2004 ICE Detention Standard on Detainee Transfer §§ III(C)(1) and III(C)(3); 2008 ICE Detention Standard on Transfer of Detainees §§ V(C) and V(D).

- **Form I-203**: **Order to Release Alien**. The form must include any special medical problems that may require attention during the transfer and any prescription medication. 2004 ICE Detention Standard on Detainee Transfer § III(D)(7); 2008 ICE Detention Standard on Transfer of Detainees § V(D)(7).

---

[52] The current ICE Detention Standard Detainee Transfer (June 16, 2004) is available at http://www.ice.gov/doclib/partners/dro/opsmanual/dettransstdfinal.pdf and in the attached **Appendix 11**. The 2004 Standard will be superseded by the ICE/DRO Detention Standard on Transfer of Detainees (published December 2, 2008) when it takes full effect in January 2010. Available at http://www.ice.gov/doclib/PBNDS/pdf/transfer_of_detainees.pdf and in the attached **Appendix 12**. The 2008 Standard also permits transfer of a detainee whose medical needs cannot be met at his/her present facility. 2008 Transfer Standard § V(A).

[53] JPATS is the acronym for Justice Prisoner Alien Transport System, whose protocols ICE follows when transferring detainees. 2004 ICE Detention Standard on Detainee Transfer § I.

4. FOIA Requests

If medical records are difficult to obtain by direct requests to the detention center, an attorney should then try to obtain them under the federal Freedom of Information Act ("**FOIA**") governing federal agencies (5 U.S.C. § 552) or a state's laws governing public access to state records. While all fifty states have public records laws that allow members of the public (including non-residents) to obtain documents and other public records from state and local government bodies, state public records laws are not identical to FOIA. Also, state court interpretations of state statutes with language similar to FOIA are not identical to federal court interpretation of FOIA. The appropriate request (federal or state) depends on whether a detainee is held in a federal or state detention facility.

a. Federal FOIA Requests

Under FOIA, a federal agency must disclose records that the agency holds when requested in writing by any person (with the exception of specific exemptions and exclusions by statute). An attorney seeking records on a detainee should submit a FOIA request to the U.S. Citizenship and Immigration Services ("**USCIS**"), which holds alien files ("**A-Files**").

The USCIS Web site provides specific instructions for making FOIA requests and recommends a specific form (G-639). (*See* http://www.uscis.gov or http://www.uscis.gov/files/pressrelease/FOIAProcessing022807FS.pdf) The request may be made by the detainee or his representative and must include the name, address and signature of the requester; the name of the subject of the record; the A-Number if available; and the signature of the subject of the record. Additional information (such as parents' names, country of birth, date of birth, date of entry or any other information available to the requester) will help USCIS process the request as well.

USCIS uses a three-track system to process FOIA requests, where "Track Three" is dedicated to requests by individuals scheduled for a hearing before an immigration judge. Track Three is relatively new (effective March 30, 2007) and provides accelerated access to A-Files. A Track-Three request must be accompanied by one of the following: a Notice to Appear (Form I-862); an Order to Show Cause (Form I-122); a Notice of Referral to Immigration Judge (Form I-863); or a written request of continuation of a scheduled hearing before the immigration judge. Practitioners should be aware that expedited requests under Track Three are unpredictable and can take approximately one to six months before records are delivered.

When making FOIA requests for medical records, the HIPAA Privacy Rules still apply.[54] Thus an attorney should make sure that a HIPAA-compliant authorization accompanies the FOIA request.

> **Practitioner's Tip:** While USCIS holds A-Files, a practitioner should be aware that additional records are held by ICE and U.S. Customs and Border Protection ("***CBP***"). For example, ICE holds transfer records and CBP holds entry records. To obtain a complete file of a detainee's records, FOIA requests have to be made of all three agencies. However, the A-File obtainable by USCIS will have most of the information that practitioners require for representation purposes.

[54] FOIA specifically permits the government to withhold all information about individuals in "personnel and medical files and similar files" when the disclosure of such information "would constitute a clearly unwarranted invasion of personal privacy." 5 U.S.C. § 552(b)(6). However, this exemption cannot be invoked to withhold from a requester information pertaining to the requester.

b. State Public-Access Requests

When a detainee is held in a state or local government facility through an intergovernmental service agreement ("**IGSA**"), the records request should be made under state public-access law. All states have public-access laws allowing members of the public to obtain public records from state and local government bodies. Though many laws are similarly worded to FOIA, state courts may interpret the state laws differently than federal courts interpret FOIA. State public access laws also may have more exemptions than the nine enumerated in FOIA. Maryland, for example, has thirty-two categories of documents exempted from public disclosure. For a compilation of state public-access laws, see http://www.foiadvocates.com/records.html.

In our experience, state public-access requests are fulfilled more quickly than federal FOIA requests, typically taking a week or less depending upon the state. For example, Virginia typically provides records within five days after receiving a FOIA request.

Some state-run detention facilities take the position that they need ICE's permission before releasing detainees' medical records. While we believe that this position is incorrect and has no legal basis, we have found that it does a practitioner little good to contest the facility's decision. If a practitioner confronts this scenario, then he should contact the detainee's ICE detention officer to get permission for release of the records.

D. Medical Consent

Medical consent issues can arise when a detainee is not receiving the medical treatment he needs, when he is receiving inappropriate medical treatment, or when he is not receiving any medical treatment when needed. The standards and law addressing medical consent vary according to the scenario. We set forth four scenarios below to help a practitioner determine what category his detained client falls under and to provide ideas on how to proceed. In this section, we also give a brief overview on the law that applies when the detainee is competent and capable of delivering informed consent. We address medical consent situations when the detainee is incompetent above (*see* Section IIB above on Competency and Guardianship).

1. Consent and Competency: 4 Scenarios

- **Scenario 1**: A mentally competent detainee requires or desires medical treatment and appropriate medical treatment is delivered. This is the straightforward scenario and the mentally competent detainee will sign the medical consent forms provided by the detention facility. Under the 2000 NDS, "[t]he facility health care provider will obtain signed and dated consent forms from all detainees before any medical examination or treatment, except in emergency situations." 2000 NDS § III(L). Under the 2008 PBNDS, documented informed consent will be obtained for the provision of health care services upon a detainee's admission to the facility. For any additional procedure, a separately documented informed consent will be obtained. 2008 PBNDS § V(T).
- **Scenario 2**: A detainee is mentally incompetent and thus cannot give valid consent to any medical treatment, whether such treatment would help him or not. In this case, if the detainee has no health care power of attorney, a legal

guardian needs to be appointed in state court to give medical consent on his behalf. *See* Section III.

- **Scenario 3**: A competent detainee is administered medication or inappropriate amounts of medication against his will; he is not adequately informed of the medication or its dosage beforehand and the effects of the medication are harmful to the detainee. In such cases, it cannot be said that a detainee has given proper informed consent to such medical treatment and the attorney should immediately notify the client's assigned case officer (with ICE's Detention and Removal Office) as well as the Court.
- **Scenario 4**: An initially competent detainee starts to refuse legitimate medication for a mental illness. For example, a schizophrenic detainee may start refusing to take prescribed medication, in which case it may have to be administered against his will. If the detained is still "competent," then he has the right to refuse medical care. As discussed above, there are exceptions; for example, in emergencies, or if the patient is a physical threat to himself or others. If the detainee started out competent and has now become incompetent, then the practitioner should go to state court to get a guardian appointed to give medical consent on behalf the now incompetent detainee. Examples of petitions for guardianship are included at **Appendix 13 – Appendix 15**. If an attorney anticipates future incompetence of a currently competent detainee, the attorney should consider securing a PAD in advance (as discussed above).

In Scenarios 3 and 4, the detention standards and the applicable state's case law on informed consent apply. The NDS recognizes that medical treatment cannot be administered against a detainee's will. 2000 NDS § III(L); 2008 PBNDS § V(T). Furthermore, the NDS requires explanation of risks before treatment and documentation of a detainee's refusal of medical treatment in the detainee's medical records (in the detainee's language or by translation, if needed (2008 PBNDS § V(T)). The 2000 NDS provides that "the medical risks faced if treatment is declined will be explained to the detainee. Medical staff will document their treatment efforts and the refusal of treatment in the detainee's medical record." 2000 NDS § III(L). Likewise, the 2008 PBNDS also provides that "[m]edical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and the refusal of treatment in the detainee's medical record." 2008 PBNDS § V(T). These provisions are helpful to the practitioner because they create documentary evidence of a detainee's refusal.

The detention standards on informed consent generally align with state standards. Most jurisdictions require disclosure to the patient of these basic elements to obtain informed consent from the patient: (1) the patient's diagnosis; (2) details about the proposed treatment and its probability of success; (3) risks of the proposed treatment; and (4) alternative treatments, their probabilities of success and their risks.

As with all general rules, there are exceptions recognized in the NDS as well as in jurisdictional (state) case law. The 2000 NDS permits medical examination or treatment without the detainee's informed consent in emergencies, although ICE must be notified. 2000 NDS § III(L). The 2000 NDS also indicates that forced treatment without consent can be performed if it complies with "strict legal restrictions". 2000 NDS § III(L). Without a clear definition of "strict legal restrictions" this emergency provision for forced treatment appears too broad and hence, inconsistent with many state common laws prohibiting forced treatment. In contrast, the 2008 PBNDS permits medical treatment without a detainee's informed consent, but requires such

treatment follow the informed consent standards of the jurisdiction (2008 PBNDS § V(T)). Most jurisdictions do recognize an emergency exception.

In addition, the 2008 PBNDS explicitly recognizes an informed consent exception for the emergency involuntary administration of psychotropic medications. 2008 PBNDS § V(K)(7). This is a narrow exception, though, and is only permitted when (1) it is permitted by "applicable laws;" (2) the authorizing physician issues specific written and detailed instructions;[55] (3) DRO management is contacted; and (4) DRO management contacts the DHS/ICE Chief Counsel. Thus, an attorney suspecting that his detained client has been involuntarily drugged would have state case law and documentary evidence to support his case.

2. Consequences of Refusing Medical Treatment

If a detainee refuses medical treatment:

- **It might be administered anyway**. As discussed above, the NDS and state law recognize exceptions to the general rule that people can refuse medical treatment. ICE must be consulted in a case of non-consent (*see* 2000 NDS § III(L) and 2008 PBNDS §§ V(T) and V(K)(7)) and it might conclude that forced treatment is nonetheless appropriate.

- **The detainee will be "convinced."** "In SPCs/CDFs, if the detainee refuses to consent to treatment, medical staff will make reasonable efforts to convince the detainee to voluntarily accept treatment." 2000 NDS § III(L). "If a detainee refuses to consent to treatment, medical staff shall make reasonable efforts to convince the detainee to voluntarily accept treatment." 2008 PBNDS § V(T).

- **The detainee will be segregated**. Upon refusal of medical treatment, the 2000 NDS requires the detainee to be segregated from the general population when recommended by the medical staff. 2000 NDS § III(L). In contrast, the 2008 PBNDS permits segregation only when medically necessary for a documented medical reason and not for punitive purposes. 2008 PBNDS § V(T).

> **Practitioner's Tip:** If a detainee refuses medication, he may end up in "medical isolation" or segregation. Continuous refusal of medication may result in continuous segregation. This will likely exacerbate any mental health issues the detainee may have. The attorney should ensure that the detainee is reassessed daily to determine whether segregation should continue, as the detention standards provide. The attorney must be a vigilant advocate and contact the facility's medical provider regularly to confirm that the facility is complying with the detention standards. Also, even segregated detainees have access to medical personnel at regularly scheduled times (sick call) under the 2000 NDS § III(F).

[55] A physician authorizing involuntary psychotropic medications to detainees must (1) review the medical record of the detainee and conduct a medical examination; (2) specify the reason for and duration of therapy and whether the detainee has been asked if s/he would consent to such medication; (3) specify the medication to be administered, the dosage and the possible side effects of the medication; (4) document that less restrictive intervention options have been exercised without success; (5) detail how the medication is to be administered; (6) monitor the detainee for adverse reactions and side effects; and (7) prepare treatment plans for less restrictive alternatives as soon as possible. 2008 PBNDS § V(K)(7).

E. Obtaining Medical Care While in Detention Facilities

1. Mental Health Treatment within the Detention Facility

Currently, detention facilities typically lack resources for adequate mental health treatment. Detention staff is trained to recognize signs and symptoms of mental illness, including suicide risk, retardation, and chemical dependency and to determine whether emergency medical care is required and, if so, to alert the health care provider or on-duty supervisor. 2000 NDS § III(H). The 2000 NDS also requires that facilities allow detainees to request health care services – "sick call" - once a week. The detainee must make a written request on a form and a health care provider reviews request slips to determine whether the detainee will be seen. 2000 NDS § III(F).

The 2008 PBNDS ideally will provide for better mental health treatment because it requires that facilities have a mental health program. The program can be in-house or arranged by contract with outsider medical practitioners. In addition to a mental health evaluation, the program must provide mental health services:

- **Acute episodes.** Each facility must have an in-house or contractual mental health program, approved by the appropriate medical authority that provides crisis intervention and management of acute mental health episodes. 2008 PBNDS § V(K)(1).

- **Medical supervision.** When a detainee requires close medical supervision, including chronic and convalescent care, a written treatment plan that includes access to health care and other personnel regarding care and supervision, must be developed and approved by the appropriate physician, dentist or mental health practitioner, in consultation with the patient, with periodic review. 2008 PBNDS §V(R).

- **Treatment plan.** As part of mental health evaluation, a mental health evaluator will recommend any appropriate treatment; for example, remaining in the general population with psychotropic medication and counseling, short-stay unit or infirmary, special management unit or community hospitalization. The mental health evaluator is also required to recommend and/or *implement a treatment plan*, including recommendations concerning transfer, housing, voluntary work and other program participation. 2008 PBNDS § V(K)(3).

2. Obtaining Medical Services Outside the Detention Center

Detainees can obtain mental health care from outside medical practitioners through two routes: (1) by referral through the detention center's procedures or (2) by requesting and paying for outside treatment.

- **Option 1: ICE Referral**. Detention centers generally have contract arrangements with nearby medical facilities or health care providers to provide "required health care not available within the facility," including specialized services (*e.g.*, mental health care). 2000 NDS § III(A); 2008 PBNDS § V(B). Relying on an ICE referral is not ideal for several reasons. First, ICE is woefully stingy with outside referrals; much-needed mental health care is often not obtained. Second, ICE may not

release the medical records from the mental health provider to the attorney. Third, medical treatment through ICE-contracted providers may be of questionable quality.

- **Option 2: Independent Expert**. A detainee can also seek a mental health evaluation or treatment from an independent practitioner, though he will have to pay for it. CAIR Coalition maintains a list of medical practitioners in the Washington, DC area who are willing to evaluate detainees, sometimes for free. One well-known national group of medical practitioners offering such services is Physicians for Human Rights, http://physiciansforhumanrights.org.

3. Requesting Medication

Detainees often have difficulty obtaining medication that has been prescribed by health care providers. DIHS must approve all medications, and scarce funds often result in long delays before medication is obtained. Attorneys can do little to expedite the process because they do not have direct contact with DIHS. The detainee's ICE detention officer has no control over the approval process, nor do other ICE personnel. The most an attorney can do is direct advocacy efforts toward the detention center to ensure that the prescription or medicine request has been forwarded to DIHS and is on order. We have had practitioners call detention facilities everyday to try to get medications for their detained clients.

Transferred detainees often experience discontinuation of medication upon arrival to a new facility. If a detainee arrives at the new facility without his medication, the attorney should start advocacy efforts right away by requesting medical records, ensuring that his client receives timely medical screenings, and contacting the detention facility to confirm that it has ordered the necessary medications. The 2008 PBNDS may improve the situation by providing that detainees "be transferred with proper medication to ensure continuity of care throughout the transfer and subsequent intake process." 2008 PBNDS § V(U)(4).

4. Challenging Abusive Segregation Practices

A common way for detention facilities to deal with mentally ill detainees is to place them in segregation. Indeed the 2000 NDS and 2008 PBNDS specifically authorize that the clinical medical authority may place a detainee in "medical isolation" (i.e., segregation or solitary confinement) if the detainee is deemed to be at high risk for violent behavior because of a mental health condition. 2008 PBNDS § V(K)(5).

Segregation will likely cause the detainee's mental condition to deteriorate, especially if it continues for long periods, which, unfortunately, is often the case. Abusive segregation practices of mentally ill detainees have been documented by the American Civil Liberties Union. *See* http://www.aclu.org/pdfs/prison/unsr_briefing_materials.pdf.

If a detainee appears to have been subjected to abusive segregation practices, the attorney has several options for helping his client. First, the attorney should create a paper trail by requesting documentation that the segregated detainee has been properly evaluated on a daily basis and that a reason has been given to justify the continued medical isolation. Clinical medical authority must provide for daily reassessment of the need for continued medical isolation of the health and safety of the detainee. 2008 PBNDS § V(K)(5). Second, in extreme cases of abusive segregation, an attorney may consider advocating for the detainee's transfer to another facility that more reasonably copes with the mentally ill. Abusive segregation is a particularly strong argument for transfer. DIHS can recommend that a detainee in need of

specialized or long-term medical care be transferred to a facility that can better meet those needs. 2000 NDS § III(N); 2008 PBNDS § V(A). Frequent segregation of a detainee is evidence supporting an argument that the current detention facility cannot meet the detainee's medical needs, and thus the detainee should be transferred for medical reasons.

A word of caution about requesting a detainee's transfer: there is no guarantee that a transferred detainee will go to a better facility or to a facility nearby. For example, a detainee transferred out of a Virginia jail could go to the next closest facility, which is in South Carolina. Instead of advocating for transfer to another ICE facility, we recommend trying to find a local halfway house that will accept the detainee. In our experience, DRO has been willing to release detainees into the care of such organizations. We have found that if an attorney provides ICE with a care plan or sponsor, ICE is cooperative and releases the detainee. We do NOT recommend requesting transfer to a mental health facility. In our experience, it is difficult to keep in touch with detainees in such facilities, which hinders the attorney's representation.

III. LITIGATION STRATEGIES FOR MENTALLY INCOMPETENT CLIENT

The majority of people with mental illness are high functioning and extremely competent. However, there remain some whose mental illness is so debilitating as to render them not competent to perform certain functions such as articulating rational legal objectives. This chapter focuses on the minority of clients with mental illness who may be considered mentally incompetent.

A. Constitutional, Statutory, and Regulatory Framework

1. Due Process Considerations

The Fifth Amendment of the United States Constitution affords due process protection to all respondents in immigration proceedings. This due process protection includes a requirement that a respondent possess a certain level of competency in order to effectively participate in a removal hearing. The essence of due process is the requirement that, "a person in jeopardy of serious loss (be given) notice of the case against him and opportunity to meet it." [56]

As a threshold matter, the Supreme Court has held that Constitutional due process protections apply to all persons, including non-citizens in removal proceedings. [57]

Although immigration hearings are civil proceedings, the liberty interest at stake is extremely significant. As recognized by the Supreme Court in the Bridges case, removal from this country "visits a great hardship on the individual and deprives him of the right to stay and live and work in this land of freedom." [58]The *Bridges* court continued, "Meticulous care must be exercised lest the procedure by which he is deprived of that liberty not meet the essential standards of fairness." *Id.* Removal has also been characterized as "a drastic measure and at times the equivalent of banishment or exile." [59]

In light of the significant interests implicated in immigration proceedings, the government must ensure that a respondent is afforded an adequate opportunity to be heard before a final adjudication is reached. The onus to provide a fair process is even greater in the case of a mentally-impaired respondent. The Court has stated, "All that is necessary is that the procedures be tailored, in light of the decision to be made, to the 'capacities and circumstances of those who are to be heard,' to insure that they are given a meaningful opportunity to present their case." [60]

Accordingly, courts recognize that due process precludes the removal of an unrepresented noncitizen who was not competent at the time of his removal hearing. [61]

Although courts have recognized that special protections be afforded incompetent respondents in immigration proceedings to ensure fairness and compliance with the Fifth Amendment's due process provision, no court has held that such protection rises to the level of

---

[56] *Mathews v. Eldridge*, 424 U.S. 319, 348-49 (U.S. 1976) (internal citations omitted).
[57] *Demore v. Kim, 538 U.S. 510, 523 (U.S. 2003); Reno v. Flores*, 507 U.S. 292, 306 (1993) (noting that it is "well-established that the Fifth Amendment entitles aliens to due process of law in deportation proceedings").
[58] *Bridges v. Wixon*, 326 U.S. 135, 154 (1945).
[59] *Tan v. Phelan*, 333 U.S. 6, 10 (1948).
[60] *Mathews*, 424 U.S. at 348-49, (1976) (internal citations omitted).
[61] *Aguilera-Enriquez v. INS*, 516 F.2d 565, 568 & n.3 (6th Cir. 1975)("Where an unrepresented indigent alien would require counsel to present his position adequately to an immigration judge, he must be provided with a lawyer at the Government's expense."); U.S. v. Campos-Asencio, 822 F.2d 506, 509 (5th Cir. 1987)(noting that, "an alien has a right to counsel if the absence of counsel would violate due process under the fifth amendment.").

immunity from removal proceedings. In *Jaadan v. Gonzales*, [62]the Sixth Circuit held that because a determination of mental incompetence does not preclude deportation of an alien, it stands to reason that mental incompetence does not prevent the commencement of removal proceedings. [63](“[T]he law specifically contemplates that removal proceedings may go forward against incompetent aliens and that incompetent aliens may be deported.”) [64]

2. Statutory and Regulatory Protections

In addition to Fifth Amendment due process considerations, the Immigration and Naturalization Act (“**INA**”) contains several provisions directed toward protecting the rights of a mentally impaired respondent. These include the right to be accompanied during execution of a removal decision, [65]as well as the following protections during proceedings:

1. **Competency to Accept Service of Notice to Appear**. Immigration authorities must ensure that an individual being served with a Notice to Appear for removal proceedings is “competent” to accept such service.[66]

2. **Obligation of the Government to Protect the Rights of the Impaired**. Section 240(b)(3) of the INA provides, “[i]f it is impracticable by reason of an alien’s mental incompetency for the alien to be present at the proceeding, the Attorney General shall prescribe safeguards to protect the rights and privileges of the alien.” Courts have generally interpreted presence to mean both mental and physical presence.

3. **Competency to Submit Pleas**. Regulations forbid immigration judges from accepting admissions of removability from incompetent individuals. [67]“The immigration judge shall not accept an admission of removability from an unrepresented respondent who is incompetent or under the age of 18 and is not accompanied by an attorney or legal representative, a near relative, legal guardian, or friend; nor from an officer of an institution in which a respondent is an inmate or patient.”[*Id.*]

4. **Physical Presence not Required if Impracticable**. When it is impracticable by reason of an alien’s mental incompetence for the alien to be present, the presence of the alien may be waived provided that the alien is represented at the hearing by an attorney or legal representative, a near relative, legal guardian or friend.[68] This provision appears to vest the family member or other guardian who received the Notice to Appear with the authority to make the strategic decisions in the legal representation of the alien. Additionally, under the regulations an attorney can make decisions on behalf of his incompetent client as well as speak on his behalf.

---

[62] 211 F. App’x. 422 (6th Cir. 2006),

[63] (“Not only would Jaadan likely fail to establish incompetency…but, even if he did, he could still be deported.”) *Id.* at 431.

[64] (citing *Wong v. INS*, 550 F.2d 521, 523 (9th Cir. 1977)). *See* also, *Brue v. Gonzales*, 464 F.3d 1227 (10th Cir. 2006)(“contrary to the substantive due process protection from trial and conviction to which a mentally incompetent criminal defendant is entitled…removal proceedings may go forward against incompetent aliens”).

[65] *See* INA § 241(f)(1), 8 U.S.C. § 1231(f)(1) (2007) (requiring the Attorney General to employ a suitable person to accompany and care for a non-citizen with mental health issues during the execution of removal),

[66] 8 C.F.R. § 103.5a(c)(ii).

[67] 8 C.F.R. § 1240.10(c).

[68] 8 C.F.R. § 3.25(a) (2000).

Practitioner's Tip: For many practitioners, the idea of making decisions on behalf of an incompetent client presents an ethical dilemma. For this reason, we recommend that attorneys obtain a guardian ad litem to assist in the representation. This is more thoroughly explained below.

Also, the regulations allow an attorney, guardian or other representative to appear on behalf of the mentally incompetent respondent, but "[i]f such a person cannot reasonably be found or fails or refuses to appear, the custodian of the respondent shall be requested to appear on behalf of the respondent." 8 C.F.R. § 1240.4. We understand that in a few jurisdictions, the Government has interpreted this regulation to allow DHS officials to appear in court on behalf of the respondent. The conflict of interest and lack of due process inherent in such case seems obvious. A removal order resulting from a hearing in which DHS acted as both prosecution and defense, can and should be contested based on the fundamental principles of fairness discussed above. Nevertheless, the fact that DHS would resort to such strategy underscores the importance of obtaining representation for these cases.

3. Case Law

Although the statutory and due process considerations suggest that judges must take special steps to ensure that mentally incompetent respondents are afforded a fair hearing in immigration court, there is virtually no guidance on what these steps should be. For example, there is no statutory or regulatory definition of competency, no explanation for how to determine whether a respondent is competent for trial and no mandate requiring judges to make a competency determination. Consequently, courts have interpreted the rules pertaining to incompetent respondents in different ways.

The practitioner should use the lack of clear guidance and consistent interpretations to his advantage. Although judges are typically reluctant to rule in a manner that is not specifically prescribed by regulation or precedent, due process and principles of fundamental fairness are powerful weapons the practitioner can use to persuade a judge to move outside his comfort zone. Also, the practitioner can refer the immigration judge to other civil contexts where incompetent litigants are afforded extra protection – such as appointment of counsel or guardian – to ensure fairness. And finally, even the Board of Immigration Appeals has explicitly recognized the need for additional safeguards in removal proceedings involving pro se incompetent respondents. [69]

a. Competency Hearing

There is no directly-applicable standard within the immigration context for determining whether a respondent is entitled to a competency hearing. Generally, courts have found that competency is only relevant when a respondent is pro se. In *Jaadan*, the Sixth Circuit Court of Appeals considered whether an alien subject to deportation proceedings had a due process right to a competency hearing before deportation. The court held that an alien involved in deportation proceedings had a right to a competency hearing only to determine whether the alien required representation by either an attorney or guardian.[70] The court held that "[t]he only time a competency hearing may be required in the immigration context is to determine whether

[69] *See* unpublished Board decisions, **Appendix 16 - Appendix 21**.
[70] *See Jaadan v. Gonzales*, 211 F. App'x. 422 (6th Cir. 2006).

an *unrepresented* alien shows sufficient evidence of incompetency to require an attorney or guardian to represent the alien's interests at the proceedings."[71]

> **Practitioner's Tip**: The practitioner should not by any means accept the Jaadan holding as settled law, but should push the court to make a determination as to the competency of a represented client. We discuss in greater detail how to best argue for a competency determination in Section II, Approaches.

b. Incompetency

Criminal proceedings analysis: The often-cited test for mental competence in the criminal context is set forth in *Dusky v. U.S.*, 362 U.S. 402 (1960), and *Drope v. Missouri*, 420 U.S. 162 (1975). These cases outline a three part test for competency. Under the *Dusky/Drope* test the trial court must determine whether the alien: "has sufficient present ability to consult with his [or her] lawyer with a reasonable degree of rational understanding";[72] has "the capacity . . . to assist in preparing his [or her] defense";[73] and "has a rational as well as factual understanding of the proceedings against him [or her]."[74] Indicia of competence can include a defendant's behavior, his demeanor at trial and any prior medical opinion on competence.[75]

A court may refuse to apply the *Dusky* standard in immigration proceedings based on the belief – not necessarily correct - that the procedural due process rights to a competency hearing articulated in *Dusky* have the sole purpose of preventing the conviction of a mentally incompetent defendant. *See*, *Vogt v. U.S.*, 88 F.3d 587, 590 (8th Cir. 1996); *Mohamed v. TeBrake*, 371 F. Supp. 2d 1043, 1046 (D. Minn. 2005). As the federal district court in Minnesota explained, the procedural requirements for a competency hearing, "exists only to ensure that a second, 'substantive' competency principle is not violated. The substantive competency principle holds that due process absolutely prohibits the trial and conviction of a defendant who is, in fact, mentally incompetent". Because there is no analogous prohibition against the deportation of a mentally incompetent respondent, the DHS may argue that the procedural due process rights articulated in *Dusky* do not apply in immigration proceedings.

Contrastingly, the Supreme Court has recognized the inherent similarities between criminal and immigration proceedings and has applied other procedural protections derived from a criminal context in immigration settings. *See, e.g., Schneiderman v. U.S.*, 320 U.S. 118, 160 (1943) (declining to consider issues not explicitly pled in the complaint, in an immigration proceeding). ("A denaturalization suit is not a criminal proceeding. But neither is it an ordinary civil action since it involves an important adjudication of status. Consequently we think the Government should be limited, as in a criminal proceeding, to the matters charged in its complaint."). Arguably, the fundamental interests at stake in removal proceedings are often tantamount to or even greater than those in criminal proceedings. This is particularly true for a respondent with mental illness facing possible deportation to a country where he will have no access to medical care, or worse, he will face persecution. Additionally, as discussed above, courts have recognized that fundamental principles of fairness require that respondents with diminished capacity be afforded higher protections.

---

[71] *Jaadan*, 211 F. App'x at 430.
[72] *Dusky*, 362 U.S. at 402.
[73] *Drope*, 420 U.S. at 171.
[74] *Dusky*, 362 U.S. at 402.
[75] *Drope*, 420 U.S.,at 180.

Civil proceedings analysis: The Federal Rules of Civil Procedure protect the rights of incompetent litigants under Fed. R. Civ. P. 17(c), which requires a court to, "appoint a guardian ad litem, for an infant or incompetent person not otherwise represented in an action or … make such other order as it deems proper for the protection of the infant or incompetent person." [76] Moreover, there is no doubt that Fed. R. Civ. P. 17(c) applies in administrative as well as civil cases.[77]

At least one Federal district court has applied the Federal Rules standard in immigration proceedings. In *Mohamed v. TeBrake*, the U.S. District Court for the District of Minnesota applied Fed. R. Civ. P. 17(c) to its analysis of a petitioner's claim that an immigration judge violated his right to due process of law for failure to hold a competency hearing. The court held, "that it is an abuse of discretion when an immigration judge, faced with evidence of a formal adjudication of incompetence or medical evidence that an alien has been or is being treated for the sort of mental illness that would render him incompetent, fails to make at least some inquiry as to whether [8 C.F.R.] §1240.4 ought to be applied."[78]

Unlike the criminal setting where a defendant's behavior or demeanor may be sufficient to compel a judicial inquiry into competency, civil proceedings typically require more evidence of incompetency before gating a judge to ascertain a litigant's competence. In *Ferrelli v. River Manor Health Care Center*, the Second Circuit held that Rule 17(c) does not, "obligate[] a district court to monitor a pro se litigant's behavior for signs of mental incompetence." 323 F.3d 196, 201 (2d Cir. 2003). The Court ruled that a judge would only have a duty to ascertain a litigant's competency if it had received evidence such as a court record or ruling by a public agency, indicating the litigant suffered from a mental illness that could render him incompetent.

Other courts have been similarly reluctant to recognize a judicial obligation to inquire into a litigant's competency unless some formal adjudication of incompetence has been brought to a court's attention. *See*, *Hudnall v. Sellner*, 800 F.2d 377 (4th Cir. 1986). But see, *Yoder v. Patla*, No. 98-4212, 2000 WL 1225476 at *3 (7th Cir. Aug. 22, 2000)("Significantly, if the state in fact has adjudged [the appellant] to be incompetent, that adjudication may not be overridden by the district court's subjective belief about [his] ability to prosecute his suit."; *Matchem v. Frank*, No. 92-1341, 1993 WL 264691 (4th Cir. July 15, 1993)(court reversed and remanded where plaintiff had submitted two letters to the district court from his treating psychologist which stated that he was not capable of adequately representing himself). *See* sample motions re competency at **Appendix 22** and **Appendix 23**.

Appointment of Guardian: Although Rule 17(c) requires a court to appoint a guardian to represent an incompetent litigant if he is not otherwise represented, courts have also recognized the need for guardians in cases where an incompetent litigant is represented by an attorney. Because the duties of an attorney are distinct from, and can conflict with, the duties of a guardian, it is imperative that they not be one and the same person. In *Johns v. Department of Justice*, the Fifth Circuit ruled that a guardian ad litem must be appointed in a case involving a

[76] *See*, *Neilson v. Colgate-Palmolive Co.,* 199 F.3d 642-57 (2d Cir. 1999) ("[Fed. R. Civ. P. 17(c)] which is is structured…to allow a district court to ensure-through appointment of a guardian ad litem-that a lawsuit by or against an incompetent can proceed"); *Richards v. Duke Univ.,* 166 F.. App'x. 595, 598 (3d Cir. 2006); *United States v. 30.64 Acres of Land,* 795 F.2d 796 (9th Cir. 1986)(reversing lower court for its failure to consider under Fed. R. Civ. P. 17(c) whether it had to appoint a guardian ad litem for appellant after appellant presented substantial evidence suggesting his…incompetency).

[77] *See*, *Ruppert v. Sec'y of the U.S. HHS,* 671 F.Supp. 151 (E.D.N.Y. 1987) *aff'd in part and rev'd in part on other grounds* by *Ruppert v. Bowen,* 871 F.2d 1172 (2d Cir. 1989).

[78] *Mohamed v. TeBrake* 371 F. Supp. 2d 1043, 1047 (D. Minn. 2005).

five year old minor respondent in legal proceedings. Although the child was represented by counsel, the same counsel represented the couple with whom she lived. The court determined that because the couple could not be assumed to represent the child's interests, a guardian should be appointed.

Contrastingly, in *Calero v. INS,* 957 F.2d 50 (2d Cir. 1992), the second circuit rejected an attorney's complaint that sought the appointment of a guardian ad litem at government expense, for his fifteen year old client in immigration proceedings. The circumstances in that case however, are easily distinguishable from those involving a mentally incompetent adult. Specifically, the court found that the respondent, although a minor, was old enough and competent enough to communicate with his attorney. In addition, the respondent lived with four adults who could represent his best interests and who could assist him in his communications with his attorney.

Notwithstanding the end result in *Calero,* the second circuit's rationale can be interpreted to support the appointment of a guardian in cases where a represented litigant is incompetent and otherwise unable to assist the attorney in the legal representation. The court emphasized the young adult's competency in that case and asserted that its decision did "not address whether the appointment of such guardian may be constitutionally required in isolated, unusual and egregious circumstances."[79]

4. Attorney- Client Relationship

If a client is deemed incompetent – whether according to the *Dusky/Drope* standard or Fed. R. Civ. P. 17(c) how are the respondent's statutory and due process rights to effective assistance of counsel met? A client must be sufficiently competent to drive the attorney-client relationship. (*See, e.g.*, the second prong of the *Dusky* standard.) In other words, the client must be able to impart information and to express goals. As a threshold matter, a practitioner may reasonably consider whether an impaired client has sufficient competency to enter into an attorney-client relationship.

The American Bar Association's Model Rules of Professional Conduct provide guidance for attorneys representing mentally incompetent clients. Instructively, the ABA Model Rule 1.2(a) provides that the client choose the legal objective while the attorney determines the legal means to pursue those goals. But where a client is incompetent, he may be unable to articulate a legal objective or choose a legal objective that is in his interest. ABA Model Rule 1.4(a) provides that "when a client's capacity to make adequately considered decisions in connection with a representation is diminished . . . the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client." Even if the practitioner finds he is unable to maintain a normal attorney-client relationship due to the diminished competency of his client, this does not necessarily bar representation under the ABA Model Rules. Rule 1.14(b) instructs attorneys that when there is a reasonable belief that his client is at risk of harm unless action is taken and the client cannot adequately act in his own best interest, then "the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian."

[79] *Calero*, 957 F.2d.at 52.

In addition to ethical considerations, due process considerations require not only that an impaired respondent be afforded representation, but that the representation is effective representation. Due process may not be satisfied by the mere presence of counsel where counsel's assistance cannot be effective due to a client's inability to articulate his legal objective (for example, whether he wants to remain in the U.S. or not).

B. Approaches

1. Requesting Competency Determination and Guardian Ad Litem

As indicated above, when an attorney takes on the representation of a client who has a mental illness, one of his first tasks should be to obtain a medical evaluation. If the evaluation indicates that the client is mentally incompetent, the attorney should submit the evaluation to the court along with a motion asking the court to make a competency ruling and to appoint a guardian ad litem for the immigration proceedings. A sample Motion to Appoint a Limited Guardian Ad Litem is included at **Appendix 24** and a sample of a government response to a Motion Requesting a Guardian Ad Litem is attached in **Appendix 25**.

a. Obtaining a Medical Evaluation

The first step of obtaining a medical evaluation may be difficult. Some attorneys are not able to commence work or expend resources on a case without first having a signed retainer agreement. And if the attorney has good reason to doubt the potential client's competency to enter into a legal agreement, he may be reluctant to enter into such agreement. However, the attorney should recognize that all persons are presumed to be competent unless shown otherwise. Based on this presumption, many attorneys are confident entering into a retainer agreement and moving forward with the initial steps in the client's case, including obtaining a medical evaluation. It should be emphasized that the nature of competence turns on the nature of the legal task at hand. Thus, a client who is not mentally competent to represent himself pro se in removal proceedings or even to aid counsel in his defense, may yet retain decisional capacity to express things like, "I want to stay in this country" and "yes, it 's okay for you to begin the process of obtaining my record."

Even when a client does not have basic decisional capacity, some attorneys believe that ethical rules and due process considerations allow for their continued representation of an individual so long as the attorney takes actions that maximize the client's options and do not foreclose any options. *See*, John Parry and Eric Drogin, Mental Disability: Law, Evidence and Testimony, 2007 ABA, p. 42. For an attorney representing someone in detention however, this theory may not work as well in practice because maximizing the client's options (applying for relief from removal) frequently results in continued detention.

If an attorney is not comfortable having the respondent sign a retainer agreement because he is not confident the respondent is competent to enter into such an agreement, the attorney may want to consider entering into an agreement with a family member, friend or the nongovernmental organization that referred the case. The attorney could then enter his appearance in court on behalf of the person or entity as Amicus curiae.

CAIR Coalition has successfully entered into such an agreement, whereby we retained pro bono counsel to represent us as Amicus curiae in proceedings involving an incompetent detainee who had no apparent family or friends willing to come forward. The regulations provide permission, "to appear, on a case-by-case basis, as amicus curiae, to an attorney or to

an organization represented by an attorney, if the public interest will be served thereby." 8 C.F.R. §1292.1. The Board of Immigration Appeals has clarified that the role of amicus is to provide, "supplemental assistance to existing parties" and to ensure a "complete presentation of difficult issues," so that a proper decision may be reached. *Matter of* Dejong, 16 I&N Dec. 739 (BIA 1979). We have included a Sample Amicus Brief in Support of Respondent's Right to a Fair Hearing in **Appendix 26** and the DHS's Response to the Amicus Brief is at **Appendix 27.**

By serving as amicus counsel, the pro bono attorney can submit a brief that sets forth the reasons the practitioner believes the respondent may not be competent and the statutory and due process concerns that are consequently implicated. Additionally, the practitioner could set forth the reasons why the court should appoint a guardian ad litem. A sample brief is included in the **Appendix 13 – Appendix 15**.

> **Practitioner's Tip:** Serving as counsel to Amicus gets the attorney into court but does not always enable him to obtain the necessary medical records or mental health evaluation he may need to compel the court to make a competency determination. Section III, Obtaining Medical Records, Consent and Treatment provides a more thorough discussion on how an attorney may obtain such medical records.

b. Competency and Appointment of Guardian

An attorney who represents a client whom a medical professional has deemed incompetent, should request that the immigration judge make a finding of incompetency and issue an order designating or acknowledging the appointment of guardian ad litem. The practitioner can base his request on the constitutional and statutory arguments, as well as case law, described above in Section I.

The practitioner is in a much better position to request a determination of incompetency and guardian appointment, if he already has a medical expert opinion asserting the client's incompetence. Immigration judges are understandably reluctant to hold a competency hearing in the absence of medical records because they do not have expertise in such matters. If the practitioner provides the court with medical proof of incompetency, the judge will be more willing make a legal determination of incompetency. Additionally, as discussed above, civil courts are often reluctant to invoke Fed. Civ. R. 17(c) without actual proof of a client's incompetence.

Another reason for the practitioner to submit an expert competency evaluation by his own expert, is to prevent the court from relying on a medical evaluation obtained by DHS. In our experience, evaluations obtained by DHS are poorly prepared and frequently overstate a client's competence. The practitioner does not want the judge to rely solely on an evaluation provided by DHS, therefore, it is imperative that the practitioner submit his own expert's evaluation before requesting a competency determination by the judge.

Although some judges may balk at the responsibility to appoint a guardian because such authority is not specifically presribed in the statute, the practitioner should emphasize that he is asking the court for the appointment of a guardian for the limited purposes of his client's removal hearing and therefore, such appointment is within the Immigration Judge's authority. In many cases, the client will have a family member or close friend willing to act as the guardian ad litem. In such cases, the immigration judge may be more willing to appoint the designated family member or friend as guardian and the government is less likely to object.

In some cases, the client has no family member or friend willing to act as a guardian ad litem. In such cases, counsel can argue that anyone who can fulfill the fiduciary duties of a guardian – i.e. identify and act in the best interests of the protected person – can act as a limited guardian ad litem. Different state law sources (*e.g.* probate law) support this proposition and counsel can draw on these. Alternatively, the attorney could move the court to either appoint a guardian ad litem itself or order the government to make such an appointment. However, the practitioner is more likely to succeed in moving the court for a continuance or administrative closure to provide the practitioner with sufficient time to obtain a state appointed guardian ad litem at his or the client's own expense. Each state has its own individual regulations and procedures for such appointment and the practitioner will have to refer to the appropriate state guardianship laws for guidance. Below, we provide an example from the state of Virginia.

Case Example: Virginia Circuit Court petition for Guardian

Pursuant to the Virginia Code, the court will automatically appoint a guardian to represent an individual for whom a guardian is sought. Although a petition must be served on the person for whom a guardian is sought, no other authorization or consent is required by that person.

The petition should explain the interest of the petitioner and the reasons for which the guardian is sought. Once the petition is received by the court, the court sets a date for a hearing on the issue of incapacity. The guardian appointed for the hearing on respondent's incapacity shall visit the respondent; advise the respondent of his rights; recommend that legal counsel be appointed if necessary; investigate the petition and evidence submitted; request additional evaluations if necessary; and submit a report to the court. The report should address whether the court has jurisdiction; whether a guardian is needed; the extent of powers and duties of the guardian; and the propriety of the person selected as guardian.

In addition, the Virginia Code requires that "a health care provider shall disclose or make available to the guardian ad litem, upon request, any information, records and reports concerning the respondent that the guardian ad litem determines necessary to perform his duties under this section."[80]

We have included in **Appendix 13 - Appendix 15** are sample petitions filed in a local Virginia court for the appointment of limited guardian in immigration proceedings. In this particular case, the pro bono attorney was able to get a continuance from the Immigration Court for the purpose of filing the petition for the guardian appointment. The first petition requests the court to appoint the respondent's sister as guardian. An amended petition was then filed after the sister determined that she could not fulfill the duties of guardian. The amended petition seeks to appoint a nonprofit service provider as guardian. A copy of the court's order granting the petition is also included.

2. Termination of Proceedings and Prosecutorial Discretion

A practitioner may argue that the Fifth Amendment's due process clause does not permit removal proceedings to be instigated against an incompetent person who cannot understand the nature of the proceedings or the charges against him, regardless of whether he has representation. Seeking complete termination on this ground is not likely to be successful

[80] Va. Code § 37.2-1003 D.

however. The regulations specifically allow for the wavier of appearance of an incompetent respondent, if he is represented.[81]

Additionally, courts have typically refused to hold that Fifth Amendment due process protection rises to the level of immunity from immigration proceedings. See, *Jaadan v. Gonzales*, 211 Fed. App'x. 422 (6th Cir. 2006) ("[T]he law specifically contemplates that removal proceedings may go forward against incompetent aliens and that incompetent aliens may be deported.") (citing *Wong v. INS*, 550 F.2d 521, 523 (9th Cir. 1977)). See also, *Brue v. Gonzales*, 464 F.3d 1227, 1233 (10th Cir. 2006) ("contrary to the substantive due process protection from trial and conviction to which a mentally incompetent criminal defendant is entitled…removal proceedings may go forward against incompetent aliens").

Civil courts have also been reluctant to terminate proceedings just because one of the litigants is deemed incompetent. Instead, the typical remedy in civil proceedings is to afford the incompetent litigant additional protective measures, such as the appointment of guardian ad litem (discussed above) so as to ensure due process.

Rather than arguing for termination based on the client's incompetency, the practitioner may have better luck trying to persuade the government attorney to exercise prosecutorial discretion and terminate the case that way. The practitioner seeking to persuade the government's exercise of prosecutorial discretion should focus on the client's equities as well as the administrative convenience of terminating such a case. We have included copies of two government issued memos on this. *See* **Appendix 28 and Appendix 29**.

3. Administrative Closure

Alternatively, the practitioner could motion the court to administratively close proceedings while the respondent seeks medical care to restore competency. This approach is not recommended for detained clients. The standard of care in immigration facilities is typically poor and mentally ill clients are more likely to deteriorate than improve in such settings. Without improvement, a detained mentally ill client could end up in indefinite detention while his case remain administratively closed.

4. Continued Representation without a Guardian Ad Litem

If the Immigration Judge refuses to appoint a guardian and the practitioner is not able to obtain a state-appointed guardian, the practitioner may consider moving forward in his representation even if his client is incompetent. Before proceeding however, the attorney should be careful to consult his state ethics rules to determine whether this is permissible in his state.

As discussed above, immigration regulations permit removal proceedings to go forward notwithstanding a respondent's incompetency. The regulations, in fact, allow the respondent's appearance to be waived if he is represented by counsel: "[w]hen it is impracticable by reason of an alien's mental incompetency for the alien to be present, the presence of the alien may be waived provided that the alien is represented at the hearing by an attorney or legal representative, a near relative, legal guardian or friend."[82]

---

[81] *See*, 8 C.F.R. § 3.25(a) (2000), discussed above.
[82] 8 C.F.R. § 3.25(a) (2000).

Further, courts have routinely accepted pleadings from attorneys in immigration proceedings on behalf of incompetent clients. See, *Brue v. Gonzales*, 464 F.3d 1227) (10th Cir. 2006) ("when mental incompetence makes an alien's presence at a removal proceeding impracticable, an IJ may conduct the proceeding provided that the alien is represented by an attorney or other person"; *Jaadan v. Gonzales*, 211 Fed. App'x. 422 (6th Cir. 2006), supra; *Hudnall v. Sellner*, 800 F.2d 377 (4th Cir. 1986), supra; *In re: Jose Estrella (aka Jose Martinez)*, A14 340 742, *unpublished decision* (BIA Dec. 4, 2003)(representation by an accredited representative is sufficient to satisfy due process and statutory obligations for a mentally incompetent respondent).

The hurdle in continuing representation of an incompetent client without the benefit of a guardian is not found in the statute, regulations or case law, but in the relevant ethical rules of attorney-client relationship. As discussed above (Section I-D), the Rules do not demand that the attorney-client relationship be dissolved because of the client's incompetency but instead explicitly state that such relationship should be maintained if appropriate to protect the client from harm. Deportation could certainly be construed as harm.[83] Even if the client's incapacity prohibits a normal attorney-client relationship the Model Rules allow for the attorney to take protective measures deemed necessary in order to continue the attorney-client relationship, including consulting with family members and support groups. As with any decision made by the attorney on behalf of his client, he should be guided by client's best interests, as well as the client's wishes and values to the extent known.[84]

[83] Rule 1.14(a).
[84] ABA Model Rules, Comment 5 for rule 1.14.

IV. LEGAL RELIEF

Several forms of substantive relief are available to people in the removal process. However, the immigration laws of the United States are complex and the availability of relief is often very fact driven. Thus, we do not attempt to provide a complete list of forms of relief that may be available to the client. Instead, this section focuses on four forms of relief commonly pursued by practitioners representing clients with mental or developmental disabilities: (1) Asylum; (2) Withholding of Removal; (3) Convention Against Torture (CAT) protection; and (4) Cancellation of Removal.

A. Fear-Based Claims: Asylum, Withholding of Removal, and CAT Protection

If a client is afraid of returning to his country of origin, the practitioner should examine the viability of filing a "fear-based" claim for relief. The three primary forms of fear-based relief in immigration law are asylum, withholding of removal, and protection under the Convention Against Torture. Claims for asylum and withholding are filed using Form I-589, "Application for Asylum, and for Withholding of Removal." Although there is no formal application for the CAT, an applicant's responses on the I-589, "constitute claims for relief under the CAT."[85] Therefore, all three claims can essentially be made using the same form. A sample form is included in **Appendix 30**.

Although the claims are similar – in that they are all fear based – they have important distinctions. Below is a table that highlights the differences. Following the table is a more detailed summary of each form of relief, as well as guidance on how to specifically apply the law to clients with mental illness.

	Asylum	Withholding of Removal	CAT Protection
Must show:	Well-founded fear of persecution. (one in ten possibility)	More likely than not will be persecuted (greater than 50%)	More likely than not will be tortured (greater than 50%)
By:	The government or group(s) the government is unwilling or unable to control.	No specific statutory actor requirement.	The government or with the government's acquiescence
On account of:	Race Religion Nationality Political opinion Membership in a social group	Race Religion Nationality Political opinion Membership in a social group	Any reason

85 *Eduard v. Ashcroft*, 379 F.3d 195 (5th Cir. 2004).

1. Asylum and Withholding of Removal

a. Asylum

Under INA § 208 (b), the Attorney General (AG) may, in his discretion, grant asylum to an individual who qualifies as a "refugee" within the meaning of INA § 101(a)(42). A refugee is someone who, regardless of his country of origin, is unwilling or unable to return to his country of nationality because of a well founded fear of persecution by the government or by a group(s) the government is unwilling or unable to control, on account of race, religion, nationality, membership in a particular social group, or political opinion.

Asylum is the most desirable of the fear-based forms of protection because when applicants are granted asylum:

a. they are permitted to remain in the United States;

b. they may apply for derivative status for immediate family members, whether in the United States or abroad;

c. they are authorized to work in the United States;

d. they are eligible for certain social services and benefits; and

e. after one year, they may apply for Lawful Permanent Resident (LPR) status and ultimately they have a path to citizenship.

The asylum applicant bears the burden of establishing that he has a well-founded fear of persecution; that the persecution he fears is by the government or by a group the government is unwilling or unable to control; and that the feared persecution is on account of race, religion, nationality, membership in a social group or political opinion. The Board of Immigration Appeals (BIA) has defined persecution as, "a threat to the life or freedom of, or the infliction of suffering or harm upon those who differ in a way regarded as offensive."[86]

If the applicant has established that he has suffered persecution in the past, a presumption is created that his fear of persecution is well-founded. The burden then shifts to the government to show that conditions in the applicant's country have changed since that persecution such that he would no longer face persecution if he were to return.

If the applicant has not suffered past persecution, he must show that there is a reasonable possibility that he will be persecuted in the future. The Supreme Court has held that the quantum measure of proof needed to establish a reasonable possibility may be as little as a one in ten chance of persecution.[87] Thus, a fear may be well founded "even if there is only a slight, though discernable, chance of persecution."[88]

The applicant satisfies his burden of proof by showing that his fear is subjectively genuine *and* that a reasonable person similarly situated would also be afraid. The testimony of the applicant may be sufficient to sustain the applicant's burden without corroboration, but only if the applicant satisfies the Immigration Judge that the applicant's testimony is credible,

[86] *Matter of Acosta*, 19 I&N Dec. 211 at 222 (BIA 1985).
[87] *INS v. Cardoza-Fonseca*, 480 U.S. 421 (1987).
[88] *Diallo v. INS*, 232 F.3d 279, 284 (2d Cir. 2000).

persuasive, and refers to specific facts sufficient to demonstrate that the applicant meets the definition of a refugee. The Immigration Judge may require corroborative evidence for otherwise credible testimony, "unless the applicant does not have the evidence and cannot reasonably obtain the evidence."[89] Thus, the practitioner should be certain to note if the client is unable to assist the practitioner in obtaining corroborative evidence due to the client's mental illness.[90] Still, it is not advisable to proceed on the applicant's testimony alone if at all possible. The practitioner can and should submit corroborating evidence such as witness testimony, expert testimony and documentation of country conditions.

It is important to remember that asylum is a discretionary form of relief. Therefore, even if the applicant is successful in establishing a well-founded fear of persecution, the Immigration Judge may still, in his discretion, deny the application. Immigration Judges typically don't use their discretionary power to deny asylum applications unless an applicant has a criminal history or other evidence of bad character.[91]

b. Withholding of Removal

An application for asylum automatically includes a claim for withholding so that in the event an applicant's asylum application is denied, the Immigration Judge automatically considers whether the applicant is entitled to withholding of removal.[92] The claims for withholding and asylum are similar but contain very important distinctions.

Section 241(b)(3)(A) of the INA outlines the requirements for withholding of removal: an adjudicator may not remove a person to a country where his life or freedom would be threatened because of his race, religion, nationality, particular social group, or political opinion. Like asylum, withholding requires a showing that the applicant would be harmed on account of one of the five protected grounds: race, religion, nationality, membership in a social group or political opinion.

Also, like asylum law, a showing of past persecution gives rise to a presumption of withholding.[93] The government may rebut this presumption if it can show that circumstances have fundamentally changed in the applicant's country or that internal relocation is reasonable.[94]

Unlike asylum, however, the applicant must establish that the likelihood of persecution is greater than fifty percent – or *more likely than not*.[95] Further, in contrast to asylum, withholding of removal is not discretionary.[96] Therefore, if the applicant meets his burden of proof (by establishing that it is more likely than not he will be persecuted on account of one of the five protected grounds) the adjudicator must grant withholding of removal.

---

[89] INA § 208(b)(1)(B).
[90] *Vera-Villegas v. INS,* 330 F.3d 1222, 1235 (9th Cir. 2003) (holding that petitioner who suffered from mental illness and was homeless was held to an unreasonable standard of having to present direct corroboration to credible testimony of 7 years of continuous presence in the U.S.).
[91] *Kouljinski v. Keisler*, 505 F.3d 534 (6th Cir. 2007) (denying asylum on discretionary grounds because the applicant had three DUI convictions).
[92] Withholding of Removal as described in this section is also known as statutory Withholding of Removal, as distinguished from CAT Withholding of Removal, discussed later in this manual.
[93] 8 C.F.R. § 208.16(b)(1).
[94] 8 C.F.R. § 208.16(b)(1)(A) and (B).
[95] *Cardoza-Fonseca*, 480 U.S. at 430.
[96] INA § 241(b)(3)(A).

An additional distinguishing element of withholding is that it is not a true form of relief. A grant of withholding still results in a final order of removal, but it bars DHS from removing the person to his home country as long as the threat to the applicant still exists. Additionally, should the threat cease to exist, DHS may move to reopen the case in order to terminate the grant of withholding.[97] If such termination is granted, the final order becomes executable and the U.S. government may proceed to deport the individual.

In addition, a grant of withholding does not entitle the applicant to bring any family members to the U.S. Someone who has withholding may apply for work authorization, but he is not guaranteed approval nor will he have access to the federal benefits of an asylum grantee.[98] Also, withholding of removal does not convey a right to remain in the U.S. itself. An individual is only granted withholding of his deportation to the country where the danger exists. If a third country is willing to accept the applicant and there is no threat to his life or freedom, the U.S. government may deport the applicant to that third country.[99]

c. Bars To Asylum And Withholding

Both forms of relief contain bars. Below is a list of the most common bars to relief. However, before deciding to forgo filing for any form of relief, the practitioner should consult with an immigration attorney or a mentoring attorney from the referring organization.

Bars to Asylum	Bars to Withholding
Failing to file within one year of arrival in the U.S.	
Firm resettlement in another country prior to coming to the U.S.	
Prior denial of asylum, unless there are changed circumstances that materially affect the claim	
Participation in the persecution of others	Participation in the persecution of others
Commission of a serious nonpolitical crime outside U.S.	Commission of a serious nonpolitical crime outside U.S.
Conviction of a "particularly serious crime" including aggravated felonies	Conviction of a particularly serious crime which demonstrates that the applicant constitutes a danger to the community
Posing a danger to the security of the U.S.	Posing a danger to the security of the U.S.
Membership in or material support to a terrorist organization	Membership in or material support to a terrorist organization

[97] 8 C.F.R. § 208.24(b)(1).
[98] INA § 241(b)(3)(A).
[99] 8 C.F.R. § 208.16(e).

Practitioner's Tip: One Year Deadline. Though this rule is strictly enforced, an applicant may be excepted from the one-year filing deadline if he can prove, "changed circumstances which materially affect the applicant's eligibility for asylum" or "extraordinary circumstances relating to the delay in filing the application within the prescribed period."[100]

The types of circumstances that may be "extraordinary" include serious illness or mental or physical disability, the death or incapacity of applicant's legal representative or family member, legal disability, extreme isolation within a refugee community, profound language barriers and profound difficulties in cultural acclimatization.[101] Several of these exceptions may apply to a mentally ill applicant who failed to file within one year.[102]

Practitioner's Tip: Particularly Serious Crime. The standard for the "particularly serious crime" bar is much lower for asylum applicants than for applicants for withholding of removal. Thus, many crimes which would bar an applicant from applying for asylum would not bar an applicant from applying for withholding. Generally, all aggravated felonies bar an applicant from asylum. However, if a person has been convicted of an aggravated felony(ies) and sentenced to less than five years of imprisonment (in the aggregate), the Attorney General may determine that the person has not been convicted of a particularly serious crime.

d. Membership in a Social Group

A client who fears persecution in his home country may fear persecution on account of several grounds. He may fear that he will be persecuted on account of his political opinions, his race and his religion. He may also fear that he will be persecuted on account of his mental illness. The practitioner should never limit the application for asylum to just one ground if his client's fear is based on more than one.[103]

In the case of a client who fears that his mental illness would subject him to persecution back home, the practitioner should include membership in a particular social group (PSG) as a basis for asylum. The foundational BIA case that defines PSG membership is *Matter of Acosta.*[104] The *Acosta* decision defines a particular social group as:

> …a group of persons all of whom share a common immutable characteristic. The shared characteristic might be an innate one such as sex, color, or kinship ties, or…shared past experiences. [The characteristic] must be one that the

[100] INA § 208(a)(2)(D).

[101] "One Year Filing Deadline," Asylum Officer Basic Training Course Manual (March 15, 2001).

[102] For example, the Seventh Circuit affirmed the Immigration Judge's recognition that "extraordinary circumstances – [petitioner's] mental health condition – could excuse his untimely filing, at least for the period after his arrival before he received treatment." *Disha v. Gonzales*, 207 F. App'x. 694, 696 (7th Cir. 2006). However, the immigration judge ultimately determined that because petitioner could have filed earlier than he did – i.e. when he began receiving medical treatment and his mental condition stabilized – he did not file his application for asylum within a reasonable time.

[103] *INS v. Elias-Zacarias*, 502 U.S. 478 (1992).

[104] 19 I&N Dec. 211 (BIA 1985) (holding that non-criminal drug informants working against the Cali drug cartel do not constitute a particular social group); overruled in part by *Matter of Mogharrabi*, 19 I&N Dec. 439 (BIA 1987).

> members of the group either cannot change, or should not be required to change because it is fundamental to their individual identities or consciences.

The BIA has recently elaborated on the PSG definition, requiring that the protected group be "socially visible" and defined with "particularity."[105] The practitioner who represents a mentally ill client and who seeks to base his client's fear-based claim on PSG membership should articulate the PSG with more specificity than just, "mentally ill persons." The practitioner should be specific in identifying the illness (particularity) and explain how persons with such illness are identifiable as a group (socially visible). While defining a PSG primarily by an applicant's mental illness may be challenging,[106] it can be done.

For example, in an unpublished 2007 BIA case[107], the Board held that "Peruvian psychiatric patients with serious and chronic mental illness" can constitute a PSG. Although the Immigration Judge never assessed the social visibility of the proposed PSG at trial,[108] the BIA noted that this "does not compel us to disturb the conclusion that such individuals constitute a particular social group." The Board cited expert testimony and record evidence that the applicant's "bipolar disorder was a chronic psychiatric condition subject to treatment and not cure" to show that the applicant's condition "was an immutable characteristic" that could thus constitute a PSG.

Additionally, the Seventh Circuit in *Kholyavskiy v. Mukasey* held that "the mentally ill" could constitute a cognizable particular social group for asylum purposes, reversing the BIA's conclusion that respondent's illness was not immutable and therefore, not a basis for a PSG.[109] The seventh circuit noted that the record did not support the BIA's characterization of the applicant's mental illness as alterable. The applicant was diagnosed with severe social anxiety disorder, depression and a personality disorder. His doctor testified that even with medication, he would remain disabled and that his personality order was not amenable to change. Although the 7th circuit ultimately upheld the BIA's denial of the applicant's asylum claim, it did so because the applicant failed to show a nexus between his PSG and the persecution he would suffer.

A more thorough discussion of how a mental illness can be the basis for a PSG claim is provided in the Immigration Judge's decision, attached in **Appendix 31**. The Immigration Judge held that "indigent, schizophrenic, bipolar individuals in Colombia" constitute a PSG.[110] He specifically held that the defined group satisfied three requirements: (1) members of the group

---

[105] *In re C-A-,* 23. I&N Dec. 951 (BIA 2006). For further refinement of the PSG standard, see *Hernandez-Montiel v. INS,* 225 F.3d 1084, 1092 (citing *Sanchez-Trujillo v. INS,* 801 F.2d 1571 (9th Cir. 1986) (holding that a PSG should be small and readily identifiable)).

[106] *See, e.g., Disha v. Gonzales*, 207 F.App'x. 694, 698 (7th Cir. 2006) (unpublished) (stating in dicta that "it is doubtful that 'mental patients who cannot receive proper treatment in Albania' could constitute a 'particular social group' for asylum purposes."); *Raffington v. INS*, 340 F.3d 720, 723 (8th Cir. 2003) (holding that petitioner, a 43-year old Jamaican citizen with a history of depression and attempted suicide failed to show that mentally ill Jamaicans, or mentally ill female Jamaicans, qualify as a particular social group for asylum purposes because they are not a "collection of people closely affiliated with each other, who are actuated by some common impulse or interest") (*quoting Safaie v. INS,* 25 F.3d 636, 640 (8th Cir. 1994)).

[107] BIA decision, May 31, 2007 re Asylum **Appendix 32**

[108] *Matter of C-A-,* I&N Dec. 951, 957 (BIA 2006) (social visibility should be a factor in identifying a PSG); *Hernandez-Montiel v. INS,* 225 F.3d 1084, 1092 (9th Cir. 2000) (citing *Sanchez-Trujillo v. INS,* 801 F.2d 1571 (9th Cir. 1986) (holding that a PSG should be small and readily identifiable).

[109] 540 F.3d 555 (7th Cir. 2008); *But see, e.g. Raffington,* 340 F.3d at 723; *Hernandez-Montiel,* 225 F.3d at 1092 (suggesting that "the mentally ill" is too broad to define PSG).

[110] Order of the Immigration Judge re Applications: Withholding of Removal to Columbia *see* **Appendix 31.**

share a common immutable characteristic that they cannot or should not be required to change,[111] (2) it had "social visibility"[112] and (3) it was defined with sufficient "particularity."[113]

To satisfy the first factor ("common, immutable"), the applicant here provided testimony from his physician and case manager which convinced the immigration judge that applicant's psychiatric disorders were incurable. To satisfy the second factor ("social visibility"), the applicant provided evidence that even when treated, he manifested symptoms of schizophrenia and bipolar disorder. Additionally, the applicant's doctor asserted that without constant medical care, the applicant exhibited delusional, paranoid, and illogical behavior which could sometimes appear frantic and aggressive. Further, the immigration judge noted that homelessness would render the applicant socially visible, "as life on the street would situate Respondent, and his behavior, in the public sphere." To satisfy the third factor ("particularity"), the immigration judge noted that "respondent's particular social group narrows his membership to a small subset of individuals who are not only mentally ill, but schizophrenic, bipolar, and indigent."[114] The immigration judge writes that "unlike the generally mentally ill population, this subset of individuals, without access to medication on the street, share a particularized characteristic of manifesting uniquely psychotic and dissociated behavior."

ON ACCOUNT OF – ESTABLISHING A NEXUS BETWEEN PERSECUTION AND MEMBERSHIP IN A PSG

Establishing that an applicant is a member of a PSG or other protected class is not enough to win an asylum case. The applicant must also establish that he has a well founded fear of persecution by the government or by a group(s) the government is unwilling or unable to control, on account of the PSG, race, religion, nationality, or political opinion. *See* **Appendix 33** for sample Motion and Brief in Support of Respondent's Request of Relief Under the Convention Against Torture and 8 U.S.C. § 241.

Establishing that the asylum seeker would suffer the necessary persecution on account of her membership in a "mental illness PSG" has proven difficult for applicants. For example, in *Kholyavskiy v. Mukassey* (discussed above), the Seventh Circuit found that the unavailability of medications to treat petitioner's mental illness was not enough to establish persecution on account of such illness, because it was not "the result of the Russian government's attempt to injure [the applicant] or, more generally, individuals with mental illnesses."[115]

Similarly, the Eighth Circuit held that unsupported assertions of being stigmatized and discriminated against because of the petitioner's mental illness were not enough to establish

[111] *Citing Matter of Kasinga,* 23 I&N Dec. 357 (BIA 1996).
[112] *Citing Matter of C-A-,* 23 I&N Dec. 951 (BIA 2006).
[113] *Citing Matter of A-M-E- & J-G-U-,* 24 I&N Dec. 69 (BIA 2007) (holding that the terms "wealthy" and "affluent" standing alone are too amorphous to meet the PSG definition).
[114] The immigration judge explicitly distinguishes this case from *Raffington v. INS.,* 340 F.3d 720 (8th Cir. 2003) where the 8th circuit upheld the Board's finding that the mentally ill are "too large and diverse a group to classify."
[115] *Kholyavskiy,* 540 F.3d at 574 (holding, however, that the unavailability of medications to treat petitioner's mental illness is a valid consideration for purposes of humanitarian asylum (see "humanitarian asylum," *supra*)). Importantly, the court highlighted that the applicant "never has claimed that he suffered past persecution on the basis of his mental illness" and those documents that the applicant submitted to show "a prevalent anti-mental illness attitude" and "considerable lack of mental health treatment" in Russia actually show otherwise; they note that "progress has been made instituting legal provisions for humane and responsible health care for the mentally ill," that these provisions set "minimum standards for humane treatment of psychiatric patients," and that "reforms have seen the focus of psychiatric care change…[with institution of] modern hospitals, with patients allowed to live in the community as much as possible."

persecution on account of the mental illness.[116] Further, a report that Jamaica devotes limited resources to treating those who are mentally ill did not establish a pattern of persecution on account of this disability.[117]

In an unpublished opinion, the Third Circuit held that evidence of the likelihood of persecution, including expert testimony that applicant would have difficulty proceeding through the airport, would have his clothes and money taken, and that he would act out if his medical illness was untreated, was not enough to establish the necessary persecution based on a PSG. In addition, there was no evidence presented that suggested authorities in Liberia were unable or unwilling to control any harm that may befall the petitioner and no evidence that Liberia had a policy of state action directed against the mentally ill.[118]

While difficult, the nexus argument is not an impossible one. In Matter of P-C, the Immigration Judge found that State Department and World Organization Against Torture reports indicated a sufficient nexus, strongly suggesting that "an indigent on the streets of Colombia who visibly exhibits the Respondent's specific mental illness would be judged as 'socially undesirable' or 'marginalized' and a threat to Colombia's social order by paramilitary, guerilla, and vigilante groups."[119] A copy of this well-reasoned decision is included in **Appendix 31**.

Practitioner's Tip: Fear based claims based on mental illness are difficult and the practitioner is strongly encouraged to submit evidence establishing each nexus of the claim, including but not limited to:

- Expert opinion confirming client's illness and explaining the manifestations of the illness;
- Affidavits, oral testimony, criminal records showing consequences when client manifests symptoms of mental illness;
- Expert opinion describing treatment of persons with mental illness in client's home country;
- State Department Country Reports documenting persecution;
- World Organization Against Torture reports documenting persecution;
- News reports or other evidence suggesting patterns or widespread degrees of abuse and stigmatization of people with mental health disorders.[120]

---

[116] *Raffington,* 340 F.3d at 723.
[117] *Raffington,* 340 F.3d at 723
[118] *Massaquoi v. AG of the U.S.,* WL 4946203 (3d Cir. 2008)
[119] The immigration judge held that these reports indicate "that the government either encourages or does not effectively control efforts by organized groups of Colombians to overcome, eradicate, or punish the characteristics of mentally ill Colombians… Specifically, the 2001, 2003, and 2005 Department of State Country Reports describe the continuation of Colombia's "social cleansing" killings by paramilitary groups, guerillas, and vigilante groups," which according to the 2003 report included targeting the mentally ill. The World Organization against Torture report further noted that "murders of socially marginalized persons has become a systematic practice in recent years."
[120] *See Raffington v. INS,* 340 F.3d 720, 723 (8th Cir. 2003) for how a State Department's Country Report was insufficient to present a prima facie case that the Jamaican government practices or condones widespread persecution of the mentally ill. Here, the Report described an incident in which a group of homeless persons that may have included the mentally ill was rounded up in Montego Bay. The court wrote that it was unclear who did the rounding up and whether any individuals were targeted because of their mental illness. In any event, the Report related that the incident triggered an official inquiry, compensation for the victims, and public criticism of those

e. Humanitarian Asylum

Codified at 8 C.F.R. § 1208.13(b)(1)(iii), an asylum seeker may qualify for humanitarian asylum if he (1) "has demonstrated compelling reasons for being unwilling or unable to return to the country [designated for removal] arising out of the severity of past persecution" *or* (2) has experienced past persecution and "has established that there is a reasonable possibility that he or she may suffer other serious harm upon removal to that country." The satisfaction of either of these prongs could qualify an applicant for humanitarian asylum. Practitioners should keep in mind the *Kholyavskiy* court's holding that lack of medications in the respondent's home country may constitute "serious harm" and be grounds for a successful humanitarian asylum claim based on the second prong.[121] Humanitarian asylum is an important form of relief for those applicants who have been persecuted in the past but are unlikely to be persecuted in the future.

2. Protection under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

States that are members of the Convention Against Torture (CAT)[122] are prohibited from sending individuals to countries where there is a strong likelihood that they will be tortured. This form of protection is very important in U.S. immigration law because it often functions as a "safety net" for individuals that do not qualify for asylum or withholding of removal. An adjudicator's determination that there is no relief available based on asylum or statutory withholding does not mean that the applicant is not eligible for CAT relief.[123] Thus, no matter the client's past history or the success or failure of other fear based claims for protection, CAT should always be considered if the practitioner believes that his client may be subject to torture if returned to his home country.

Two forms of relief are available under CAT – withholding of removal and deferral of removal. Much like statutory withholding, a final order of removal under either form of CAT relief is entered against the applicant. However, due to treaty obligations, DHS must refrain from executing the final order and removing the individual to the torturing country. A grant of deferral or withholding under CAT does not allow the applicant to bring family members to the United States, nor does it guarantee that the applicant will be granted permission to work while in the U.S. Also, both forms of CAT relief may be terminated should the threat of torture cease to exist. Further, winning a CAT claim preventing the government from removing a client to his country of origin does not preclude the government from attempting to remove the client to a different country.

---

responsible. Thus, the court held that "this one incident hardly shows a pattern of mistreatment of the mentally ill." In this case, other evidence supplementing the report and filling in its noted inadequacies may have produced a different result.

[121] *Kholyavskiy,* 540 F.3d at 576.

[122] The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) entered into force on June 26, 1987, ratified by the United States on April 18, 1988 and implemented in 1998 when Congress passed the Foreign Affairs Reform and Restructuring Act (FARRA), Pub. L. No. 105-277, Div. G, Title XXII, § 2242, 112 Stat. 2681-822 (codified as a note to 8 USC § 1231).

[123] *Li Fang Lin v. Mukasey*, 517 F.3d 685, 696-97 (4th Cir. 2008).

> **Practitioner's Tip:** Due to the ability of the government to remove individuals to countries other than their country of origin, the practitioner may wish to consider including arguments that will prevent the government from removing his client not only to his country of origin, but also to any country in which the client may have ties such as family ties or previous residence.[124]

a. Legal Standard

The Convention Against Torture demands that its signatories not have policies to "expel, extradite, or otherwise effect the involuntary return of any person to a country in which there are substantial grounds for believing the person would be in danger of being subjected to torture."[125] The Convention Against Torture defines "torture" as:

> any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, 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 an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.[126]

In addition to showing that the treatment the client may suffer rises to the level of "severe pain and suffering," a CAT applicant has the burden to establish that it is more likely than not that he or she would be subject to such treatment in the country of removal.[127] In assessing whether it is more likely than not that an applicant would be tortured in the proposed country of removal, all evidence relevant to the possibility of future torture should be considered, including but not limited to:

1. evidence of past torture inflicted upon the applicant;[128]
2. evidence that the applicant could relocate to a part of the country of removal where he or she is not likely to be tortured;[129]

---

[124] Respondent's Pre-Hearing Brief in Support of Deferral of Removal Under Convention Against Torture at **Appendix 34**.

[125] *In re J-F-F-*, 23 I&N Dec. 912 (A.G. 2006) (citing FARRA § 2242(a), 112 Stat. 2681, 2681-761, 2681-822.).

[126] Convention Against Torture, art. 1.

[127] "Because [CAT] does not provide a definition of 'lawful sanction,' the United States Senate was concerned when it ratified the Convention that the 'lawful sanctions' exception could be interpreted too broadly. Although the Senate did not adopt a reservation defining the term, it did qualify its ratification with the understanding that a state 'could not through its domestic sanctions defeat the object and purpose of the Convention to prohibit torture' . . . [a]ccordingly, [an applicant] is entitled to relief under the Convention if he has shown that 'he is more likely than not to suffer intentionally-inflicted cruel and inhuman treatment that either (1) is not lawfully sanctioned by that country or (2) is lawfully sanctioned by that country, but defeats the object and purpose of CAT.'" *Nuru v. Gonzales,* 404 F.3d 1207, 1221 (9th Cir. 2005) citing *Wang v. Ashcroft*, 320 F.3d 130, 134 (2nd Cir. 2003).

[128] "Past torture is the first factor we consider in evaluating the likelihood of future torture because past conduct frequently tells us much about how an individual or a government will behave in the future. Specifically, if an individual has been tortured and has escaped to another country, it is likely that he will be tortured again if returned to the site of his prior suffering, unless circumstances or conditions have changed significantly, not just in general, but with respect to the particular individual." *Gonzales,* 404 F.3d at 1218. It is important to note, however, that past torture does not create any sort of presumption or burden shifting as it does in asylum and statutory withholding of removal claims.

3. evidence of gross, flagrant or mass violations of human rights within the country of removal, where applicable; and

4. relevant information regarding conditions in the country of removal.[130]

As with asylum and statutory withholding claims, the testimony of the applicant, if credible, may be sufficient to sustain the burden of proof without corroboration; however, as recommended above, the practitioner should present as much expert testimony and corroborating evidence as the practitioner can to support the client's claim.[131] In a CAT claim, the burden of proving that the torture is more likely than not to occur always rests with the applicant and there are no presumptions or burden shifting as found in the other forms of fear based protection. It is also important to show that the torture is not due to a sanctioned or lawful punishment, but occurs extra-judicially or without lawful basis.[132]

Two important distinctions between CAT protection and asylum or statutory withholding are that: (1) there is no requirement that the feared torture be inflicted "on account of" a protected ground; and, (2) the feared harm cannot be mere "persecution" but must rise to the level of torture.[133] A third distinction lies in the requirement that the applicant show that the torture will occur at the hands of or with the acquiescence of someone acting in an official governmental capacity.[134] Though there has been some dispute between the BIA and circuit courts about what constitutes government acquiescence, the prevailing opinion is that willful blindness is enough to meet the standard.[135]

b. Deferral vs. Withholding Under CAT

Protection under CAT can be granted in the form of withholding of removal or deferral of removal.[136] The regulations provide that in a CAT claim, withholding of removal shall be granted

---

[129] ". . . it will rarely be safe to remove a potential torture victim on the assumption that torture will be averted simply by relocating him to another part of the country." *Gonzales,* 404 F.3d at 1219.

[130] "It is well-accepted that country conditions alone can play a decisive role in granting relief under CAT.'" *Gonzales,* 404 F.3d at 1219; *cf Matter of J-E-,* 23 I&N Dec. 291 (BIA 2002) ("country conditions alone are not sufficient to qualify for relief").

[131] 8 C.F.R. § 1208.16(c); *cf. Gonzales*, 404 F.3d at 1216, (" . . .under the applicable law, [finding the applicant's uncontradicted testimony credible] is not enough"). "When an alien credibly testifies to certain facts, those facts are deemed true, and the question remaining to be answered becomes whether these facts, and their reasonable inferences, satisfy the elements of their claims for relief." However, specific facts must demonstrate that the alien would be personally at risk. *Matter of S-V-*, 22 I&N Dec. 1306 (BIA 2000).

[132] 8 C.F.R. §§ 208.18(a)(3), 1208.18(a)(3).

[133] 8 C.F.R. § 1208.16(c)(3).

[134] "To qualify for relief under [CAT], the torture must be 'inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity." *Zheng v. Ashcroft*, 332 F.3d 1186, 1188 (9th Cir. 2003) citing 8 C.F.R. § 208.18(a)(1) (emphasis included).

[135] *See* Asylum Primer, *supra*, at 269. *See also Villegas v. Mukasey,* 523 F.3d 984, 989 (9th Cir. 2008) (holding, among other things, that conditions in the Mexican mental health system exist not out of a deliberate intent to inflict harm, but merely because of officials' historical gross negligence and misunderstanding of the nature of psychiatric illness) *quoting Pierre v. Gonzales*, 502 F.3d 109, 113-19 (2d Cir. 2007) ("A private actor's behavior can constitute torture under the CAT without a government's specific intent to inflict it if a government official is aware of the persecutor's conduct and intent and acquiesces in violation of the official's duty to intervene . . . But in that scenario, there is specific intent – the intent of the private actor"). "Accordingly . . . to establish a likelihood of torture for purposes of the CAT, a petitioner must show that severe pain or suffering was specifically intended – that is, that the actor intend the actual consequences of his conduct, as distinguished from the act that causes these consequences." *Id. See also Pierre v. Attorney General of the United States*, 528 F.3d 180 (3d Cir. 2008) ("for an act to constitute torture, there must be a showing that the actor had the intent to commit the act as well as the intent to achieve the consequences of the act").

[136] 8 C.F.R. § 1208.16(c)(4).

unless the alien is subject to a mandatory denial of withholding of removal under Section 241(b)(3) of the INA (bars to withholding). If the applicant is not eligible for withholding under CAT, then the regulations require that deferral of removal be considered instead.[137] It is important to remember that both withholding and deferral under CAT are mandatory forms of relief and the adjudicator may not deny either one in his discretion.

A grant of deferral is the least desirable form of fear based protection because it is the most tenuous. It can be more easily terminated than withholding or asylum grants because the government is not required to file a motion to reopen to terminate a deferral grant.[138]

c. How CAT Protection Applies to Mentally Ill Clients: More likely than not: establishing a chain of likelihoods

When representing a mentally ill client with a CAT claim, it is essential to understand the Attorney General's decision in *In Re J-F-F*.[139] In this case, the respondent applied for deferral of removal under CAT. The respondent suffered from schizoaffective and bipolar disorders and claimed that as a result of not taking or not having adequate medication, he would be picked up by the police, incarcerated, and subjected to treatment that was the equivalent of torture. Both the immigration judge and the BIA agreed with his argument, and supported his grant of CAT deferral.

On review, however, the Attorney General (AG) denied the respondent's claim. The AG noted that in order to qualify for deferral of removal under CAT, the court must find that the respondent "is more likely than not to suffer intentionally-inflicted cruel and inhuman treatment that either (1) is not lawfully sanctioned by that country or (2) is lawfully sanctioned by that country, but defeats the object and purpose of CAT."[140] After applying the above definition, the AG found that "the Immigration Judge improperly strung together a series of suppositions: that respondent needs medication in order to behave within the bounds of the law; that such medication is not available in the Dominican Republic; that as a result respondent would fail to control himself and become "rowdy"; that this behavior would lead the police to incarcerate him; and that the police would torture him while he was incarcerated."[141] The AG held that when arguing this sort of claim, the applicant must prove that each step in the hypothetical chain of events will more likely than not occur.[142] Thus, if the practitioner argues that the client will suffer torture based on his mental illness that involves a cascading chain of events, it is essential to provide evidence that each event will more likely than not occur.

It has been possible for applicants with mental illness to succeed on a CAT claim and provide enough evidence to satisfy the chain of evidentiary proof standard articulated in *In re JFF.* Both the Ninth and Eleventh Circuits have held that the mentally ill criminal deportees to Haiti can find relief under CAT due to the possibility that they will be singled out because of their mental illnesses in Haitian prisons and thus be subject to torture.[143]

---

[137] *See* 8 C.F.R. §§ 1208.16(c)(4), 1208.17.
[138] 8 C.F.R. § 1208.17(b)(iii), (iv).
[139] 23 I&N Dec. 912 (A.G. 2006).
[140] *Id.*, citing *Gonzales* 404 F.3d at 1221.
[141] *Id.*
[142] *Id.,*citing *Matter of Y-L-*, 23 I&N Dec. 270 & n. 16 (A.G. 2002) (holding that a string of speculative events in a country with violent incidents but a non-complacent government insufficient for CAT showing).
[143] *See Saint-Fort v. Mukasey*, 305 F. App'x 364, No. 06-73645, 2008 WL 5383583 (9th Cir. Nov. 21, 2008) (recognizing that "the BIA has held that mentally ill criminal deportees face a likelihood of torture in Haitian prisons because of their mental illness" (citing *In re M-D-,* No. A-40-136-479 (BIA Oct. 6, 2005), *In re J-F-,* No. A-23-606-566

The Eleventh Circuit in *Jean-Pierre v. U.S. Attorney General* held that the BIA failed to give reasoned consideration to the CAT claims of petitioner, a Haitian national with advanced HIV/AIDS and AIDS related dementia, who alleged that he was entitled to withholding of removal under CAT because he was more likely than not to be tortured in a Haitian prison by guards who beat mentally ill patients.[144] The Eleventh Circuit noted that in prior similar cases, "petitioners failed because, among other things, they could not establish that they would be individually and intentionally singled out for harsh treatment."[145] In this case, however, petitioner "was not limited to the assertion that placing a man with AIDS in a Haitian prison amounts to a death sentence but instead claimed that 'placing this man in a Haitian prison, with guards who beat mentally ill patients with metal rods and lock them in small crawl spaces, would violate the commitment of the U.S. not to remove a person who is 'more likely than not to be tortured in the country of removal.'"[146]

B. Cancellation of Removal

Cancellation of removal is a form of relief that may be available to individuals who have been present in the U.S. for a certain period of time and can meet several additional requirements that will allow for their removal to be "cancelled."[147] The general idea behind cancellation of removal is that if a non-citizen has been in the U.S. for a certain period of time, has maintained good moral character, and but for some small infractions or violations of the immigration laws would still be eligible to remain in the U.S., the INA will afford him a second chance at applying to stay in the U.S.

The Act provides two types of cancellation of removal: (1) cancellation of removal for non-citizens who are not Legal Permanent Residents, or "10 year cancellation;" and (2) cancellation of removal for non-citizens who are Legal Permanent Residents (LPRs), or "seven year cancellation." [148] Below is a table that highlights key differences between the two forms of relief. Following the table is a more detailed description of the standards for each type of removal, and how they may apply to the client.

(BIA Jun. 2, 2005), and *In re-,* 26 Immig. Rptr. B1-161 (BIA Mar. 18, 2003), noting that "in each of those cases, the BIA held that evidence of mental illness sufficiently distinguished the petitioner's circumstances from those in *In re J-E-.*"); *See also Jean-Pierre v. AG,* 500 F.3d 1315 (11th Cir. 2007) (remanding because BIA failed to consider that it was likely that if returned to Haiti, petitioner would be singled out for crawl-space confinement, striking on held and ears, and beatings with metal rods as a result of mental illness.)

[144] *Jean-Pierre,* 500 F.3d at 1315. In this case, the petitioner had a physical ailment, but the court considered him mentally ill due to the high likelihood of psychiatric complications and consequent deviant behaviors of persons afflicted with advanced HIV/AIDS.

[145] *Id.* at 1324. The cases referenced in this opinion include *In re J-E-,* 23 I&N Dec. 291 (BIA 2002) (*en banc*) and *Cadet v. Bulger*, 377 F.3d 1173 (11th Cir. 2004), both of which held, among other things, "that Haiti is a poor country, and that its inability to maintain better prisons did not mean that it tortures those it holds, even when it indefinitely confines criminals deported from the United States and may subject them to mistreatment short of torture." *Jean-Pierre,* 500 F.3d at 1324.

[146] *Id.* at 1325 (emphasis included).

[147] In order to make a cancellation claim, you must also file an application for cancellation of removal, Form EOIR-42A, which can be found at http://www.usdoj.gov/eoir/eoirforms/eoir42a.pdf.

[148] *See* INA § 240A(b) and INA § 240(a).

	LPR Cancellation (7 Year Cancellation)	Non-LPR Cancellation (10 Year Cancellation)
Years of LPR status required:	5	0
Years of continuous residence in U.S. required:	7	10
Minimum character requirements	No Aggravated Felony convictions	Good Moral Character for last ten years; plus No convictions that would render applicant inadmissible or removable
Discretionary Standard:	Warrants favorable discretion	Removal would result in exceptional and extremely unusual hardship to USC or LPR spouse, parent or child

Both forms of cancellation of removal are discretionary forms of relief and are heavily centered on showing certain equities that will convince the adjudicator that the client deserves a second chance. Mental illness is often one of the equities that adjudicators find important. Other important factors considered include:

- Positive factors:
  - Family ties within the U.S.;
  - Residency of long duration in the U.S.;
  - Evidence of hardship to the respondent and family if deportation occurs;
  - Service in Armed Forces;
  - History of employment;
  - Existence of property or business ties;
  - Existence of value and service to the community;
  - Proof of genuine rehabilitation if a criminal record exists;
  - Evidence attesting to a respondent's good character
  - Negative Factors:
  - Nature and underlying circumstances of grounds of removal;
  - Additional significant immigration violations;
  - Existence of criminal record;
  - Other evidence of bad character or undesirability.[149]

1. Cancellation of Removal for Non-LPRs (10 Year Cancellation)

For a non-LPR, cancellation may be granted at the discretion of the adjudicator if the non-LPR can meet the following threshold eligibility requirements. The client must be:

1. physically present in the U.S. for a continuous period of not less than ten years immediately preceding the date of application;

2. able to show that he has been a person of good moral character during the ten year period;

[149] *See In re C-V-T-*, 22 I&N Dec. 7 (BIA 1998).

3. not convicted of certain criminal offenses;[150]

4. able to demonstrate that his removal from the U.S. would be an exceptional and extremely unusual hardship on his U.S. citizen or LPR husband, wife, parent, or unmarried child/children under age twenty-one;[151]

5. he has not previously applied for and been granted cancellation of removal or suspension of deportation.[152]

Continuous Presence in the U.S. for at least 10 years: In order to be *prima facie* eligible for ten year cancellation of removal, the client must establish that he has lived in the U.S. continuously for ten years. Furthermore, the client must not be subject to a "stop the time" discontinuance of his presence. A client's continuous presence may be tolled if one of the following events occur,

1. DHS issues the client a "Notice to Appear" - which is the document that charges the client with a violation of the immigration code – and files it with the immigration court. Once this document is served on the client, the time accumulating toward the ten year requirement is stopped.

2. The client commits an offense that renders him removable or inadmissible. At the time the client commits a crime or other offense which renders him removable or inadmissible, the time accumulating toward the ten year requirement is stopped.[153]

Furthermore, if the client has taken any trips outside the U.S., such trip(s) may interrupt his continuous presence. Brief trips abroad do not interrupt presence, but a trip that lasts a period of ninety-one days or trips that last an aggregate of one hundred and eighty-one days may interrupt his continuous presence in the U.S.

Good Moral Character: Once the practitioner establishes that the client meets the ten years of continuous residence requirement, the practitioner must then show that the client is a person of good moral character.[154] While violations of the immigration laws and criminal convictions may weigh against an applicant's good moral character, it is important to keep in mind that the BIA has "long held that good moral character does not mean moral excellence and that it is not destroyed by a single incident."[155]

[150] INA § 212(a)(2); 237(a)(3).
[151] INA § 240A(b).
[152] INA § 240A(b).
[153] The types of crimes that may stop your client's time are the same crimes that can also make him or her ineligible to apply for cancellation altogether. These are described in more detail below.
[154] *See Matter of Turcotte*, 12 I&N Dec. 206 (BIA 1967)(where specific conduct does not result in statutory ineligibility for good moral character, the Immigration Judge may still consider it as a discretionary matter).
[155] *Matter of Sanchez-Linn*, 20 I&N Dec. 362 (BIA 1991).

INA § 101(f) governs the statutory eligibility requirements relating to a finding of good moral character. This finding is subject to a substantial-evidence test,[156] and under the statutory requirements an alien will not be deemed a person of good moral character if, during the requisite ten year time period, he is one of the following:

1. a habitual drunkard;
2. a person who derives most of his income from illegal gambling activities or who has been convicted at least twice for gambling offenses;
3. a person who gave false testimony in order to obtain immigration benefits;
4. a member of one or more of the following classes of persons: practicing polygamist, prostitute, or smuggler;
5. or a person convicted of a crime of moral turpitude[157], multiple crimes or a drug crime (except a single offense for simple possession of thirty grams or less of marijuana);
6. a person who has been convicted of any crime and confined in jail or prison for an aggregate period of one-hundred eighty days or more;
7. a person who has been convicted of an aggravated felony at any time;
8. a person who at any time has assisted in Nazi persecution, genocide or commission of acts of torture or extrajudicial killings, or a person who, at any time, has been involved in severe violations of religious freedom; or
9. a person who falsely claims U.S. citizenship or registers to vote or votes in violation of restrictions.[158]

If the client falls within one of the above statutory classes, he is automatically barred from a finding of good moral character.

Even if the client meets the statutory requirements for good moral character, the practitioner must convince the immigration judge to make a discretionary finding of good moral character. The judge will consider past criminal behavior and the alien's general conduct over time.[159]

Not convicted of an offense under Section 212(a)(2) or 237(a)(3). Even if the client has resided in the U.S. for ten years or more and the immigration judge finds that he is a person of

[156] *Omagah v. Ashcroft*, 288 F.3d 254, 258 (5th Cir. 2002) (affirming BIA determination that conviction for conspiracy to possess illegal immigration documents with intent to defraud the government demonstrates a lack of good moral character).
[157] a crime involving moral turpitude is a term of art in immigration law, and involves a very unwieldy and case-law defined series of crimes. You should consult an immigration practitioner or source of information outside of this manual before making determinations about crimes involving moral turpitude.
[158] unless that person can prove that (1) each parent is or was a U.S. citizen; (2) the person permanently resided in the U.S. before the age of sixteen; and (3) the person reasonably believed he was a U.S. citizen when he made the statement.
[159] *See Ikenokwalu-White v. INS*, 316 F.3d 798, 804-05 (8th Cir. 2003).

good moral character, the client may still be barred from ten year cancellation if he has been convicted at *any* time of one or more of the following crimes:

1. high speed flight from an immigration checkpoint;
2. firearm offense;
3. espionage, sabotage, treason for which the sentence was five years or more;
4. document fraud;
5. false claim to U.S. citizenship;
6. domestic violence;
7. stalking;
8. child abuse, neglect, or abandonment;
9. a crime involving moral turpitude (exception for certain petty offenses);
10. drug offenses(except for one offense for possession of Marijuana less than 30 grams);
11. drug trafficking;
12. two or more crimes with aggregate sentences to confinement of 5 years or more;
13. prostitution or procuring prostitution; or
14. serious offense for which the applicant received immunity from criminal prosecution.

Practitioner's Tip: Before coming to a final conclusion about whether or not the client is rendered ineligible for cancellation based on criminal convictions, the practitioner should be careful to do a full analysis of the immigration consequences of the client's criminal convictions. We suggest that the practitioner consult an immigration practitioner or expert in criminal immigration matters if the practitioner is unsure about the client's eligibility for certain forms of relief.

Exceptional and extremely unusual hardship. The next element to establish in a cancellation of removal claim is the exceptional and extremely unusual hardship the client's U.S. citizen or LPR immediate family member would suffer if the client is removed. Hardship on the applicant himself is generally not relevant to a ten year cancellation case. However, the BIA has held that an applicant's hardships may be considered "to the extent they affect the potential level of hardship to his or her qualifying relatives."[160]

[160] *Matter of Recinas*, 23 I&N Dec. 467, 471 (BIA 2002).

"Exceptional and extremely unusual hardship" is not defined in the INA, but instead has developed through case law. In considering a cancellation claim, the adjudicator weighs the following criteria:

Age of affected family member(s);
Strength of family ties;
Length of residency in the U.S.;
Health and medical conditions;
Economic impact on family;
Political conditions in the country of removal;
Financial status;
Immigration history.[161]

Hardship can be established based on finances, emotional hardship, and medical history, among other things. Because all of these factors may be taken into account, it is important to show as many examples as possible that may present an exceptional and extremely unusual hardship on the client's qualifying relatives. This is especially true when the hardships can be aggregated, as the BIA has held that even if each hardship is not extreme in itself, all hardships must be considered in the aggregate in determining whether extreme hardship exists.[162]

The practitioner must establish that the hardship faced by qualifying family members are extremely unusual and much greater than the usual hardships faced by family members losing a loved one to deportation. The practitioner representing a client with mental illness should emphasize the unique circumstances of a person with mental illness and how such unique circumstances significantly increases the level of hardship to the family.

Practitioner's Tip: When arguing that removing a mentally ill client from the U.S. would create an exceptional and extremely unusual hardship on his qualifying relative, it is important to emphasize the *unique* hardships that relatives of mentally ill persons face when relief is not granted. Examples of such unique hardships that should be emphasized include:

- Exceptional emotional trauma of knowing that loved one will be removed to a country where he will not receive necessary care;
- Exceptional financial burden of having to send costly medications otherwise unavailable to client in his home country (if indeed, sending medication is even possible);
- Exceptional stress of ensuring that any medication sent is received;
- Exceptional stress of arranging for medical assistance in the country the client is removed to;
- Exceptional burden of arranging for proper living arrangements, financial assistance, psychiatric treatment, and other special accommodations necessary for a mentally ill client to reside safely outside of the U.S;
- Exceptional hardship the family member would face if forced to accompany client to his home country.

[161] *Matter of Recinas,* 23 I&N Dec. 467, 471 (BIA 2002); *and see Matter of Anderson*, 16 I&N Dec. 596 (BIA 1978).
[162] *Matter of Ige,* 20 I&N Dec. 880 (BIA 1994).

Documenting the hardship on family members:

The practitioner should have psychological and medical evaluations done for qualifying family members to establish the emotional impact a client's removal would have. The practitioner should also submit affidavits from each qualifying family member that describe in each family member's own words, the hardship he would face if the client is removed. The affidavits should describe the type of relationship they have with the client, and what it would mean to them if the client is removed from the U.S.

The practitioner should provide a schedule of expenses that would be incurred by the family, including: costs of medication, costs of sending medication and all other costs associated with special arrangements needed for the care of person with mental illness.

If any qualifying family member believes that he would be forced to return with the mentally ill client to the client's home country, the family member should describe what it would mean for him to have to leave the United States, how hard life in a new country would be, and what sort of hardships would be involved in trying to support the mentally ill applicant in that country.

The practitioner should provide documentation of conditions in the client's home country pertaining to healthcare, education, political unrest and other circumstances that would demonstrate the difficulties U.S. or LPR family members would suffer if they returned with the client to the country of removal.

The practitioner should submit documentation about the conditions in his client's home country regarding the treatment of the mentally ill. Is there a government sponsored cleansing program (or ignores such a program)? Is there any evidence that the government routinely targets or mistreats mentally ill individuals (or ignores such mistreatment)? Are the mentally ill regularly incarcerated? Is there any mental health treatment or medications available to a mentally ill deportee? All of this information will be relevant in trying to persuade the adjudicator to exercise his discretion, particularly if the practitioner can link the harsh country conditions to the suffering or hardship that distant or helpless family members will experience if the client is subjected to mistreatment.

Letters of support need not come from family members alone. Former employers, doctors, treating nurses, friends, church members, probation officers and individuals familiar with the client's condition and character are excellent sources of corroborating evidence in the client's case. The practitioner should also submit records or evaluations of the client's mental health status.

The practitioner should arrange for a treating physician or mental health expert to testify on the client's behalf, if possible. If the mental health condition resulted in the client getting into criminal trouble, the expert can explain why this was the case, and what sort of rehabilitation the client (or his family members) have sought on the client's behalf.

2. Cancellation of Removal LPRs (7 Year Cancellation)[163]

For an LPR, cancellation may be granted at the discretion of the adjudicator if he can meet the following threshold eligibility requirements:

1. he has been lawfully admitted for permanent residence for five years;
2. he has resided in the U.S. continuously for at least seven years after having been admitted in any status;
3. he has not been convicted of an aggravated felony at any time;
4. he has not been found by a judge to be a spy, terrorist, threat to national security, persecutor, torturer, to have committed genocide or extrajudicial killing, or severe violations of religious freedom; and
5. he has not previously been granted cancellation, or suspension of deportation.

LPR status for the last 5 years: The clock starts when the client obtains LPR status. Any time accumulated in the in the U.S. in any other status will not count towards this time requirement. An applicant may not rely on his parent's status in order to meet the five year requirement. If LPR status was obtained by fraud or mistake the individual will be deemed to have not been lawfully admitted for permanent residence.[164]

7 year continuous residence: The clock starts as soon as the client is admitted into the U.S. – in any status. Like the continuous physical presence requirement in ten year cancellation, the client must not be subject to a "stop the time" discontinuance of his presence. A client's continuous presence may be stopped under the "stop time rule" if one of the following events occur:

- DHS issues the client a "Notice to Appear" - which is the document that charges the client with a violation of the immigration code and files it with the immigration court. Once this document is served on the client, the time accumulating toward the seven year requirement stops.
- The client commits an offense that renders him removable or inadmissible. At the time the client commits a crime or other offense which renders him removable or inadmissible, the time accumulating toward the seven year requirement stops.[165]

Like ten year cancellation, a client's extended absence from the U.S. could interrupt the required continuous presence. Unlike ten year cancellation, however, there are no specific guidelines that detail the number of days that will prohibit the client from obtaining

[163] *See* **Appendix 35 – Appendix 37** for Memorandum of Law in Support of Application for Cancellation of Removal for Certain Permanent Residents and Withholding of Removal; Closing Statement in Support of Respondent's Application for Cancellation of Removal; Decision and Order.

[164] *Savoury v. U.S.* ,449 F.3d 1307, 1313-17 (11th Cir. 2006) (where petitioner fully disclosed his prior drug conviction but DHS granted AOS by mistake, BIA correctly concluded he was not an LPR because LPR status acquired by fraud or mistake nullifies status).

[165] The types of crimes that may stop your client's time are the same crimes that can also make him or her ineligible to apply for cancellation altogether. These are described in more detail below.

cancellation.[166] Thus, if the client has been absent from the U.S. for an extended period of time either continuously or in the aggregate, the practitioner should be prepared to show the judge that the client intended to keep the U.S. as his or her permanent home. This can be done by showing the client has certain ties to the United States, such as land, a home, other property, a job, family members, or a bank account.

No Aggravated Felony Conviction: The client must not have been convicted of an aggravated felony at any time. A complete list of what crimes qualify as aggravated felonies is found at INA § 101(a)(43), but below are examples of some commonly charged aggravated felonies:

- drug trafficking;
- certain crimes for which a person received a sentence of one year or more (whether time was served or not) including any of the following:
  - theft
  - burglary
  - a crime of violence
  - document fraud
  - obstruction of justice, perjury or bribing a witness
  - commercial bribery, counterfeiting, forgery, or trafficking in vehicles with alter identification numbers
- fraud or income tax evasion if the victim lost over $10,000
- failure to appear if convicted of either (1) missing a court date on a felony charge for which a sentence of at least two years could be imposed or (2) not showing up to serve a sentence for a crime where a sentence of five years could be imposed.

As with all cases involving a criminal conviction, the practitioner should carefully examine the client's criminal records – including conviction order, charging document and sentencing report. We strongly encourage the practitioner to consult with an immigration practitioner or his referring organization for a full analysis of the client's criminal history.

No security threat: In order to obtain seven year cancellation the applicant must have never been found by an Immigration Judge to be a spy, terrorist, threat to national security, persecutor, torturer or a person who has committed genocide, extrajudicial killings or violations of religious freedom.

No Previous Cancellation: Section 240(A)(c)(6) of the INA prohibits a person from obtaining cancellation if he has ever before been granted cancellation, suspension of deportation or other similar types of relief (such as § 212(c) relief).

Warrants favorable discretion: The Immigration Judge must examine the totality of evidence, weighing favorable and adverse factors in determining whether an applicant merits discretionary relief. So, in addition to describing any positive equities (family ties, community ties, length of residence in U.S., etc.) the attorney representing a client with mental illness may wish to emphasize two important factors that may not be given weight in the non-LPR cancellation case: (1) hardship to the client himself if he is forced to return to a country with inadequate medical care, and (2) manifestations of the client's mental illness as the cause of past criminal behavior and other adverse factors (such as unstable employment history). The practitioner

---

[166] *See* the section above on the continuous presence requirement for 10 year cancellation for more detailed information on the time requirements for that form of relief.

should also demonstrate the damage his removal will have to family members even though harm to family members is not a requirement for statutory eligibility.

Case Example: An unpublished decision by an Immigration Judge included in **Appendix 37** the respondent applied for LPR cancellation of removal pursuant to section 240(a) of the INA. The respondent was mentally ill and had been admitted to several psychiatric hospitals during his time as an LPR in the U.S., but at times was able to function and support his family with proper medical supervision. The government initiated removal proceedings because of a criminal conviction and the respondent then filed for seven year cancellation in order to prevent his removal to Jamaica.

At trial, the Immigration Judge granted LPR cancellation. He found under INA § 240(A)(a) that the respondent had been lawfully admitted for permanent residence for not less than five years; had resided in the United States continuously for seven years after having been admitted in any status; and had not been convicted of an aggravated felony.

In addition to satisfying the statutory requirements, the Immigration Judge found that the applicant warranted a grant of relief. The judge took special note that DHS's refusal to move the respondent to a psychiatric facility during his immigration detention prevented the respondent from participating in his own hearing. As a result, the judge determined that he was required to give the respondent, "the benefit of every doubt" and adopted respondent's closing statement as the court's rationale. Accordingly, the court determined that: (1) the length of respondent's presence in the U.S. (over twenty years); (2) his strong family ties in the U.S.; (3) the lack of any meaningful ties to Jamaica; and, (4) the likelihood that respondent would become homeless and bereft of any assistance on account of his mental illness, compelled a grant of relief.

V. CREATING THE RECORD TO WIN THE CLAIM

This excellent article, *Past Persecution, Mental Illness and Humanitarian Asylum: Creating the Record to Win the Claim,* addresses a precedent setting case (Kholyavskiy) involving “mental illness as a ground for asylum and for humanitarian asylum.”[167] *See* **Appendix 38**.

[167] Maria Baldini-Potermin, Esq., *Past Persecution, Mental Illness and Humanitarian Asylum: Creating the Record to Win the Claim*, West Interpreter Releases, January 26, 2009. (reprinted with permission of Thomas Reuters).

VI. POST-ADJUDICATION ISSUES

This section of the manual identifies issues of importance to mentally ill immigrant detainees following adjudication of their cases in the U.S. Immigration Courts. Subsections A – J below discuss common mental health issues and issues that are not specific to mentally ill detainees, but that nonetheless commonly arise in the immigrant population, often with particular impact on the mentally ill.

For each issue discussed, this section of the manual highlights general principles that attorneys should be aware of, as well as a list of national and local resources relevant to the issue in question.

A. Mental Health Issues

For a variety of reasons, certain mental health problems present in the general (i.e., non-immigrant) population may be more pronounced among the immigrant-detainee population. For example, with respect to the refugee segment of the immigrant population, it is estimated that between 5% to 30% are survivors of torture. *See* Linda Piwowarczyk, Seeking Asylum: A *Mental Health Perspective*, 16 Geo. Immigr. L.J. 155, 155-56 (2001). Torture and refugee trauma aside, it is believed that all forms of human rights violations can have serious mental health consequences. *Id*.

Pro bono counsel should expect that the same mental health issues that complicate the attorney-client relationship during removal proceedings will persist following the conclusion of your representation. For this reason, it is important to be aware of the resources available to your client upon his release from detention. We encourage you to help your client access these resources.

1. General Resources

a. National Resources

American Psychological Association ("APA")
750 First Street, NE # 605
Washington, DC 20002
(800) 374-2721 or (202) 336-5500
http://www.apa.org/

- Represents psychologists in the United States; with 148,000 members, APA is the largest association of psychologists worldwide.

- Advances the creation, communication, and application of psychological knowledge to benefit society and improve people's lives.

Mental Health America ("MHA")
2000 N. Beauregard Street, 6th Floor
Alexandria, VA 22311
(703) 684-7722
http://www.nmha.org/go/home

- Addresses the full spectrum of mental and substance use conditions and their effects nationwide; works to inform, advocate, and enable access to quality behavioral health services. MHA has over three hundred affiliates in forty-one states and the District of Columbia.

- Promotes mental health, preventing mental and substance use conditions and achieving victory over mental illnesses and addictions through advocacy, education, research, and service.

- Provides information about area mental health programs and services including treatment, support groups, state and local prescription assistance, community legal and advocacy services.

Physicians for Human Rights
2 Arrow Street, Suite 301
Cambridge, MA 02138
(617) 301-4200
http://physiciansforhumanrights.org

- Mobilizes health professionals to advance health, dignity, and justice, and promotes the right to health for all.

- Investigates human rights abuses and works to stop them.

Torture Abolition & Survivors Support Coalition International ("TASSC")
4121 Harewood Road, NE, Suite B
Washington, DC 20017
(202) 529-2991
http://www.tassc.org

- Works to end torture wherever it occurs and to support and empower survivors, their families and communities wherever they are.

- Operates "Helping Hands," a direct assistance program for torture survivors.

- Offers a list of treatment centers around the world that recognize and address the unique psychological needs of survivors of torture.

b. District of Columbia

Community Connections of Washington, DC
801 Pennsylvania Avenue, SE, Suite 201
Washington, DC 20003
(202) 546-1512
http://www.communityconnectionsdc.org/index.htm

- Provides comprehensive, respectful, and effective mental health and residential services to residents of the District of Columbia and Montgomery County, Maryland.

- Offers a variety of clinical services, including trauma services addressing physical and sexual abuse.

District of Columbia Department of Mental Health (“**DCDMA**”).
64 New York Avenue, NE, 4th Floor
Washington, DC 20002
(202) 673-7440
http://dmh.dc.gov/dmh/site/default.asp

- Provides comprehensive mental health services to adults, children, youths, and their families.

- Operates through the DMH Community Services Agency (the District’s direct provider of mental health services and “safety net for uninsured residents”), and through other community-based mental health service providers under contract to DCDMA. Services and resources of interest include the following:

  - Pharmacy: DCDMA operates a pharmacy for consumers without pharmacy benefits who are unable to pay for their medications.

  - Inpatient Psychiatric Services: all such services, whether acute, long-term, or forensic, are provided at Saint Elizabeth’s Hospital.

  - Comprehensive Psychiatric Emergency Program: (“CPE”) provides emergency psychiatric evaluation, treatment and stabilization, and observation for individuals eighteen years of age and older who are experiencing a psychiatric crisis.

  - Homeless Outreach Teams: crisis assessment and interventions to homeless persons experiencing a mental health crisis whether on the streets or in homeless shelters.

- Multicultural Mental Health Services: multilingual and culturally sensitive mental health services for people eighteen and older and for families from various ethnic and linguistic minority groups.

The District of Columbia Department of Mental Health's ("DMH") Multicultural Mental Health Services
1250 U Street, NW
Washington, DC 20009
(202) 673-2058
http://dmh.dc.gov/dmh/cwp/view,a,3,q,515861,dmhNav,|31262|.asp

- Provides multilingual and culturally sensitive mental health services to people eighteen, and to older and families from various ethnic and linguistic minority groups.

- Accepts walk-ins and scheduled appointments.

- Fees determined on a sliding scale basis: no one is turned away because of an inability to pay.

- The following services may be useful to immigrants:

  - Outpatient Program: provides psychiatric assessment, medication, case management, parenting workshops, English as a second language, and individual, group, and family counseling. Groups are available for stress management, depression, dance therapy, art therapy, life skills training, and spiritual discussions.

  - Medical Clinic: performs physical examinations, and provides follow-up care for some physical health related problems, EKGs, and laboratory studies for persons receiving treatment at the Multicultural Services Division.

  - School Based Program: offers child and adolescent psychiatric services including a full range of diagnostic evaluation and treatment services to help students adjust to a school environment.

  - Parenting Skills Training: encourages mutual respect and helps parents communicate with their children (Spanish, English, and Amharic)

Meyer Treatment Center ("**MTC**")
Washington School of Psychiatry
5028 Wisconsin Avenue, Suite 400
Washington, DC 20016-4118
(202) 237-2700
http://www.wspdc.org/treatment.htm

- Provides clinical services at an affordable price to people from Washington, DC and the surrounding communities.

- Offers individual, group, couples, and family psychotherapy, as well as psychiatric evaluations and medication consultations.

Torture Abolition & Survivors Support Coalition International ("TASSC")
4121 Harewood Road, NE, Suite B
Washington, DC 20017
(202) 529-2991
http://www.tassc.org/

- Provides limited on-site counseling services and referrals to psychiatrists and psychologists in the area.

c. Maryland

Advocates for Survivors of Trauma and Torture ("**ASTT**")
431 East Belvedere Avenue
Baltimore, MD 21212
(410) 464-9006
http://www.astt.org/

- Alleviates the suffering of those who have experienced the trauma of torture, educates the local, national, and world community about the needs of torture survivors, and advocates on their behalf.

- Offers mental health services including psychological assessment, individual and family psychotherapy, and group treatment.

- Refers clients to an in-house psychologist or clinical social worker when counseling or psychological assessment is a part of a client's personal wellness plan.

Montgomery County Victim Assistance & Sexual Assault Program ("**VASAP**").
1301 Piccard Drive, Suite 4100
Rockville, MD 20850
(240) 777-1355 (Mail Line)
(240) 777-HELP (Crisis Line)
http://www.montgomerycountymd.gov/hhstmpl.asp?url=/content/hhs/vasap/index.asp

- Serves only Montgomery County residents who are victims of crime or victims of all types of crimes committed in Montgomery County, their families and significant others

- Charges for ongoing counseling services on a sliding scale, based on ability to pay. No one is denied services due to lack of funds. All other victim assistance services are free.

d. **Virginia**

Northern Virginia Family Service, Multicultural Human Service Programs ("MHS")
6400 Arlington Blvd., Suite 110
Falls Church, VA 22042
(703) 533-3302
http://www.nvfs.org/mhs_programs.htm

- **Mental Health Services**: MHS's multicultural mental health services address the mental health needs of low-income, English-limited immigrants and refugees for whom existing services are inaccessible due to language and cultural barriers. Clients include individuals from all cultural and ethnic groups whose mental health and stability is compromised as a result of trauma, poverty, chronic stress, and other challenges posed by the process of cultural adjustment. Services address such issues as depression, anxiety, loss and trauma, and are offered in variety of modalities, such as individual, couples, group, and family therapy. Services include:

    - Individual (adult & child), couples, group, and family therapy
    - Domestic Violence counseling and support group
    - Anger Management
    - Batterer's Intervention Program (Groups)
    - Parenting class (Groups)
    - Substance Abuse Education and Counseling (Korean and Vietnamese); and
    - Medication Management/Consultation with Psychiatrist (available for MHS's active clients).

Fees

- Payment is accepted on a sliding-scale, self-pay for insurance basis.

Contact Information/Referral Process

- Intake and Referral: 703-533-3302 ext. 303

- **Program for Survivors of Torture and Trauma ("PSTT")** **PSTT** was established to address the consequences of human rights abuses. The program assists survivors of *politically-motivated* torture by providing a comprehensive range of services to address the complex consequences of their torture. PSTT holds a holistic view of survivors' needs and offers a team approach that encompasses a full range of services and interventions. This includes mental health, medical, legal, language, and social services. The program serves over 200 survivors of torture per year. Services include:

  - Mental Health Services (counseling and therapy);
  - Psychiatric Services (medication management);
  - Case Management;
  - Psychological Evaluations; and
  - Legal and Social Services.

Fees

- PSTT does not charge clients who meet certain eligibility requirements.

Contact Information/Referral Process

- Intake and Referral: 703-533-3302 ext. 303

Mental Health Association of Virginia ("MHAV")
3212 Cutshaw Avenue, Suite 315
Richmond, VA 23230
(804) 257-5591
http://www.mhav.org/home.html

- Promotes mental health, preventing mental illness, assuring the proper treatment of the mentally ill, and eliminating the stigma associated with mental illness.

2. Commitment - Voluntary and Involuntary

The rules regarding voluntary and involuntary commitment of mentally ill individuals are established at the state level. For this reason, we provide only local resources. Counsel should

familiarize themselves with the applicable jurisdiction's rules thoroughly. A discussion of certain basic local regulations follows below:

a. District of Columbia

Title 21 of the District of Columbia Code concerns "Fiduciary Relations and the Mentally Ill." Chapter 5 of that Title deals with hospitalization of the mentally ill. The various subchapters therein proscribe rules for the admission and treatment of mentally ill patients under different circumstances. For example:

- Subchapter II addresses "Voluntary and Non-Protesting Hospitalization."
- Subchapter III addresses "Emergency Hospitalization."
- Subchapter IV addresses "Commitment Under Court Order."

(i) Voluntary Admission and Treatment

Pursuant to § 21-511 ("Voluntary Hospitalization and Treatment"), individuals can apply to a public or private hospital, to the Department of Mental Health, or to any mental health provider in the District to become a voluntary patient for purposes of observation, diagnosis, and treatment of a mental illness. Admission decisions are made by the administrator of the hospital to which application is made, following an examination by an admitting psychiatrist or an admitting qualified psychologist. Provisions concerning the release of voluntary patients can be found at § 21-512.

When an examination reveals that the person requesting admission is not in need of hospitalization, but is in need of outpatient treatment, the hospital administrator should arrange voluntary outpatient treatment by the DMH, a core services agency, or another provider.

Another method of "voluntary admission" under District law is "Hospitalization of Non-Protesting Persons." Pursuant to § 21-513, "a friend or relative of a person believed to have a mental illness may apply on behalf of that person" for admission to a hospital. Admission under the non-protesting person provisions requires presentation of the person to be admitted, "together with a referral from a practicing physician or qualified psychologist." *Id.* Public hospitals must admit such persons if the admitting psychiatrist or psychologist determines there is a need for examination and treatment, and if the person to be admitted signs a statement that he does not object to hospitalization. *See id.* Private hospitals have discretion to admit or to deny admission under the same circumstances. Provisions concerning the release of non-objecting patients can be found at § 21-514.

(ii) Involuntary Admission

There are two processes by which an individual can be involuntarily committed in the District of Columbia. The first, "Emergency Hospitalization" is covered in Subchapter III of Chapter 5. The second, "Commitment Under Court Order," is covered by Subchapter IV.

The "Emergency Hospitalization" provisions authorize certain people (*e.g.*, police, physicians, qualified psychologists) to take an individual into custody without a warrant, transport him to a public or private hospital, and apply to admit him for emergency observation and diagnosis. The person so authorized must have reason to believe that a person to be taken into custody is mentally ill and, because of the illness, is likely to injure himself or others if he is

not immediately detained. *See* § 21-521 (Detention of Persons Believed to be Mentally Ill; Transportation and Application to Hospital).

The "Commitment Under Court Order" provisions allow certain people (*e.g.*, spouses, parents, legal guardians, physicians, qualified psychologists, police, etc.) to file a petition for a court order to involuntarily commit a mentally ill individual. *See* § 21-541 (Petition to Commission; Copy to Person Affected). Among other things, the petition must include information to the effect that the person to be committed is mentally ill, and because of the illness is likely to injure himself or other persons if not committed. *See id.*

The following provisions in Subchapter IV offer additional guidance concerning court-ordered commitment in the District of Columbia:

- § 21-542 (Hearing by Commission to determine an individual's mental condition);
- § 21-543 (Representation by Counsel; Compensation; Recess);
- § 21-544 (Determinations of Commission; Right to Jury Trial);
- § 21-545 (Hearing and Determination by Court or Jury);
- § 21-545.01 (Renewal of Commitment Status by Commission; Review by Court);
- § 21-546 (Periodic Examinations of Committed Patients; Procedure for Examination and Detention or Release; Petition to Court); and
- § 21-547 (Judicial Determination of Petition filed under § 21-546).

Finally, Subchapter V of Chapter 5 contains information about the rights of committed persons in the District of Columbia (*e.g.*, the right to communicate, the right not to be secluded or restrained, *etc.*). *See* § 21-561-65.

b. Maryland

Maryland's "Mental Hygiene" regulations appear in Title 10, Subtitle 21 of the Code of Maryland Regulations ("COMAR"). Maryland uses the term "admission" instead of "commitment."

(i) Voluntary Admission

There are two ways that individuals can voluntarily admit themselves to an inpatient facility in Maryland. One option is to sign and endorse a formal application for voluntary admission pursuant to Health-General Article § 10-609 or § 10-610 of the Annotated Code of Maryland. Alternatively, individuals may make an "informal request for admission" pursuant to § 10-609. *See* MD. Code Regs. 10 § 21.01.02(B)(33) (year).

(ii) Involuntary Admission

Chapter 1 of Subtitle 21 governs procedures for the involuntary admission of individuals to "inpatient mental hygiene facilities, including State facilities, private psychiatric facilities, acute general hospitals with inpatient psychiatric units, and Veterans' Administration hospitals[.]" *See* MD. Code Regs. 10 § 21.01.01.

Involuntary admission requires an application to the Maryland Mental Hygiene Administration. Pursuant to the mental hygiene regulations, the individual submitting the

application must have "a legitimate interest in the welfare of the individual for whom involuntary admission is sought." MD. Code Regs.10 § 21.01.03. Applications must include certificates from two physicians or one physician and one psychologist. *See* MD. Code Regs. 10 § 21.01.04 (setting forth the requisite elements of the "Physician's or Psychologist's Certificate for Involuntary Admission.").

Among other requirements, the physician's or psychologist's certificate must include copies of "any available current medical reports or records that support the individual's need for involuntary care or treatment in an inpatient facility[.]" MD. Code Regs. 10 § 21.01.04C(4). Such reports must include an explanation of why the individual meets the following requirements for involuntary admission:

- The individual has a mental disorder;
- The individual needs inpatient care or treatment;
- The individual presents a danger to the life or safety of the individual or of others;
- The individual is unable or unwilling to be admitted voluntarily;
- There is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual; and
- Unless the individual is an emergency evaluee, if the individual is 65 years old or older and is being referred for admission to a State inpatient facility or a VA hospital, a GES team has determined that there is no available, less restrictive form of care or treatment that is adequate for the needs of the individual[.]

MD. Code Regs. 10 § 21.01.04C(4)(c)(i)-(vi).

See Chapter 1 of Subtitle 21 for various other provisions concerning the procedures and guidelines relevant to involuntary admission in Maryland. Examples of particular importance include the following:

- § 21.01.05 (Notice of Status and Rights) (requiring staff at inpatient facilities to inform involuntarily admitted individuals of their status and legal rights, including, for example, the right to legal counsel, and the right to request a judicial hearing on the cause and legality of the individual's admission and continued detention);
- § 21.01.07(E) (Observation Status) (entitling individuals confined on observation status in inpatient facilities "the rights granted in accordance with Health-General Article, Title 10, Subtitle 7, and Title 4, Subtitle 3, Annotated Code of Maryland.");
- § 21.01.08 (Schedule of IVA Hearings) (setting forth procedures applicable to changing the admission status of individuals in inpatient facilities); and
- § 21.01.09 (Conduct of IVA Hearings) (setting forth the powers and duties of Administrative Law Judges, the rights of the parties, and the procedural and substantive rules applicable to IVA hearings).

c. Virginia

Title 37.2 of the Virginia Code addresses issues of "Mental Health, Mental Retardation, and Substance Abuse Services." Chapter 8 of that title deals with "Emergency Custody and Voluntary and Involuntary Civil Admissions." *See* VA Code § 37.2-800-47.

According to the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services ("VA DMHMRSAS"), the 2008 General Assembly made significant changes to Virginia's civil commitment laws with respect to the criteria and procedures for emergency custody orders, temporary detention orders, involuntary commitment proceedings and other important measures. These changes took effect on July 1, 2008.[168]

(i) Voluntary Admission

VA Code § 37.2-805 ("Voluntary Admission") provides that "Any state facility shall admit any person requesting admission who has been (i) screened by the community services board or behavioral health authority that serves the city or county where the person resides or, if impractical, where the person is located, (ii) examined by a physician on the staff of the state facility, and (iii) deemed by the board or authority and the state facility physician to be in need of treatment, training, or habilitation in a state facility."

(ii) Involuntary Admission and Treatment

Pursuant to VA Code § 37.2-817, Virginia district court judges and special justices may order mentally ill persons to be (1) admitted involuntarily to a state facility or (2) to undergo mandatory outpatient treatment.[169] § 37.2-817C sets forth the standard applicable to involuntary commitment in Virginia:

> After observing the person and considering (1) the recommendations of any treating physician or psychologist licensed in Virginia, if available, (2) any past actions of the person, (3) any past mental health treatment of the person, (4) any examiner's certification, (5) any health records available, (vi) the preadmission screening report, and (6) any other relevant evidence that may have been admitted, if the judge or special justice finds by clear and convincing evidence that
>
> (a) the person has a mental illness and there is a substantial likelihood that, as a result of mental illness, the person will, in the near future,
>
>> (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or

[168] *See* http://www.dmhmrsas.virginia.gov/OMH-MHReform.htm

[169] Note that § 37.2-832 (Persons with Mental Illness Not to be Confined in Cells with Criminals) provides that "in no case shall any sheriff or jailer confine any person with mental illness in a cell or room with prisoners charged with or convicted of crimes."

> > (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, and . . .
>
> (b) all available less restrictive treatment alternatives to involuntary inpatient treatment have been . . . determined to be inappropriate, the judge or special justice shall order that the person be admitted involuntarily to a facility for a period of treatment not to exceed 30 days from the date of the court order.

See VA Code § 37.2-817C (emphasis added).

With respect to mandatory outpatient treatment, § 37.2-817D provides in relevant part:

> After observing the person and considering (1) the recommendations of any treating or examining physician or psychologist licensed in Virginia, if available, (2) any past actions of the person, (3) any past mental health treatment of the person, (4) any examiner's certification, (5) any health records available, (6) the preadmission screening report, and (7) any other relevant evidence that may have been admitted, if the judge or special justice finds by clear and convincing evidence that
>
> (a) the person has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future,
>
> > (1) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or
> >
> > (2) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs;
>
> (b) less restrictive alternatives to involuntary inpatient treatment that would offer an opportunity for improvement of his condition have been investigated and are determined to be appropriate; and
>
> (c) the person (A) has sufficient capacity to understand the stipulations of his treatment, (B) has expressed an interest in living in the community and has agreed to abide by his treatment plan, and (C) is deemed to have the capacity to comply with the treatment plan and understand and adhere to conditions and requirements of the treatment and services; and
>
> (d) the ordered treatment can be delivered on an outpatient basis by the community services board or designated provider, the judge or special justice shall by written order and specific findings so certify and order that the person be admitted involuntarily to mandatory outpatient treatment.

See VA Code § 37.2-817D (emphasis added).

Chapter 8 of Title 37.2 contains various other provisions concerning the procedures and guidelines relevant to involuntary admission.. Examples include the following:

(1) § 37.2-808 (Emergency Custody; Issuance and Execution of Order);

(2) § 37.2-809 (Involuntary Temporary Detention; Issuance and Execution of Order);

(3) § 37.2-814. (Commitment Hearing for Involuntary Admission; Written Explanation; Right to Counsel; Rights of Petitioner);

(4) § 37.2-815 (Commitment Hearing for Involuntary Admission; Examination Required);

(5) § 37.2-816 (Commitment Hearing for Involuntary Admission; Preadmission Screening Report);

(6) § 37.2-817 (Involuntary Admission and Mandatory Outpatient Treatment Orders); and

(7) § 37.2-818 (Commitment Hearing for Involuntary Admission; Recordings and Records).

See also Bruce J. Cohen, Richard J. Bonnie, & John Monahan, *Understanding and Applying Virginia's New Statutory Civil Commitment Criteria*, available on the VA DMHMRSAS website at http://www.dmhmrsas.virginia.gov/OMH-MHReform/080603Criteria.pdf.

3. Local Mental Health Hospitals

A variety of public and private facilities are available serve the underserved. Below is a description of a sampling of services available in the Washington, DC metropolitan area.

a. District of Columbia Facilities.

The District of Columbia Department of Mental Health ("DMH") operates an emergency psychiatric facility (through the Comprehensive Psychiatric Emergency Program), an in-patient psychiatric facility (Saint Elizabeth's Hospital), and several services for the homeless. There are also several community-based hospitals in the District that offer mental health services. A good starting point when looking for the appropriate mental health resources in the District is the "DMH Access HelpLine."

Comprehensive Psychiatric Emergency Program ("CPEP")
DC General Hospital Compound
1905 E Street, SE, Building 14
Washington, DC 20003
(202) 673-9319
http://dmh.dc.gov/dmh/cwp/view,a,3,q,515833,dmhNav,|31250|.asp

CPEP is the District's "psychiatric emergency room." CPEP operates on a twenty-four hour basis to provide emergency psychiatric evaluation, treatment and stabilization, and observation for individuals eighteen years of age and older who are experiencing a psychiatric crisis. Services can be accessed by telephone or in person.

DC Department of Mental Health Access HelpLine
(888) 793-4357
http://dmh.dc.gov/dmh/cwp/view,A,3,Q,515987,dmhNav,|31250|.asp

DC residents can obtain mental health services twenty-four hours a day, seven days a week, by calling the HelpLine. Residents may also obtain in-patient services by calling the HelpLine; a clinician helps patients and their families decide on the best facility for in-patient services.

Georgetown University Hospital
Department of Psychiatry
Kober-Cogan Building–Fifth Floor
3800 Reservoir Road, NW
Washington, DC 20007
(202) 687-8609
http://www.georgetownuniversityhospital.org/body.cfm?id=512

The Department of Psychiatry of Georgetown University Hospital provides comprehensive programs in clinical patient care, education, research, and community outreach. Georgetown also sponsors a Center for Mental Health Outreach, which is dedicated to improving the mental health of underserved children, adults, and families in the Greater Washington D.C. area through education, public awareness, direct clinical care, and collaboration with social service providers.

The George Washington University Hospital
Psychiatric Services Department
900 23rd Street, NW
Washington, DC 20037
(202) 715-4000
http://www.gwhospital.com/index.php?PageID=1922

Pyschiatric services at GW Hospital include inpatient hospitalization, emergency room assessments, ECT – inpatient and outpatient, treatment for mood disorders, depression and bipolar disorder and treatment for those with a dual diagnosis (mental health/substance abuse).

Howard University Hospital
2041 Georgia Avenue
Washington, DC 20060
(202) 865-6611
http://huhealthcare.com/departments.asp?id=13

Howard University Hospital Department of Psychiatry consists of clinical faculty representing generalists and subspecialists in psychiatry and psychology, including the diagnosis and treatment of disorders in inpatient and outpatient settings. Several

members of the department participate in ongoing basic and clinical research. The department has an alliance with the National Institute of Mental Health's intramural program to support collaborative research on twenty-five different projects. Areas of expertise and specific services also include but are not limited to: anxiety disorders such as phobias, panic disorder, others depression, bipolar illness, schizophrenia, suicide assessment, trauma, parent/child or family problems, chemical and behavioral management of addiction, and partial hospitalization.

Mental Health Services for the Homeless
64 New York Avenue, NE, 4th Floor
Washington, DC 20003
(202) 671-0388 (Main)
(888) 793-4357 (24-Hour Helpline)
http://dmh.dc.gov/dmh/cwp/view,a,3,q,515840,dmhNav,|31250|.asp

The District's Department of Mental Health ("DMH") Homeless Outreach Teams provide crisis assessment and interventions to homeless persons experiencing a mental health crisis whether on the streets or in homeless shelters. The District also provides day services at the Hermano Pedro Day Program, and case management and mental health services at Franklin Shelter.

DMH has programs to help homeless people suffering from mental illness get off the streets and into safe, decent housing where they can get the support they need. DMH also helps prevent evictions of individuals receiving mental health services.

Saint Elizabeth's Hospital
2700 Martin Luther King Jr. Avenue, SE
Washington, DC 20032
http://dmh.dc.gov/dmh/cwp/view,a,3,q,516064.asp

Saint Elizabeth's Hospital is the District's public in-patient psychiatric facility. The hospital provides intensive, inpatient care for individuals with serious and persistent mental illness who need the security and structure to assist in their recovery. Saint Elizabeth's also provides mental health evaluations and care to patients committed by the courts.

b. Maryland Facilities.

The Maryland Mental Hygiene Administration ("MD MHA") operates six hospitals that provide acute, intermediate, and long-term care for adults, one psychiatric forensic facility, and two residential treatment facilities for adolescents. Springfield Hospital offers inpatient care for individuals who are deaf or hard of hearing. The addresses and contact information for each facility is as follows:[170]

Baltimore Regional Institute for Children & Adolescents
605 South Chapel Gate Lane
Baltimore, MD 21229
(410) 368-7801
http://www.dhmh.state.md.us/rica-balto/index.html

[170] *See* http://www.dhmh.state.md.us/mha/psychiatricfacilities.html

RICA-Baltimore is a mental health residential treatment facility which serves adolescents and their families from the central Maryland region, the Eastern Shore, and parts of Western Maryland. RICA-Baltimore is staffed by qualified multidisciplinary treatment teams, providing treatment and educational programs for adolescent boys and girls aged twelve to eighteen who are experiencing emotional, behavioral and learning difficulties

Clifton T. Perkins Hospital Center ("CTPHC")
8450 Dorsey Run Road
Jessup, MD 20794
(410) 724-3002
http://www.dhmh.state.md.us/perkins/

CTPHC is a maximum security facility, commonly referred to as Maryland's forensic psychiatric hospital. CTPHC receives patients requiring psychiatric evaluation who have been accused of felonies and have raised the "not criminally responsible" ("NCR") defense and/or for whom the issue of mental competency is in question. CTPHC provides treatment to offenders who have been adjudicated NCR and/or incompetent to stand trial ("IST") and CTPHC accepts, by transfer, felony inmates from correctional facilities who meet the criteria for involuntary commitment. Additionally, CTPHC accepts patients from other state regional psychiatric hospitals whose behavior is violent and aggressive.

Eastern Shore Hospital Center ("ESHC")
5262 Woods Road
Cambridge, MD 21613
(410) 221-2300 or (888) 216-8110
http://www.dhmh.state.md.us/eshc/index.htm

ESHC is an eighty bed facility that provides mental health services on the Eastern Shore for adults age eighteen and older.

John L. Gildner Regional Institute For Children & Adolescents ("**JLG-RICA**")
15000 Broschart Road
Rockville, MD 20850
(301) 251-6800
http://www.dhmh.state.md.us/jlgrica/

JLG-RICA is a public community-based, residential, clinical, and educational facility serving children and adolescents with severe emotional disabilities. The program is designed to provide residential and day treatment for students ranging in age from ten to eighteen. The JLG-RICA program has the capacity for one hundred day students and eighty residential students. Day students are admitted from Montgomery County for the elementary, middle, and senior high programs. Residential students are admitted primarily from Montgomery, Carroll, Frederick, Howard, Prince George's, Washington, and other counties in Maryland..

Springfield Hospital Center
Route 32
Sykesville, MD 21784
(410) 795-2100
http://www.dhmh.state.md.us/springfield/

Springfield Hospital Center is a regional psychiatric hospital.

Spring Grove Hospital Center
55 Wade Avenue
Catonsville, MD 21228
(410) 402-7455
http://www.springgrove.com/

Spring Grove Hospital Center is a four hundred and forty bed complex that provides a broad spectrum of inpatient psychiatric services to adults and adolescents, as well as residential psychiatric services to adults.

Thomas B. Finan Center
Box 1722
Country Club Road
Cumberland, MD 21502
(301) 777-2240
http://www.dhmh.state.md.us/finan/

The Thomas B. Finan Center is a licensed one hundred and nineteen bed state of Maryland operated inpatient psychiatric hospital. The Center serves as an integral inpatient component in the network of mental health services for Washington, Allegany, Garrett and Frederick counties for adults and includes Carroll, Howard, and Montgomery counties for adolescents.

Upper Shore CMHC
P.O. Box 229
Chestertown, MD 21620
(410) 778-6800 or (888) 784-0137

Walter P. Carter Center (“**WPCC**”)
630 West Fayette Street
Baltimore, MD 21201
(410) 209-6201
http://www.dhmh.state.md.us/carter/

WPCC is an acute inpatient psychiatric hospital, which currently operates fifty-one beds in three units, all of which are co-ed.

c. Virginia Facilities.

Virginia’s public mental health system includes sixteen facilities in the Department of Mental Health, Mental Retardation and Substance Abuse Services (“DMHMRSAS”) and forty Community Services Boards (“CSBs”). The local Community Services Board is the gateway to mental health services and refers individuals to DMHMRSAS facilities. The public mental health

system serves individuals who have or who are at risk of mental illness, serious emotional disturbance, mental retardation, or substance abuse disorders. All of the facilities listed below are part of Virginia's public mental health system.

Catawba Hospital
Catawba Hospital Drive
Highway 320
Catawba, VA 24070
(540) 375-4201
http://catawba.dmhmrsas.virginia.gov

Catawba Hospital specializes in serving adults who need mental health care. The hospital offers both short-term "acute care" units and dedicated geriatric units. Both private and semi-private rooms are available.

Central State Hospital
26317 W. Washington Street
Petersburg, VA 23803
(804) 524-7000
http://www.csh.dmhmrsas.virginia.gov

Central State Hospital serves the Central Virginia area for Civil Admissions. Forensic Admissions are taken from anywhere within Virginia.

Commonwealth Center for Children & Adolescents
PO Box 4000
Staunton, VA 24402-4000
(540) 332-2100
http://www.ccca.dmhmrsas.virginia.gov

The Commonwealth Center for Children & Adolescents is an acute care, mental health facility for youth under the age of eighteen years.

Eastern State Hospital
4601 Ironbound Road
Williamsburg, VA 23188-2652
(757) 253-5161
http://www.esh.dmhmrsas.virginia.gov/main.html

The four hundred and one bed facility provides treatment to approximately three hundred eighty-five patients with about nine hundred staff.

Northern Virginia Mental Health Institute
3302 Gallows Road
Falls Church, VA 22042
(703) 207-7100
http://www.nvmhi.dmhmrsas.virginia.gov

The institute is a short-term hospital providing intensive treatment to individuals with acute mental health needs living in Northern Virginia. All patients participate in treatment planning activities and receive group treatment services. Family therapy

services are provided as needed. Program options include group psychotherapy, independent living skills training, medication education, stress management, community reintegration, and a variety of recreational activities.

Piedmont Geriatric Hospital ("PGH")
5001 East Patrick Henry Highway
Burkeville, VA 23922-0427
(434) 767-4401
http://www.pgh.dmhmrsas.virginia.gov/default.htm

PGH is a one hundred and thirty-five bed geropsychiatric hospital. It is the only Virginia state facility that exclusively treats elderly persons (sixty-five+ years of age) who are in need of inpatient treatment for mental illness; meet the requirements for voluntary or involuntary admission as determined by their mental health center, and do not have a medical condition that requires priority treatment in an acute care hospital.

Poplar Springs Hospital
350 Poplar Drive
Petersburg, VA 23235
(804) 796-2100
http://www.psysolutions.com/facilities/poplarsprings/site/

Poplar Springs Hospital is a freestanding psychiatric facility, currently licensed for a total of one hundred and ninety-nine beds, which include seventy-five acute ,one hundred and eight residential , and sixteen group home beds. Programs include psychological and behavioral treatment for adults and adolescents aged eleven-eighteen, extended adolescent acute, residential, sexual abuse prevention, and group homes.

Southern Virginia Mental Health Institute
382 Taylor Drive
Danville, VA 24541
(434) 799-6220
http://www.svmhi.dmhmrsas.virginia.gov/

The facility provides inpatient psychiatric services to persons ages eighteen to sixty-five residing in its catchment area. Services include diagnosis, medication management psychological assessment, group therapy, activity therapy, family education, and community meetings.

Southwestern Virginia Mental Health Institute ("SWVMHI")
340 Bagley Circle
Marion, VA 24354
(276) 783-1200
http://www.swvmhi.dmhmrsas.virginia.gov/

SWVMHI is a one hundred and seventy-two bed state psychiatric institute, which serves adult, geriatric, and adolescent individuals.

Virginia Center for Behavioral Rehabilitation ("VCBR")
4901 E. Patrick Henry Highway
Burkeville, VA 23922
(434) 767-7800
http://www.vcbr.dmhmrsas.virginia.gov/

The VCBR is a model behavioral treatment center.

Western State Hospital
1301 Richmond Avenue
Staunton, VA 24401
(540) 332-8000
http://www.wsh.dmhmrsas.virginia.gov

4. Appointment of Guardian or Conservator

a. General Principles

As discussed in Section IIB, "guardian" and "conservator" are synonyms for someone with the legal authority and duty to care for the person and/or property of another (the "ward"), usually because of the "ward's" legal infancy, incapacity, or disability. In the context of a mentally ill detainee, a duly appointed guardian or conservator will have the authority to make certain decisions for the ward with respect to the disposition of property, actions in litigation, and other matters.

Because the scope and nature of a guardian's or conservator's authority are established at the state level, the practitioner must understand the relevant statutes and regulations in the jurisdiction to which the client is subject.

b. Local Resources

Jewish Family Service of Tidewater
6465 College Park Square, Suite 300
Virginia Beach, VA 23464
(757) 938-9130
http://www.jfshamptonroads.org/index.html

Commonwealth Catholic Charities
1512 Willow Lawn Drive
Richmond, VA 23230-0565,
(804) 545-5952
http://www.cccofva.org/services/guardianship/index.html

- Offers a local public guardian/conservator program for incapacitated, indigent adults 18 years of age or older.
- Serves clients in Chesterfield, Henrico, Surry, Essex, Prince George, Dinwiddie, and Greenville counties.
- Accepts individuals who have exhausted all other efforts to find a guardian.

B. Other Issues

According to the Catholic Legal Immigration Network, Inc. ("CLINIC"), each year, approximately 20,000 people from over one hundred and fifty nations are granted asylum in the United States. (Refugees are distinguished from asylees in that the former apply for refugee status before they arrive in the U.S., while people apply for asylee status after arriving in the U.S.). Federal regulations specify that refugees and asylees are eligible for the same benefits and services. However, where all newly arriving refugees are sponsored by resettlement agencies, asylees are not. Accordingly, asylees are at a distinct disadvantage in finding the public and private resources to help smooth their adjustment and facilitate their early self-sufficiency in the United States. This section of the Practitioners' Manual discusses those resources.

1. Employment

To be eligible to work in the United States, immigrants must provide evidence of legal authorization to work. Even with the necessary papers, finding employment may be a challenge for many immigrants, particularly those with mental illnesses. The following organizations and resources may be able to offer assistance with a range of employment-related issues.

a. National Resources

Catholic Charities USA
Sixty-Six Canal Center Plaza, Suite 600
Alexandria, Virginia 22314
(703) 549-1390
http://www.catholiccharitiesusa.org

- Serves people nationwide of all faiths, and provides a wide range of services, including housing, emergency services, health care, child care, adoption, and other critical services.

- Locate local programs and services at: http://www.catholiccharitiesusa.org/NetCommunity/Page.aspx?pid=292

Catholic Legal Immigration Network, Inc. ("*CLINIC*")
Labor Project/Immigrant Workers' Justice Project
415 Michigan Avenue, NE, 2nd Floor
Washington, DC 20017
(202) 635-2556
http://www.cliniclegal.org; www.cliniclegal.org/Programs/LaborProject.html

- Helps "to improve the lives of immigrant workers across the country through training, technical assistance, advocacy, and program development."

CLINIC National Asylee Information & Referral Line
(800) 354-0365
http://www.cliniclegal.org/index.html

- Provides a single, centralized source of information about service eligibility and programs across the country.

- Refers asylees to more than five hundred local providers of resettlement services such as English language classes, employment training and placement assistance, cash assistance, and health care. Speaking eighteen languages, the phone line's counselors offer asylees access to the resources that they need to become integrated within the community.

Catholic Charities of the Archdiocese of Washington
924 G Street, NW
Washington, DC 20001-4532
(202) 772-4300
http://www.catholiccharitiesdc.org/

- Offers the following employment-related programs and services at the locations indicated:

- Building Maintenance Job Readiness Training
  924 G Street, NW
  Washington, DC 20001
  (202) 772-4307
  http://www.catholiccharitiesdc.org/find/services/index.php?id=89

Free weekend classes are available to District residents.

- Computer Classes
  924 G Street, NW
  Washington, DC 20001
  (202) 772-4303
  http://www.catholiccharitiesdc.org/find/services/index.php?id=91

Free evening classes are offered in Microsoft Office applications.

- Economic Development
  1618 Monroe Street, NW
  Washington, DC 20010
  (202) 939-2426
  http://www.catholiccharitiesdc.org/find/services/index.php?id=163

Free Pre-Apprenticeship Construction Program classes are offered for District and Maryland residents eighteen years or older. Ten-week classes include Construction Safety OSHA-10; Technical ESL for Construction; Occupational Math; skills for employment searches; Flaggers Safety; CPR training and Job Referral Assistance with Union Trades & Construction Companies; and hands-on practice at DC Habitat for Humanity every Thursday. Program offers a stipend consisting of a weekly bus pass and T-shirts.

- Employment Referrals and Job-Readiness Training

See office locations listed below.

Matches employers looking for workers with people looking for work. This division maintains a database of workers and gives out a list of employment

opportunities from employers who advertise within the division to potential employees that seek our services. Job seeking orientation session offered in Washington and in Hyattsville.

Washington Office
1618 Monroe Street, NW
Washington, DC 20010
(202) 939-2415
http://www.catholiccharitiesdc.org/find/services/index.php?id=164

Match Grant Employment Program
1438 Rhode Island Avenue, NE
Washington, DC 20018
(202) 526-5794
http://www.catholiccharitiesdc.org/find/services/index.php?id=167

- "Provides refugees and asylees who are residents of the District of Columbia or Maryland with employment services leading to job placement and self-sufficiency."

- Lists on its website a variety of educational and training-related resources under the "Find Services and Locations" tab.

Parenting Education Certification Training
924 G Street, NW
Washington, DC 20001
(202) 772-4344
http://www.catholiccharitiesdc.org/find/services/index.php?id=94

- A professional training program to fulfill the educational requirements for parent educator certification. forty contact hours. Fees apply. Discounts given to CCS employees.

Catholic Community Services Refugee Service Center
1501 Columbia Road
Washington, DC 20009
(202) 667-9000
http://www.refugeevolunteernetwork.com

- Creates "new life opportunities whereby refugees and asylees can become full participants and contributors in their new society and community."

- Offers job counseling, a "Job Club," resume and interview preparation, and job development and placement assistance to DC residents. Some programs are available to Maryland residents.

b. Maryland

Catholic Charities of the Archdiocese of Baltimore
320 Cathedral Street
Baltimore, MD 21201-4421
(410) 547-5490
http://www.catholiccharities-md.org/

- Offers the following employment-related programs and services at the locations indicated:

  Gaithersburg Office
  13-15 Deer Park Drive, Suite 203
  Gaithersburg, MD 20877
  (301) 417-9114
  http://www.catholiccharitiesdc.org/find/services/index.php?id=166

  Hyattsville Office
  7949 - 15th Avenue, #100
  Hyattsville, MD 20783
  (301) 434-6453
  http://www.catholiccharitiesdc.org/find/services/index.php?id=165

Maryland Re-Entry Partnership ("*REP*")
725 Fallsway
Baltimore, MD 21202
(443) 986-9000 or (443) 986-9042
http://www.catholiccharities-md.org/emergency/maryland-re-entry-program.html

- Serves men leaving MD State prisons and returning to neighborhoods in Baltimore City.
- Provides intensive community-based case management for one year, which connects ex-offenders with the necessary support services for a positive transition to their communities.
- Provides pre- and post-release programs, housing assistance, substance abuse treatment, mental health counseling, vocational/occupational training, and educational services.

Our Daily Bread ("ODB") Employment Center
725 Fallsway
Baltimore, MD 21202
(443) 986-9000 or (443) 986-9027
http://www.catholiccharities-md.org/emergency/odbec.html

- Offers a comprehensive resource center for people who are poor and resources to help participants achieve self-sufficiency through employment and housing.

- Combines the "Our Daily Bread" hot meal program, the Christopher Place Employment Academy, the Maryland Re-entry Partnership, case management, and an array of unemployment, education, referral and emergency services.

Esperanza Center (formerly the Hispanic Apostolate)
430 South Broadway
Baltimore, MD 21231-2410
(443) 825-3437
http://www.catholiccharities-md.org/immigrants/hispanic-apostolate.html

- Provides a wide range of services to new immigrants to the Baltimore Metropolitan Area, including short-term social services, referrals to appropriate resources, employment counseling, and English-as-a-Second- Language classes our bilingual staff works with Hispanic and other immigrants to help them acclimate to their new home.

Lutheran Social Services of the National Capital Area ("LSS")
Main Office (Administration)
4406 Georgia Avenue, NW
Washington, DC 20011
(202) 723-3000

Baltimore Office (Refugee/Immigrant Services)
3516 Eastern Avenue
Baltimore, MD 21224
(410) 558-3168

Montgomery College Refugee Training Center
8561 Fenton Street, Suite 210
Silver Spring, MD 20910
(301) 560-1668

Montgomery County Office
7410 New Hampshire Avenue
Takoma Park, MD 20912
(301) 445-9537 or (301) 445-9541

Suburban Washington Resettlement Center (Refugee/Immigrant Services)
8700 Georgia Avenue
Silver Spring, MD 20910
(301) 562-8633
http://www.lssnca.org/

- Provides job placement and follow-up services, including the "Way to Self-Sufficiency" services for refugee clients living in Montgomery and Prince George's Counties and Baltimore City.

- Offers training opportunities, including pre-employment training, behind-the-wheel driving instruction, computer training, staff development training, and referral to other services.

English for Speakers of Other Languages ("ESOL")
415 East Diamond Avenue
Gaithersburg, MD 20877
(301) 740-2523
http://www.catholiccharitiesdc.org/find/services/index.php?id=92

- Focuses on providing English for speakers of other languages, Spanish literacy for Spanish speakers, and Spanish classes for English-speaking Volunteer Teachers.

c. Virginia

Northern Virginia Family Service's Multicultural Human Services ("MHS")
6400 Arlington Blvd, Suite 110
Falls Church, VA 22042

- Provides case management, safe housing, counseling, medical and dental access, child care and development, affordable loans, foster and respite care, and job training.

Lutheran Social Services of the National Capital Area ("**LSS**")
7401 Leesburg Pike
Falls Church, VA 22043
(703) 698-5026
http://www.lssnca.org/

- Offers the "Road to Self-Sufficiency" collaborative project with the Indochinese Community Center serving refugees in Fairfax County with aggressive case management and employment services.

Virginia Employment Commission, Job Seeker Services
Various locations
http://www.vec.virginia.gov/vecportal/seeker/intro.cfm

2. Education

For immigrants lacking certain basic skills, educational opportunities in the United States may be as important as the employment resources discussed above. Education can contribute to a client's self-sufficient and well-being. As examples, language skills can help facilitate social integration, while adult education classes can improve an immigrant's employment prospects.

a. National Resources

CLINIC National Asylee Information & Referral Line
(800) 354-0365
http://www.cliniclegal.org/index.html

- Provides a single, centralized source of information about service eligibility and programs across the country.

b. District of Columbia

Catholic Charities of the Archdiocese of Washington
924 G Street, NW
Washington, DC 20001-4532
(202) 772-4300
http://www.catholiccharitiesdc.org/

- Offers the following education-related programs and services at the locations indicated:

  Adult Education Program
  924 G Street, NW
  Washington, DC 20001
  (202) 772-4303

  Satellite locations:

  1500 Franklin Street, NE and
  2700 Martin Luther King Avenue, SE.
  http://www.catholiccharitiesdc.org/find/services/index.php?id=93

  - Offers free Adult Basic Education ("ABE"), External Diploma Program ("EDP"), and General Educational Development ("GED") preparation classes for DC residents sixteen years of age and up. Specialized tutoring in the GED math subject areas are offered in the evening program.

  Adult Education (Day & Evening)
  801 Buchanan Street, NE
  Washington, DC 20017
  (202) 529-7600
  http://www.catholiccharitiesdc.org/find/services/index.php?id=105

  - Provides courses for adults and parents in DC with developmental disabilities for GED preparation, life skills, and literacy development.

  Computer Classes
  924 G Street, NW
  Washington, DC 20001
  (202) 772-4303

  - Free evening computer training in MS Office applications.

English Language/Citizenship Classes
1001 Lawrence Street, NE
Washington, DC 20017
(202) 481-1420
http://www.catholiccharitiesdc.org/find/services/index.php?id=381

- Teaches English skills in a free class and prepares individuals for the naturalization test or about American government and history. Offers a combination of class and conversation circles.

Parenting Education Certification Training
924 G Street, NW
Washington, DC 20001
(202) 772-4344
http://www.catholiccharitiesdc.org/find/services/index.php?id=94

- Designed to fulfill the educational requirements for parent educator certification. Fees apply.

Professional Education Counseling Program
924 G Street, NW
Washington, DC 20001
(202) 772-4344
http://www.catholiccharitiesdc.org/find/services/index.php?id=95

- Designed to fulfill the educational requirements necessary to become certified or recertified as an addictions counselor. Fees apply.

Spanish Classes
924 G Street, NW
Washington, DC 20001
(202) 772-4344
http://www.catholiccharitiesdc.org/find/services/index.php?id=96

- Beginning and Intermediate levels of Spanish language classes taught by bilingual instructors. Fees apply.

Catholic Community Services Refugee Service Center
1501 Columbia Road
Washington, DC 20009
(202) 667-9000
http://www.refugeevolunteernetwork.com

- Offers English classes to men and women after asylum is granted.

- Affiliated with the Catholic Charities of the Archdiocese of Washington.

3. Maryland

CASA of Maryland
Takoma Park
Contact: Darwin Bonilla
(301) 431-4185 ext. 208
http://www.casademaryland.org/

- Current classes include financial literacy, citizenship preparation, home improvement licensure prep courses, Spanish literacy, computer classes, vocational training, and seven levels of ESOL (English for Speakers of Other Languages). Most classes are fee-based.

Literacy Council of Montgomery County Maryland, Inc.
21 Maryland Avenue, Suite 320
Rockville, MD 20850
(301) 610-0030
http://www.literacycouncilmcmd.org

- Provides free reading, writing and English language tutoring to adults in Montgomery County, Maryland.

4. Virginia

Fairfax County Library
http://www.fairfaxcounty.gov/library/englishclasses/

Arlington County Libraries
http://www.arlingtonva.us/departments/Libraries/info/americans/LibrariesinfoAmericansEnglish.aspx

Literacy Council of Northern Virginia
2855 Annandale Rd
Falls Church, VA 22042
(703) 237-0866
http://www.lcnv.org/index.cfm

- Offers instruction one on one or in small group settings. Free for students. Requires students to be below a 5th-grade reading level to qualify.

5. Financial Resources.

Most financial services are offered in tandem with other forms of assistance by organizations that offer a broad variety of benefits. *See* the discussion in "Public Benefits" section below.

6. National Resources

CLINIC National Asylee Information & Referral Line
(800) 354-0365
http://www.cliniclegal.org/index.html

- Provides a single, centralized source of information about service eligibility and programs across the country.

- Offers information on cash assistance.

U.S. Department of Health and Human Services
Administration for Children and Families ("ACF")
Philadelphia Regional Office (DE, DC, MD, PA, VA, and WV)
Public Ledger Building, Suite 864
150 South Independence Mall West
Philadelphia, PA 19106
(215) 861-4000
http://www.acf.hhs.gov/

- Administers the programmatic and financial management of ACF programs in the region and provides guidance to grantees and other entities responsible for administering these programs, such as State and local governments. *See* the Philadelphia Region's website for more information:

http://www.acf.hhs.gov/programs/region3/index.html

- Note that ACF does not deliver services directly to individuals, but awards grants to State and local governments, and other organizations that have responsibility for direct delivery of services. *See* the Office of Family Assistance webpage for information concerning financial-related resources:

  http://www.acf.hhs.gov/programs/ofa/

7. Medical Health Care (Non-Mental Health)

a. National Resources

CLINIC National Asylee Information & Referral Line
(800) 354-0365
http://www.cliniclegal.org/index.html

- Provides a single, centralized source of information about service eligibility and programs across the country. *See* the discussion of the services offered through the hotline in the employment section above.

District of Columbia

District of Columbia Department of Health
(202) 442-5841

- Offers free refugee health screening.

b. Maryland

Holy Cross Hospital OB/GYN Clinic
1500 Forest Glen Road
Silver Spring, MD 20910
(301) 754-7000
http://www.holycrosshealth.org/svc_womens_gynecological.htm

- Offers to any woman, regardless of her ability to pay for services, annual gynecological exams, routine screenings (*e.g.*, PAP smears and breast exams), surgical care for gynecological problems, assistance in scheduling mammograms, and care for routine and high-risk pregnancies.

Montgomery County Health Department
(240) 777-1800

- Offers free refugee health screening.

Prince George's County Health Department
(301) 583-3110

- Offers free refugee health screening

c. Virginia

Arlington Free Clinic at Virginia Hospital Center
3833 North Fairfax Drive, Suite 400
Arlington, VA 22203
(703) 979-1400
http://www.virginiahospitalcenter.com/medical/arlington.aspx

- Provides access to quality health care services to low-income, uninsured county residents.

8. Housing/Shelters

Housing will likely be a great challenge for many of your clients. The irony is that detainees cannot leave detention until they have a residence, but shelters will not commit to providing housing until they can conduct an intake session, which rarely happens outside of their offices. Detention does not qualify someone to be considered "homeless." Options for housing include homes of family members and friends, local shelters, subsidized leases, and, in certain circumstances, placement in an appropriate mental health facility.

a. National Resources

Asylum Hotline
(800) 354-0365

- Provides information on local housing resources.

b. District of Columbia

Adam's Place Shelter
2210 Adams Place, NW
Washington, DC 20018
(202) 832-8317

- Twelve hour emergency shelter operating daily from 7:00 p.m. to 7:00 a.m. and open to single adult men ages eighteen and older.

Catholic Charities, Migration/Refugee Services
(202) 772-4313
http://www.catholiccharitiesdc.org/find/result/?service=Housing

- Provides comprehensive list of shelter locations in the DC Metropolitan area on its website.

Centro Catolico
1618 Monroe Street, NW
Washington, DC 20010
(202) 939-2420

- Works with agencies in trying to find housing for new immigrants and Spanish speaking homeless.

- Recommended that individuals bring a referral from another organization.

Community for Creative Non-Violence ("**CCNV**")
425 Second Street, NW
Washington, DC 20001
(202) 393-1909 or 393-4409
http://users.erols.com/ccnv/

- Runs a shelter with a bed capacity of one thousand three hundred and fifty for homeless men, women, and children, and also operates a long-term shelter (six month contract).

- Ensures that the rights of the homeless and poor are not infringed upon and that every person has access to life's basic essentials -- food, shelter, clothing, and medical care.

- Protects the rights of the homeless, advocates on behalf of the underserved, and prepares homeless men and woman to re-enter into mainstream society as skilled and productive citizens.

Community Partnership for the Prevention of Homelessness
801 Pennsylvania Avenue, SE, Suite 360
Washington, DC 20003
(800) 535-7252
http://www.community-partnership.org/index.php

- Provides emergency shelter and social services.

Franklin School Temporary Shelter
925 13th Street, NW
Washington, DC
(202) 638-7424

- Intake at 6:00 p.m.; first-come, first-served.

Hannah House
612 M Street, NW
Washington, DC 20001
(202) 289-4840
www.hannahhouse.org

- sixteen bed transitional shelter for women (stays usually limited to approximately nine months, but if the woman has children ages three-thirteen with her she can stay for twelve to fifteen months).

- Must be referred by a social worker or case manager; need a medical and psycho-social evaluation; offer help with job training, etc.

Lutheran Immigration and Refugee Service (“**LIRS**”)
122 C Street, NW, Suite 125
Washington, DC 20001
(202) 783-7509

- Offers a “Match Grant Program” that provides services for people awarded asylum within the previous 30 days.

- Services include assistance in finding housing.

Mary House
4303 13th Street, NE
Washington, DC 20017
(202) 635-0534
http://www.maryhouse.org/about.asp

- Works predominately with the low-income Latin American population at twelve sites in Northeast Washington and Takoma Park, Maryland. Recently expanded its services to resettling Bosnian and Kosovar refugee families.

Mt. Carmel House
471 G Place, NW
Washington, DC 20001
(202) 289-6315

- Temporary shelter for women aged twenty-five and older only.

N Street Village
1333 N Street, NW
Washington, DC 20005
(202) 939-2068
http://www.nstreetvillage.org/

- Provides a thirty-one bed transitional shelter for women and affordable rental housing for low and moderate-income individuals and families.

National Capital Region 2-1-1 Website
http://www.211metrodc.org/

- Provides a search engine to locate health and human service programs available in the Washington DC metro region, and includes jobs, health care, emergency services, etc.

Pathways to Housing DC
101 Q Street, NE, Suite G
Washington, DC 20002
(202) 529-2972
http://pthdc.org/

- Works to end homelessness for people living with psychiatric disabilities by providing housing first and giving support and treatment for their recovery and integration into the community.

Refugee Resettlement Program
1438 Rhode Island Ave, NE
Washington, DC 20018
(202) 526-5794 (ext. 104)
12247 Georgia Avenue

- Offers reception and placement services for ninety days for newly arriving refugees referred by the United States Conference of Catholic Bishops ("USCCB") only.

Reverend Samuel McPherson
75 I Street, SW
Washington, DC
(202) 479-0017

- Serves males only. Shelter is open from 7:00 p.m. to 7:00 a.m.

TASSC House
4121 Harewood Road NE, Suite B
Washington, DC 20017
(202) 529-2991
www.tassc.org

Transitional Housing Corporation ("**THC**")
5101 16th Street, NW
Washington, DC 20011
(202) 291-5535
http://www.thcdc.org/

- Provides housing and comprehensive support services to homeless and at-risk families. Houses twenty-seven families in two transitional housing apartment buildings.

University Legal Services ("**ULS**")
Housing Counseling Program
220 I Street, NE, Suite 130
Washington, DC 20002
(202) 547-4747
http://www.uls-dc.org/About_ULS-HCP.htm

- Intake center for the Department of Housing and Community Development's housing programs that help low and moderate-income families and individuals buy homes, rehabilitate homes, and prevent mortgage default and foreclosure.

- Provides rental counseling and assists DC residents with locating affordable and accessible housing.

Migration and Refugee Services United States Conference of Catholic Bishops
3211 Fourth Street, N.E.
Washington, DC 20017
(202) 541-3350
http://www.usccb.org/mrs/contactmrs.shtml

- Serves refugees, asylees, and other forced migrants and immigrants, with special concern given to minors unaccompanied by parents or adult guardians, and the victims of human trafficking.

c. Maryland

Bethesda House
4848 Cordell Avenue
Bethesda, MD 20814
(301) 907-9597

- Offers transitional housing for homeless men with chronic mental illness. Open to Montgomery County residents only.

- Referrals accepted from case managers from county or social services agencies only.

Refugee Resettlement Program
12247 Georgia Avenue
Silver Spring, MD 20902
(301) 942-1790 (ext. 125)

- Offers reception and placement services for ninety days for newly arriving refugees referred by the United States Conference of Catholic Bishops "(USCCB") only.

Saint Andrews Way Community House
9407 St. Andrews Way
Silver Spring, MD 20901
(301) 587-5326

d. Virginia

Lutheran Immigration and Refugee Service ("**LIRS**")

7401 Leesburg Pike
Falls Church, VA 22043
(703) 698-5026
http://www.lirs.org/Contact/dc.htm
http://www.lssnca.org

- Offers a "Match Grant Program" that provides services for people awarded asylum within the previous thirty days.

- Services include assistance in finding housing.

Alexandria Community Shelter
2355B Mill Road
Alexandria, VA 22301
(703) 838-4239

- Serves singles, couples, and families with children. Residents must participate in service planning and can stay up to ninety days.

Alive House
2723 King Street
Alexandria, VA 22302
(703) 684-1430
http://www.alive-inc.org/alive_house.htm

- Serves single women and families with children.

Carpenter's Shelter
930 N. Henry St.
Alexandria, VA 22314
(703) 548-7500
http://www.carpentersshelter.org/

- Serves singles and families with children.

Arlington Community Guide to Homeless Services
http://www.arlingtonva.us/Departments/HumanServices/Xtend/ page59886.aspx

Volunteers of America Residential Program Center
1554 Columbia Pike
Arlington, VA 22204
(703) 228-0022

Bailey's Crossroads Community Shelter
3525 Moncure Ave.
Baileys Crossroads, VA 22041
(703) 820-7623

- Serves single adults ages eighteen and older.

- Residents must participate in service planning and may stay up to thirty days.

New Hope Housing Eleanor Kennedy Shelter
9155 Richmond Hwy.
Ft. Belvoir, VA 22060
(703) 799-0200

Embry Rucker Shelter
11975 Bowman Towne Dr.
Reston, VA 20190
(703) 437-1975
http://www.restoninterfaith.org/pages/page.asp?page_id=15288

Homeless and Emergency Shelters in Fairfax County

http://www.fairfaxcounty.gov/dfs/factsheets/EMERShelter.htm

http://www.fairfaxcounty.gov/news/2005/05014.htm

Social Security and Social Services Office Locations
Virginia: http://www.dss.virginia.gov/localagency/index.html

9. Legal Services.

The legal hurdles do not end once your client is either granted asylum or his removal is withheld. Your client should understand basic forms that must be completed and the resources available.

a. National Resources

Catholic Legal Immigration Network, Inc. (“**CLINIC**”*)*
415 Michigan Avenue, NE, Second Floor
Washington, DC 20017
(202) 635-2556
http://www.cliniclegal.org/index.html

- Works to “enhance and expand delivery of legal services to indigent and low-income immigrants principally through diocesan immigration programs and to meet the immigration needs identified by the Catholic Church in the United States.”

National Immigrant Legal Center (“**NILC**”)
3435 Wilshire Boulevard, Suite 2850
Los Angeles, CA 90010
(213) 639-3900
www.nilc.org

- Protects and promotes the rights of low-income immigrants and their family members.
- Offers expertise on immigration, public benefits, and employment laws affecting immigrants and refugees.

b. District of Columbia

Ayuda
1707 Kalorama Road, NW
Washington, DC 20009
(202) 387-4848

Asian Pacific American Legal Resource Center
1600 K St., NW, Mezzanine Level
Washington, DC 20006
(202) 393-3572

Catholic Legal Immigration Network Inc. (“**CLINIC**”)
McCormick Pavilion, 415 Michigan Avenue, NE
Washington, DC 20017
(202) 635-2556

Immigration Legal Services (“**ILS**”)
1618 Monroe Street NW
Washington, DC 20010
(202) 939-2420

924 G Street NW
Washington, DC 20001
(202) 772-4352

415 E. Diamond Avenue
Gaithersburg, MD 20877
(301) 740-2523

7949 15th Avenue, Suite 100
Langley Park, MD 20783
(301) 434-6453

12247 Georgia Avenue
Silver Spring, MD 20902
(301) 942-1790

- Provides direct immigration legal assistance to foreign born individuals, including: naturalization (citizenship), asylum, employment and family-based permanent residency, H-1Bs, relief from removal, self-petitions, TPS, etc.

- Primarily for clients residing in Maryland, DC and Virginia. No income restrictions.

National Disability Rights Network ("**NDRN**")
900 Second Street, NE, Suite 211
Washington, DC 20002
(202) 408-9514
http://www.napas.org/aboutus/default.htm

- Serves a wide range of individuals with disabilities – including, but not limited to, those with cognitive, mental, sensory, and physical disabilities – by guarding against abuse; advocating for basic rights; and ensuring accountability in health care, education, employment, housing, transportation, and within the juvenile and criminal justice systems.

Spanish Catholic Center of Catholic Charities
924 G Street, NW
Washington, DC 20001
(202) 722-4356

Washington Lawyers' Committee for Civil Rights and Urban Affairs
1300 19th Street, NW, Suite 500
Washington, DC 20036
(202) 319-1000
http://www.washlaw.org/

Washington Legal Clinic for the Homeless
1200 U Street, NW, 3rd Floor
Washington, DC 20009
(202) 328-5500
http://www.legalclinic.org/

Central American Resource Center ("CARECEN")
1460 Columbia Rd., NW, C-1
Washington, DC 20009
(202) 328-9799

c. Maryland

Associated Catholic Charities
1504 St. Camillus Drive
Silver Spring, MD 20903
(301) 434-5980

Justice for Our Neighbors-Baltimore Washington Conference
United Methodist Committee on Relief
8900 Georgia Avenue, Room 208
Silver Spring, MD 20910
(301) 927-6133

Catholic Charities' Immigration Legal Services
430 South Broadway Street
Baltimore, MD 21231
(410) 534-8015

7949 15th Avenue, Suite 100
Hyattsville, MD 20783
(301) 434-6453

Foreign-born Information Referral Network ("**FIRN**")
5999 Harpers Farm Road, Suite E-200
Columbia, MD 21044
(410) 992-1923 or (888) 399-3476
info@firnonline.org

- Assists Howard County residents with job placement, immigration counseling, and translation services.

International Rescue Committee ("**IRC**")
1730 M Street, NW, Suite 807
Washington, DC 20036
(202) 822-0043
http://www.theirc.org/

3516 Eastern Avenue
Baltimore, MD 21224
(410) 327-1885

- Assists newly arrived refugees achieve self-sufficiency by helping them establish a new home, find jobs, and enroll in English and job training courses.

Maryland Department of Human Resources (“**MDDHR**”).

- Offers a broad variety of benefits and service programs for eligible individuals, including food stamp assistance, temporary cash assistance, temporary disability assistance, legal assistance, children’s health services, medical assistance, long-term care, energy assistance, electric universal service, and child care subsidies.

  http://www.dhr.state.md.us/how/

Maryland Match Grant Programs. These programs provide a range of benefits aimed at increasing self-sufficiency. Call to find out if you qualify. Thirty day deadline from date asylum granted

- USCC Catholic Charities: (301) 942-1790
- The International Rescue Committee: (202) 822-0433
- Lutheran Social Services: (703) 698-5026 (ext. 118)

Maryland Office for New Americans (“**MONA**”)
Department of Human Resources, Saratoga State Center
311 West Saratoga Street, Room 222
Baltimore, MD 21201
(410) 767-7514
http://www.dhr.maryland.gov/mona/service.htm

- Provides recent asylees with information about their options and can locate a local Social Services office that provides assistance to residents in their counties including medical assistance, food stamps, and cash assistance.

Medical Assistance, Food Stamps and Cash Assistance in Maryland

- Montgomery County (240) 777-1245
- Prince George’s County (301) 909-7026

d. Virginia

Northern Virginia Family Service, Multicultural Human Service Program
6400 Arlington Blvd., Suite 110
Falls Church, VA 22042
(703) 533-3302
http://www.nvfs.org/mhs_programs.htm

Immigration & Human Rights Law Group, PLLC
9119 Church St.
Manassas, VA 20110
(703) 335-2009

Just Neighbors
5827 Columbia Pike, Suite #320
Falls Church, VA 22041

13600 Frying Pan Rd.
Herndon, VA 20171
(703) 979-1240

Lutheran Social Services of the National Capital Area
7401 Leesburg Pike
Falls Church, VA 33042
(703) 698-5026 (Ext. 100)

Hogar Hispano-Catholic Charities
6201 Leesburg Pike, #307
Falls Church, VA 22044

Treatment Advocacy Center ("**TAC**")
200 N. Glebe Road, Suite 730
Arlington, VA 22203
(703) 294-6001/6002
www.treatmentadvocacycenter.org

6131 Willston Drive, Room 8
Falls Church, VA 22044
(703) 241-0300
http://www.newcomerservice.org/actual_web/

Virginia Department of Social Services Office of Newcomer Services ("**ONS**")
7 North Eighth Street
Richmond, VA 23219
(804) 726-1700
http://www.dss.virginia.gov/family/ons/index.html

- Provides support for refugees and asylees.- Provides legal analysis of applicable mental health regulations (on a state by state basis) on its website and general articles including medical fact sheets and resources.

10. Other Public Benefits and Social Services.

Many organizations offer a broad array of social services including health care, housing, food, employment and educational training, and legal services. There are several types of assistance available to asylees; some are specifically targeted for refugees and asylees while others are available to the general public as well. Eligibility for all of these benefits is determined by government officials at the applicable state and federal agencies. By calling **(800) 354-0365** you are able to identify social services office locations by zip code and can obtain assistance in finding other organizations (volunteer agencies) that provide services to asylees. Social services frequently recommend contacting these organizations first as they are specifically designed to meet the needs of asylees, and can coordinate with local social services offices for necessary eligibility information. The organizations listed in this section offer an expansive array of services and thus are not listed in the preceding sections of this Manual.

a. National Resources

Temporary Assistance to Needy Families (“**TANF**”). TANF is a federally funded, state-administered program that provides employment options and financial assistance. TANF is available to all refugees, asylees, and U.S. citizen families that meet the financial and non-financial requirements of the program. Family size, income, and resources are taken into account when determining TANF eligibility.

Refugee Cash Assistance (“**RCA**”). Because many asylees are not eligible for TANF for non-financial reasons, this program is designed to provide cash support to asylees in lieu of TANF. The financial requirement for RCA are similar to those for TANF and in most cases asylees that meet financial requirements of TANF are automatically considered for RCA if they fail to meet other TANF requirements. Eligibility can be determined by the local office of social services or through a local volunteer agency. RCA is only available for eight months after the date asylum was granted.

Supplemental Nutrition Assistance Program (“**SNAP**”) (formerly known as “**Food Stamps**”). To get SNAP benefits, households must meet certain tests, including resource and income tests. Applications must be submitted at the local Social Security Administration office.

http://www.fns.usda.gov/FSP/rules/Memo/02/POLIMGRT.HTM
http://www.fns.usda.gov/FSP/

Supplemental Security Income (“**SSI**”). SSI is available for certain refugees and other noncitizens for up to seven years. Applications must be submitted at the local Social Security Administration office.

http://www.ssa.gov/pubs/11051.html

Medicaid is a state administered health insurance program that provides care for certain low-income individuals and families. Each state sets its own guidelines regarding eligibility and services.

http://www.cms.hhs.gov/Medicaidgeninfo/

District of Columbia website:
http://dchealth.dc.gov/doh/cwp/view,a,3,q,573226,dohNav_GID,1807,dohNav,|33345|.asp

Maryland website: http://www.dhmh.state.md.us/mma/mmahome.html

Virginia website: http://www.dss.virginia.gov/benefit/me_famis/

Refugee Medical Assistance (“**RMA**”). Qualified RCA applicants are automatically eligible for RMA (if they are ineligible for Medicaid) although a determination of ineligibility for RCA does not preclude application for RMA. RMA is designed to provide services like inpatient and outpatient hospital care, physicians services, psychological services, and prescription drug coverage and family planning for a period of eight months.

Match Grant Programs. Match Grant programs are set up by volunteer agencies and organizations. The programs distribute money and are much like RCA although most must be

applied to within thirty days of a grant of asylum. Asylees may not receive both RCA and Match Grant money.

Miscellaneous. In addition to the major benefits listed above, available in your jurisdiction may also be other services, including family assistance ("**FA**"), safety net assistance ("**SNA**"), foster care/adoption assistance, head start, post-secondary education loans and grants, job training partnership, special supplemental food program for women, infants and children ("**WIC**"), school breakfast/lunch programs, public health assistance for immunizations, *etc.* Many of these programs have no deadline and can be applied for at any time. The local volunteer agencies or office of social services can provide more information of specific services at the time of application for other benefits. Existing programs vary by state but generally include on-the-job training, English language instruction, vocational training, employment assessment services, skill recertification, child day-care, transportation services and citizenship/naturalization services.

b. Maryland

Baltimore Resettlement Center ("**BRC**")
3516 Eastern Avenue
Baltimore, MD 21224
(410) 327-1685 or (410) 327-1885

- Provides services such as English classes, health screenings, medical assistance, cash assistance, food stamps, employment services, and match grant programs. Eligibility for these programs depends on your family status and other factors.

Social Security and Social Services Office Locations
Maryland: http://www.dhr.state.md.us/county.htm

c. District of Columbia

Bread for the City
1525 7th Street, NW
Washington, DC 20001
(202) 265-2400
www.breadforthecity.org

- Provides food distribution to DC residents from SW or SE only (exception: there is a one-time-only exception for non-residents). Must go before 3:30 p.m. and bring a referral on CAIR letterhead; must have access to some sort of cooking facilities.

Catholic Charities offers comprehensive services including:

Family Strengthening Initiative Program
1438 Rhode Island Ave, NE
Washington, DC 20018
(202) 526-5794 (ext. 105)

- Offers services of a case manager who concentrates on assisting refugee and asylee families apply for benefits, navigate the medical and educational systems in the U.S., and work towards self-sufficiency.

- Offers a weekly cultural orientation class, that focuses on family resettlement concerns.

Social Services
1618 Monroe Street NW
Washington, DC 20010
(202) 939-2414

- Provides information and referrals, emergency assistance with rent/mortgage/utilities, holiday baskets, case management, supportive counseling, weekly food distribution, emergency food and clothing distribution, enrollment of non-citizen children in public schools, liaison/translation services between parents and school administrators.

- Open to families in need.

The District of Columbia Refugee Resettlement Program (“**DCORR**”)
Department of Human Services
2146 24th Place, NE
Washington, DC 20024
(202) 541-3949
http://dhs.dc.gov/dhs/cwp/view.asp?Q=492705&a=3&dhsNAV=%7C30980%7C

- Provides social services, cash, and medical assistance to eligible refugees and their families through sub-grant arrangements with community-based nonprofit agencies.

- Offers programs on employment, job placement, English language training, and support services.

Ethiopian Community Development Council (“**ECDC**”)
2437 15th Street, NW
Washington, DC 20009
(202) 483-0780
http://www.ecdcinternational.org/

Newcomer Community Service Center (“**NCSC**”)
1628 16th Street, NW
Washington, DC 20009
(202) 462-4330

- Helps refugees and immigrants from all countries achieve self-sufficiency and become participating members of American society.

Social Security and Social Services Office Locations
District of Columbia: http://ssc.rrc.dc.gov/ssc/site/default.asp

So Others May Eat ("SOME")
71 O Street, NW
Washington, DC 2 0001
(202) 797-8806
http://www.some.org/

- Helps the poor, homeless, elderly, and individuals with mental illness by offering food, clothing, and health care, affordable housing, job training, addiction treatment, and counseling.

11. Relocation Issues

Often when individuals are granted withholding from removal, immigration officers require such persons to contact other embassies to apply for VISAs. While the government is allowed to remove persons to a third country and is permitted to ask your client to make attempts to relocate, in our experience, these efforts are rarely successful. If your client receives such instructions, he should send letters to a number of embassies, requesting lawful admission into those countries. The client should keep copies of his correspondence as evidence of his efforts to relocate.

Attached at **Appendix 39** is a sample letter to Request Lawful Admission.

12. Other Cultural and Community Support

Advocates for Survivors of Trauma and Torture ("**ASTT**")
431 East Belvedere Avenue
Baltimore, MD 21212
(410) 464-9006

Gilchrist Center for Cultural Diversity
11319 Elkin Street
Wheaton, MD 20906
(240) 777-4940

Foundry United Methodist Church
1500 16th Street NW
Washington, DC 20036
http://www.astt.org/

- Alleviates the suffering of those who have experienced the trauma of torture, educates the local, national, and world community about the needs of torture survivors, and advocates on their behalf.

- Provides "social services support, information, and referrals that help address a range of concerns that affect survivors of torture and war trauma. These may include psychosocial adjustment, living situation, medical and nutritional status, or cultural and linguistic barriers."

Community Connections of Washington, DC ("**CC**")
801 Pennsylvania Ave SE # 201
Washington, DC 20003
(202) 546-1512
http://www.communityconnectionsdc.org/index.htm

- Provides comprehensive, respectful, and effective mental health and residential services to residents of the District of Columbia and Montgomery County, Maryland.

- Offers a variety of clinical, residential, and employment-related services.

Green Door
1221 Taylor Street NW
Washington, DC 20011
(202) 727-1000
http://www.greendoor.org/about/

- Prepares people with severe and persistent mental illness to work and live independently.

- Services include medication education and monitoring, community support/case management services, and housing, counseling groups, job training and job placement programs.

Lutheran Immigrant and Refugee Service ("**LIRS**")
7401 Leesburg Pike
Falls Church, VA 22043
(703) 698-5026
http://www.lssnca.org

- Provides services, including assistance with finding housing for people awarded asylum within the previous thirty days with its LIRS' "Match Grant Program."

National Alliance on Mental Illness ("**NAMI**")
422 8th Street, SE, 2nd Floor
Washington, DC 20003
(202) 546-0646
http://www.nami.org/MSTemplate.cfm?MicrositeID=74

- Offers information on mental illnesses, family support groups, and consumer support groups as part of its education, support, and advocacy efforts.

13. Issues For Persons To Be Removed

For clients facing removal, counsel will likely have little opportunity to provide assistance of any nature on an on-going basis. Accordingly, counsel should consider what - if anything - can be done to help prepare a client for their deportation.

a. Medical and Mental Health Issues

Counsel, with access to his clients' medical records should assemble a complete file of those documents for use upon removal. Because files often are not transferred from one detention facility to another or between criminal law enforcement officials and ICE officials, you may need to collect records at every facility in which your client has been detained. Please see Section II, Obtain Medical Consent, Records and Treatment, *infra*.

b. Communicating Diagnosis to Receiving Country

For some clients, it may be advisable to notify the receiving country of the client's medical or mental health condition. However, because of the varying cultural and social norms concerning mental health, the decision to disclose a client's medical information should be made on a case-by-case basis and in consultation with the client. For example, in cultures where mental illness carries significant stigma, disclosing a client's mental health condition may put that client at risk in the receiving country.

ACRONYMS

“A” File	Alien file(s) (held by USCIS)
“A” Number	Alien’s name and alien registration number
ACA	American Correction Association
APA	American Psychological Association
ASTT	Advocates for Survivors of Trauma and Torture
BIA	Board of Immigration Appeals
BRC	Baltimore Resettlement Center
CARECEN	Central American Resource Center
CAT	Convention Against Torture
CBP	U.S. Customs and Border Protection
CBS	Community Services Boards
CC	Community Connections of Washington, DC
CCNV	Community for Creative Non-Violence
CDF	Contract Detention Facilities
CLINIC	Catholic Legal Immigration Network, Inc.
CPEP	Comprehensive Psychiatric Emergency Program
CTPHC	Clifton T. Perkins Hospital Center
DCDMA	District of Columbia Department of Mental Health
DCORR	District of Columbia Refugee Resettlement Program
DHS	U.S. Department of Homeland Security
DIHS	Division of Immigration Health Services
DMH	District of Columbia Department of Mental Health Services
DMHMRSAS	Department of Mental Health, Mental Retardation and Substance Abuse Services

DRO	Detention & Removal Office
ECDC	Ethiopian Community Development Council
EOIR	Executive Office for Immigration Review
ESHC	Eastern Shore Hospital Center
ESOL	English for Speakers of Other Languages
FA	Family assistance
FIRN	Foreign-born Information Referral Network
FOIA	Freedom of Information Act
HIPAA	Health Insurance Portability and Accountability Act
ICE	U.S. Immigration and Customs Enforcement
IIRIRA	Illegal Immigration Reform and Immigrant Responsibility Act
IGSA	Intergovernmental service agreement(s)
ILS	Immigration Legal Services
INS	Immigration and Naturalization Service
IRC	International Rescue Committee
IST	Incompetent to Stand Trial
JLG-RICA	John L. Gildner Regional Institute For Children & Adolescents
JPATS	Justice Prisoner Alien Transport System
LIRS	Lutheran Immigration and Refugee Service
LSS	Lutheran Social Services of the National Capital Area
MDDHR	Maryland Department of Human Resources
MD MHA	Maryland Mental Hygiene Administration
MHA	Mental Health America
MHAV	Mental Health Association of Virginia
MHS	Northern Virginia Family Services Multicultural Human Service Programs

MONA	Maryland Office for New Americans
MTC	Meyer Treatment Center
NAMI	National Alliance on Mental Illness
NCSC	Newcomer Community Service Center
NDRN	National Disability Rights Network
NDS	National Detention Standard
NIBF	National Immigrant Bond Fund
NILC	National Immigrant Legal Center
NTA	Notice to Appeal
ODB	Our Daily Bread (Employment Center)
OIC	Officer-in-Charge
ONS	Virginia Department of Social Services Office of Newcomer Services
PAD	Psychiatric advance directive(s)
PBNDS	ICE Performance Based National Detention Standards
PGH	Piedmont Geriatric Hospital
PSTT	Program for Survivors of Torture and Trauma
PTSD	Post Traumatic Stress Disorder
RCA	Refugee Cash Assistance
REP	Maryland Re-Entry Partnership
RMA	Refugee Medical Assistance
SNA	Safety net assistance
SNAP	Supplemental Nutrition Assistance Program (formerly “food stamps”)
SOME	So Others May Eat
SPC	Service Processing Center(s)
SSI	Supplemental Security Income

SWVMHI	Southwestern Virginia Mental Health Institute
TAC	Treatment Advocacy Center
TANF	Temporary Assistance to Needy Families
TASSC	Torture Abolition & Survivors Support Coalition International
THC	Transitional Housing Corporation
TVC	Televideo conferencing
ULS	University Legal Services
USCCB	United States Conference of Catholic Bishops
USCIS	U.S. Citizenship and Immigration Services
VASAP	Montgomery County Victim Assistance & Sexual Assault Program
VCBR	Virginia Center for Behavioral Rehabilitation
WIC	Special supplemental food program for women, infants and children
WPCC	Walter P. Carter Center

APPENDIX

Appendix	Referred to in the Manual as
Appendix 1	INS Detention Standard Medical Care form (September 20, 2000)
Appendix 2	ICE/DRO Detention Standard Medical Care, December 2, 2008
Appendix 3	Sample requests for medical and mental health records: Letter from G. Pleasants to Columbia Care Center
Appendix 4	Sample requests for medical and mental health records: Letter from G. Pleasants to BHC Alhambra Hospital
Appendix 5	Sample requests for medical and mental health records: Letter from G. Pleasants to ICE FOIA Office
Appendix 6	Sample requests for medical and mental health records: Combined Authorization to Disclose Protected Health Information and Other Records
Appendix 7	Sample requests for medical and mental health records: Authorization for Request or Use/Disclosure of Protected Health Information (PHI)
Appendix 8	INS Healthcare Program Authorization for Disclosure of Information (Form I-813)
Appendix 9	Division of Immigration Health Services Authorization for Release of Confidential Health Information (Form DIHS-003)
Appendix 10	HIPAA Privacy Authorization Form
Appendix 11	ICE Detention Standard Detainee Transfer (June 16, 2004)
Appendix 12	ICE/DRO Detention Standard Transfer of Detainees (December 2, 2008)
Appendix 13	Examples of petitions for guardianship: Circuit Court City of Portsmouth – Petition for the Appointment of G L as Limited Guardian for PAL
Appendix 14	Examples of petitions for guardianship: Virginia Circuit Court City of Portsmouth – Supplement to Petition for the Appointment of a Limited Guardian for PAL
Appendix 15	Examples of petitions for guardianship: Virginia Circuit Court City of Portsmouth – Order (appointing Limited Guardian)

Appendix	Referred to in the Manual as
Appendix 16	Incompetent respondents (unpublished decisions): Decision of Immigration Judge U.S. DOJ EOIR NY, NY (April 4, 2003)
Appendix 17	Incompetent respondents (unpublished decisions): Interim Order of the Immigration Judge, U.S. DOJ EOIR, Arlington, VA (April 2, 2008)
Appendix 18	Incompetent respondents (unpublished decisions): Decision of BIA, Falls Church, VA, re Houston, TX file (February 18, 2009)
Appendix 19	Incompetent respondents (unpublished decisions): Decision of BIA, Falls Church, VA, re Newark file, (February 3, 2006)
Appendix 20	Incompetent respondents (unpublished decisions) Decision of BIA, Falls Church, VA, re CA file (May 2, 2008)
Appendix 21	Incompetent respondents (unpublished decisions): Decision of BIA, Falls Church, VA, re San Pedro file (December 8, 2003)
Appendix 22	Competency Motion: U.S. DOJ EOIR, BIA, Respondent's Appeal Brief *In the Matter of R H-*, December 20, 2005
Appendix 23	Competency Motion: U.S. DOJ EOIR, BIA Falls Church, VA, Respondent's Motion to Reopen, March 2008
Appendix 24	Sample Motion to Appoint a Limited Guardian Ad Litem: U.S. DOJ EOIR, Elroy, AZ – Respondent's Motion to Appoint a Limited Guardian Ad Litem
Appendix 25	U.S. DOJ EOIR San Diego, CA - Government's Response to a Motion for Guardian Ad Litem
Appendix 26	U.S. DOJ EOIR Arlington, VA - Amicus Brief in Support of Respondent's Right to a Fair Hearing
Appendix 27	U.S. DOJ EOIR York, PA - DHS Brief in Response to Amicus Brief

Appendix	Referred to in the Manual as
Appendix 28	Government memos: U.S. DOJ Memo, November 17, 2000 re Exercising Prosecutorial Discretion
Appendix 29	Government memos: U.S. DHS/ICE Memo, November 7, 2007 re Prosecutorial and Custody Discretion
Appendix 30	Application for Asylum and for Withholding of Removal, (Form I-589)
Appendix 31	U.S. DOJ EOIR Arlington, VA - Order of the Immigration Judge re Applications: Withholding of Removal to Columbia
Appendix 32	BIA Decision, Falls Church, VA re San Francisco file May 31, 2007
Appendix 33	U.S. DOJ EOIR - Motion and Brief in Support of Respondent's Request of Relief Under the Convention Against Torture and 8 U.S.C. § 241
Appendix 34	U.S. DOJ EOIR, Arlington, VA – Respondent's Pre-Hearing Brief in Support of Deferral of Removal Under Convention Against Torture
Appendix 35	LRP U.S. DOJ EOIR, Arlington, VA - Memorandum of Law in Support of Application for Cancellation of Removal for Certain Permanent Residents and Withholding of Removal (March 7, 2008)
Appendix 36	LRP U.S. DOJ EOIR, Arlington, VA – Closing Statement in Support of Respondent's Application for Cancellation of Removal (February 10, 2006)
Appendix 37	LRP U.S. DOJ EOIR, Arlington, VA – Decision and Order (March 3, 2006)
Appendix 38	Article - Past Persecution, Mental Illness and Humanitarian Asylum: Creating the Record to Win the Claim
Appendix 39	Sample letter to Embassies re Request for Lawful Admission