**Explanatory Memorandum for Motion to Provide Safeguards for Clients With Mental Illness or Cognitive Limitations in Immigration Court[[1]](#footnote-1)**

**Introduction: Why This Motion May be Necessary**

Courts in many other areas of American law have begun to recognize the importance of providing accommodations for people with mental health conditions or cognitive limitations. However, immigration courts have made very little progress on this front. As a result, respondents with cognitive disabilities or mental health illnesses are often expected to perform under the same standards and procedures as non-disabled respondents, which works to their disadvantage. Particularly in the context of immigration court, where the testimony of the respondent may be critical to winning a case, it is of tantamount importance that immigration courts provide meaningful accommodations so that people with mental health issues may have a fair immigration proceeding.

Currently, immigration courts only require safeguards for respondents who have been deemed “incompetent” in a formal *M-A-M* hearing. *See Matter of M-A-M*, 25 I. & N. Dec. 474 (BIA 2011). This is despite the fact that the BIA recognizes that safeguards may be useful without a formal finding of incompetency. *Matter of J-R-R-A*, 26 I. & N. Dec. 609, 611–12 (BIA 2015). The BIA’s definition of competency is extremely narrow and excludes a large number of immigration respondents with intellectual disabilities or mental health illnesses.   
  
To address this gap in the current case law, we have prepared two sample motions to allow attorneys to request accommodations for clients with mental illness or cognitive limitations. The first sample motion is for clients with cognitive or intellectual impairments. The second sample motion is for clients with mood disorders (including bipolar disorder and depression) or PTSD[[2]](#footnote-2). The majority of safeguards requested in the motions are the same. However we separate the motions here because, although the behavior of a person with a cognitive impairment may be very similarly in court to that of a person with PTSD or depression, the reasons for the similar behavior are generally quite different. Consequently we think it wise to keep them separate for the sake of clarity.

This guide provides detailed instructions on how to use these motions, includes brief comments on the strategic considerations one should bear in mind when considering if and when to use the sample motions, and concludes with some background information on cognitive disabilities and mood disorders.

**Does My Client Need Safeguards? A Checklist**

As your client’s attorney, the degree of information you have about your client’s mental health may vary. You may sense that your client has difficulty following along in conversation, or has trouble remembering dates and names. Perhaps your client has a formal diagnosis of PTSD or depression, or maybe you merely suspect, based on your knowledge of the client’s history, that he or she may be suffering from one of these conditions. In order to determine what is best for your client, consider running through the following checklist:

1. ***Identify What Mental or Cognitive Difficulties Your Client Has***

The first and most important step is getting a better sense of what difficulties your client might have.

* + *Arranging an evaluation*. If you work at an office that has in-house social workers, consider arranging an evaluation for your client so that you may determine what, if any mental heath issues or cognitive limitations your client has.
  + *Requesting any previous mental health or cognitive functioning records* Try to request any records that your client could have documenting any mental health issues they might have. This should include school records, hospital records, prison records, records from social services, and any other kinds of records that might be available regarding your client.
  + *Talk to your client’s family members* *or friends* Even if formal evaluations or records are not possible, you could talk to your client’s family members and friends to ask if they recall the client ever having any trouble in school, experiencing symptoms of depression, or having any other kinds of mental health or cognitive issues.
  + *Talk to your client* This may not always be the most fruitful avenue to get what you need, as sometimes people can be reluctant to admit to having difficulty understanding conversations or following. But talking to your client to get a better sense of any mental health issues they have had or currently experience, or of any cognitive limitations they have can be useful. There are also evaluations called “minicogs” that an attorney might use to better discern if their client might have problems with cognitive functioning. However use of such tests may diminish trust in the attorney-client relationship, especially if the attorney is not clear with the client about the purpose of such an assessment. As much as possible, if you suspect that your client might have problems with cognitive functioning, try and obtain an evaluation for them conducted by somebody else.
    - *Signs of Possible Intellectual/Cognitive Limitations[[3]](#footnote-3)*
      * Sensitivity to light
      * Pretending to understand when it seems clear that the client does not
      * Strong desire to please authority figures
      * Difficulty with eye contact
      * Anxious or nervous appearance
      * Vulnerable to peer pressure
      * Poor impulse control
      * Trouble remembering dates or names
    - *Signs of Mood Disorder or PTSD*
      * Flat affect
      * Difficulty with eye contact
      * Difficulty telling open-ended narrative with sufficient detail

1. ***Determine Whether Your Client Should Testify***

This is the second most important consideration. There many cases, particularly those in which your client is seeking relief based on persecution they may face or have faced on the basis of a cognitive impairment or mental health disability, where having your client testify, despite their cognitive or mental limitations is best. But there could be other cases where your client could easily become agitated and confused, and another person such as a social worker or family member, could be a more effective witness than the client his or herself. Both motions contain language that can be deleted or inserted based on whether or not you decide to have your client testify. In making this decision, consider the following:

* ***Client’s Demeanor During Testimony*** What is your client like when he or she testifies? Does she come across as a sympathetic? Does he answer questions well and look at the person who is asking him questions? Does your client answer questions in monotone or avoid direct eye contact? A judge might initially view those latter two qualities as a sign of the speaker’s incredibility, but those aspects of your client’s demeanor may actually be coping mechanisms developed in response to extreme trauma or depression. In both sample motions we have created accommodations that should allow a client to testify despite concerns about their demeanor, but if you feel that those accommodations will not be sufficient, then it may be better to have a friend or family member testify in your client’s stead.
* ***Client’s Credibility*** A bigger issue might be if your client has consistent trouble remembering names and dates. If your client has cognitive limitations or functioning, it might not always be obvious from interviewing them. Your client could confidently state an incorrect date or story, and the people listening would be none the wiser. Alternatively, your client could give very short answers to questions that require a fuller or more open-ended narrative. In the sample motion for accommodations for people with cognitive limitations, we have created accommodations that should allow a client who has trouble remembering details to testify, but if you feel that that those accommodations will not be sufficient, then it may be better to have a friend or family member testify in your client’s stead.

1. ***Determine Which Accommodations Are Best for Your Client***

After you have determined whether or not your client will testify, determine which accommodations are best. Most of the accommodations in both motions are written for clients who will testify, but some of the accommodations, particularly the courtroom environment accommodations, could be useful even for a client who does not testify.

1. ***Determine When is Best to Request Accommodations and Other Strategic Considerations***

Some of the accommodations in this motion are designed specifically for the merits hearing, and may be best to submit ahead of time before trial. A judge may be unlikely to grant some accommodations, but it may still be useful to develop a record for appeal that the request was made. On the other hand, if your client is detained, requesting a specific hearing on the accommodations motion may take more time and prolong your client’s detention. Ultimately, as the attorney, you will need to decide when is best to file, but here are different factors to consider that may guide and inform that decision:

* ***Detention*** If your client is detained, then scheduling a separate hearing on the accommodations requested may only further prolong his or her detention. This might influence what times you think it best to file.
* ***If a M-A-M hearing has already been requested and scheduled***: Prior to the *M-A-M* hearing, you may want to file the accommodations motion and then request that the accommodations requested be discussed in the course of the *M-A-M* hearing
* ***If the judge wants to request a M-A-M hearing after receiving this motion*:** The Court is obligated to accommodate people with mental health illnesses regardless of whether or not a M-A-M hearing has been requested or scheduled. Feel free to emphasize this fact, but if your judge is unwilling to consider your requests without a *M-A-M* hearing first, ask whether the judge can decide on the accommodations during the *M-A-M* hearing

**How to Use the Motions**

* These boilerplate motions are exactly that: boilerplate. You should by no means feel bound by the language and organization that we have used. Feel free to edit sections as you see fit and to delete any accommodations that you think might not be necessary.
* There are several places in the motions that use yellow highlighting to indicate areas where the attorney needs to fill in relevant information or determine whether or not to keep or delete a section. For example, in both motions, the first safeguard is a request that the court not make adverse inferences if a client does not testify. If your client is not testifying, then many of the remaining accommodations will no longer be relevant and should be deleted. Alternatively, if you client *does* testify, then you can delete the section regarding adverse inferences from silence from the motion.

**Introduction to Cognitive Impairments**

**Terminology**

Three different terms are often used to refer to cognitive impairments: 1) intellectual disabilities; 2) cognitive disabilities or 3) developmental disabilities. However, these terms have particular meanings within the psychiatric community that may not be reflected in legal discourse. **[See Appendix for Further Explanation on Terminology.]**   
  
For the purpose of the sample motion, the broadest possible term, ***cognitive impairments***,has been chosen because not all clients may reach the federal definition of disability. As used here, ***cognitive impairment*** describes any individual with an impairment that affects his or her thought process.

**Background**

Approximately 7.5 million Americans are believed to have an intellectual or developmental disability.[[4]](#footnote-4) These disabilities are characterized by limitations in two major areas: 1) intellectual functioning and 2) adaptive behavior. Adaptive behavior encompasses daily-living, social, and practical living skills. [[5]](#footnote-5) Although cognitive disabilities vary in severity, they all affect an individual’s awareness, perception, reasoning, judgment, memory, and communication.

While accommodations for physical disabilities have become common-place in recent years, people with cognitive disabilities are still often overlooked. This is likely because, unlike physical impairments, cognitive impairments are not immediately apparent to an observer. Additionally, many people with cognitive disabilities may conceal the extent of their deficits in order to blend in, a phenomenon known as*masking*.

***Challenges with Giving Testimony: Masking and Confabulation.***  Individuals with cognitive disabilities are significantly more prone to being suggestible, and thus more likely to acquiesce in response to questions that they don’t understand.[[6]](#footnote-6)

Numerous studies have demonstrated that people with cognitive disabilities are often perceived as less credible witnesses than they actually are.[[7]](#footnote-7) This is seemingly because many of the key indicators people use to assess an individual’s credibility are precisely the areas where people with cognitive impairments are most deficient. Factors that are often used as proxies for credibility-—including detail, and length of responses—prove particularly difficult for people with cognitive disabilities. When recounting events, people with cognitive impairments may had difficulty remembering dates and times, affecting their ability to provide detailed autobiographical accounts.[[8]](#footnote-8)   
  
 **Introduction to Mood Disorders and PTSD**

Mood disorders are mental health illnesses characterized by changes to one’s emotional state.[[9]](#footnote-9) Mood disorders include mental health illnesses like depression and bipolar disorder. Post-traumatic stress disorder is “a delayed or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.”[[10]](#footnote-10) An estimated 360 million people in the world have either depression or bipolar disorder.[[11]](#footnote-11) Additionally, about 6-7% of the population in surveyed countries currently has PTSD.[[12]](#footnote-12) While the specific manifestations of these mental health illnesses may be different, both mood disorders and PTSD lead to two difficulties relevant to court proceedings: flat affect and overgeneral memory.

People with mood disorders or PTSD tend to suffer from emotional numbing, which is characterized by diminished or blunted emotional response, including flat affect.[[13]](#footnote-13) A person with a flat affect may speak with a monotonous voice, have limited emotional expressions, and may generally appear very apathetic. Flat affects, common in people with mood disorders or PTSD, are best understood as coping mechanisms and may not reflect how a person actually feels about what they have experienced. *See generally* John W. Mason et al., *Psychogenic Lowering of Urinary Cortisol Levels Linked to Increased Emotional Numbing and a Shame-Depressive Syndrome in Combat-Related Posttraumatic Stress Disorder*, 63 Pyschosomatic Medicine 387 (2001) (describing how people with PTSD initially have lower levels of the stress hormone cortisol because of extensive use of dissociative techniques, including emotional numbing and flat affect).

People with PTSD or mood disorders may also develop coping mechanisms that affect how they recall memories. A common assumption is that people are more likely to remember particular events that recall a heightened emotional state or that occurred during a period of emotional intensity. This is true, but only to a certain extent.[[14]](#footnote-14) What actually happens, particularly for traumatic events, is that while people may recall the event, they forget many peripheral details, an example of what cognitive psychologists call “overgeneral memory.” Several studies indicate that people with PTSD and depression are more likely to have overgeneral memory.[[15]](#footnote-15) Psychiatrists theorize that because retrieval of detailed negative experiences may cause distress, by remembering specific details, the person retrieving the memory is subconsciously avoiding negative feelings of distress.[[16]](#footnote-16)

Because of overgeneral memory, people with mood disorders or PTSD are more likely to confuse names and dates. Their ability to remember details and tell a full-fledged narrative may also suffer. They may have a flat affect that makes them appear cold or unaffected by traumatic or violent events they may have witnesses or experienced. All of these difficulties are manifestations of the person’s mental health conditions.

**Appendix A: Disability Terminology**

**Intellectual Disability (Formerly Mental Retardation)**– ID is now the most prevalent term used by medical, educational, and advocacy groups.[[17]](#footnote-17)

According to the American Association of Intellectual and Developmental Disabilities, (“AAIDD”) an ID originates before the age of 18 and involves significant impairment in two areas:

* **intellectual functioning** - reasoning, learning, problem solving
* **adaptive functioning** - conceptual (money, time, self-direction), social and practical skills (personal care, travel/transport, safety). ***CITE – AAIDD.***

Until recently, a diagnosis of relied heavily on an individual’s IQ score, reflecting a larger “major paradigm” [[18]](#footnote-18) shift in how ID’s are now approached and diagnosed Now, **adaptive functioning** is the determinative factor and IQ is used as a tool of assessing general intellectual ability. Many courts and legislation has adjusted to the new approach and still use “mentally retarded” and set specific limits on IQ, typically under 75.   
  
**Cognitive Disability –** Refers broadly to disabilities affecting thought processes.

* *Associated Diagnoses:*ADHD, Aphasia, Language Delay, Learning Disabilities (Dyslexia, Dyscalculia), and Brain Injury*.*

**Developmental Disability** – An umbrella term that includes ID’s and any disability that occurred prior to the age of 22 that impairs one’s ability to perform 3+ major life activities.

* *Associated Diagnoses:* Cerebral Palsy, Autism, all ID’s

1. Created by Nora E Kirk and Oluwadamilola Obaro through the NYU Immigrant Rights Clinic. [↑](#footnote-ref-1)
2. Mood disorders are mental health illnesses characterized by changes to one’s emotional state. *See* World Health Organization, *Int’l Statistical Classification of Diseases and Related Health Problems*, 10th Revision (2016), http://apps.who.int/classifications/icd10/browse/2016/en#/F30-F39. Mood disorders include mental health illnesses like depression and bipolar disorder. Post-traumatic stress disorder is “a delayed or protracted response to a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.” World Health Organization, *Int’l Statistical Classification of Diseases and Related Health Problems*, 10th Revision (2016), http://apps.who.int/classifications/icd10/browse/2016/en#/F40-F48. [↑](#footnote-ref-2)
3. This list is excerpted from Nat’l Ctr. Crim. J. & Disability, *Shining a Light on Traditionally Hidden Disabilities* (2014), https://cops.usdoj.gov/html/dispatch/12-2014/shining\_a\_light\_on\_hidden\_disabilities.asp. [↑](#footnote-ref-3)
4. Administration on Intellectual and Developmental Disabilities (AIDD), *AIDD: The President's Committee for People with Intellectual Disabilities* (2016), https://acl.gov/Programs/AIDD/Programs/PCPID/index.aspx (last visited Apr 1, 2017). [↑](#footnote-ref-4)
5. Introduction to Intellectual Disabilities - The Arc, The Arc, http://www.thearc.org/document.doc?id=3661 (last visited Apr 2, 2017). [↑](#footnote-ref-5)
6. Carol K. Sigelman et al., W*hen in Doubt Say Yes: Acquiescence in Interviews with Mentally Retarded Persons* 19 Mental Retardation, 53–58 (1981). [↑](#footnote-ref-6)
7. *See* Georgina Stobbs & Mark Rhys Kebbell, *Jurors' Perception of Witnesses with Intellectual Disabilities and the Influence of Expert Evidence*, 16 J. of Applied Res. Intellectual Disabilities 107 (2003); L. Henry et al., *Perceived Credibility and Eyewitness Testimony of Children with Intellectual Disabilities*, 55 J. of Intellectual Disability Res. 385 (2011); M. Peled, et al., *Eyewitness Testimony and Perceived Credibility of Youth with Mild Intellectual Disability*, 48 J. of Intellectual Disability Res. 699–703 (2004); Nitza B. Perlman et al., *The Developmentally Handicapped Witness: Competency as a Function of Question Format*, 18 L. & Hum. Behav. 171–187 (1994). [↑](#footnote-ref-7)
8. *See* Thomas Leyhe et al., *Impairment of Episodic and Semantic Autobiographical Memory in Patients With Mild Cognitive Impairment and Early Alzheimer’s Disease*, 47 Neuropyschologia 2464 (2009) (describing and comparing the memory problems of people with mild cognitive impairment to those with Alzheimer’s disease). [↑](#footnote-ref-8)
9. *See Int’l Statistical Classification of Diseases and Related Health Problems*, 10th Edition (2016). [↑](#footnote-ref-9)
10. World Health Organization, *Int’l Statistical Classification of Diseases and Related Health Problems*, 10th Revision (2016), http://apps.who.int/classifications/icd10/browse/2016/en#/F40-F48. [↑](#footnote-ref-10)
11. *Mental Health Disorders*, http://www.who.int/mediacentre/factsheets/fs396/en/ (Apr. 2017) *World Health Organization*. [↑](#footnote-ref-11)
12. Lukoye Atwoli et al., *Epidemiology of Posttraumatic Stress Disorder: Prevalence, Correlates and Consequences*, 28 Curr. Opin. Psychiatry 307 (2015). [↑](#footnote-ref-12)
13. Richard L. Amdur et al., *Emotional Processing in Combat-Related Posttraumtic Stress Disorder: A Comparision With Traumatized and Normal Controls*, 14 J. Anxiety Disorders 219, 220 (2000); Howard Berenbaum & Thomas F. Oltmanns, *Emotional Experience and Expression in Schizophrenia and Depression*, 101 J. Abnormal Psych. 37 (1992). [↑](#footnote-ref-13)
14. Anne E. Van Giezen et al., *Consistency of Memory for Emotionally Arousing Events: A Review of Prospective and Experimental Studies.* 25Clinical Psych. Rev. 945 (2005); *cf.* Shamsul Haque, *Autobiographical Memory and Hierarchical Search Strategies in Depressed and Non-Depressed Participants*, 14 BMC Psychiatry 310 (2014)(describing how depressed patients were more likely to retrieve autobiographical memories that mirrored their current emotional state). [↑](#footnote-ref-14)
15. *See, e.g.*, Birgit Kleim, et al., *The Impact of Imprisonment on Overgeneral Autobiographical Memory in Former Political Prisoners*, 26 J. of Traumatic Stress 626, 626 (2013). [↑](#footnote-ref-15)
16. Shamsul Haque, *Autobiographical Memory and Hierarchical Search Strategies in Depressed and Non-Depressed Participants*, 14 BMC Psych. 310 (2014). [↑](#footnote-ref-16)
17. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition http://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm01#x98808.2725092 [↑](#footnote-ref-17)
18. American Psychological Association (2016), http://www.apa.org/pi/disability/resources/publications/newsletter/2016/09/intellectual-disability.aspx (last visited Mar 12, 2017). [↑](#footnote-ref-18)