

# Beyond borders: A qualitative study on the use of forensic medical evaluations in securing humanitarian parole and Title 42 exemptions

Andrew Ly<sup>1</sup>, Olivia Febles Simeon<sup>1</sup>, Manya Balachander<sup>1</sup>, W. Courtland Robinson<sup>2</sup> and C. Nicholas Cuneo<sup>2,5,6</sup>

- 1 Johns Hopkins University School of Medicine, Baltimore, Maryland, USA
- 2 Center for Humanitarian Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland, USA
- 3 Department of Pediatrics and Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA
- 4 Migrant Health and Human Rights Program, Center for Public Health and Human Rights, Johns Hopkins University Bloomberg School of Public Health, Baltimore, Maryland, USA
- 5 HEAL Refugee Health & Asylum Collaborative, Baltimore, Maryland, USA
- 6 Correspondence to: [nick.cuneo@jhmi.edu](mailto:nick.cuneo@jhmi.edu)

## Key points of interest:

- Forensic medical evaluations can be administered remotely for cases seeking humanitarian parole into the U.S.
- Transit routes expose migrants to systemic violence and rights violations, directly challenging previous “safe third country” designations and indicating the need for strengthened protections in migration corridors.

## Abstract

*Introduction:* Forensic Medical Evaluations (FMEs), which provide objective documentation of physical and psychological consequences of past abuse, can be pivotal in immigration proceedings, offering critical evidence of persecution endured by asylum seekers, which may corroborate their claims. Yet their applicability in humanitarian parole and Title 42 exemption cases remains underexplored. *Aim:* To characterise the role of Istanbul Protocol-informed FMEs in support of humanitarian parole and Title 42 exemption requests in the United States, and to describe associated clinical, psychosocial, and procedural features. *Methods:* This qualitative study examined 21 cross-border FMEs and medical vulnerability letters submitted from 2021 to 2024 by an academic medical centre-based asylum clinic in Baltimore, Maryland, in support of applications for humanitarian parole or Title 42 exemption. *Results:* Remote evaluations were utilised in 85.7% of cases. The largest demographic seeking protection (42.9%) was women from Honduras, Mexico, and Guatemala residing in Ciudad Juárez, Mexico, at the U.S.-Mexico border. Our analysis revealed a significant prevalence of a history of physical or sexual assault spanning from the country of origin to transit. Threats of death or harm, robbery, and racial discrimination were also noted across various stages of the migration journey. Post-traumatic stress disorder (PTSD) was the most common psychiatric diagnosis at 88.9%, followed by major depressive disorder (MDD) and generalised anxiety disorder (GAD) at 66.7% and 22.2%, respectively. Many cases (63.6%) cited inadequate mental health services in their country of origin or transit, with 57.1% of these also highlighting the unavailability of necessary medical treatment. A diverse array of medical reasons for humanitarian protection was identified, including developmental, cardiovascular, pulmonary, renal, infectious, and psychiatric diseases. All cases with

known outcomes received humanitarian protection. *Conclusion:* Our findings demonstrate proof of concept for the utility of remote medico-legal evaluations for cases seeking humanitarian parole into the U.S. in addition to providing a window into the diversity of such claims.

**Keywords:** forensic medical evaluations, humanitarian parole, Title 42, asylum, immigration

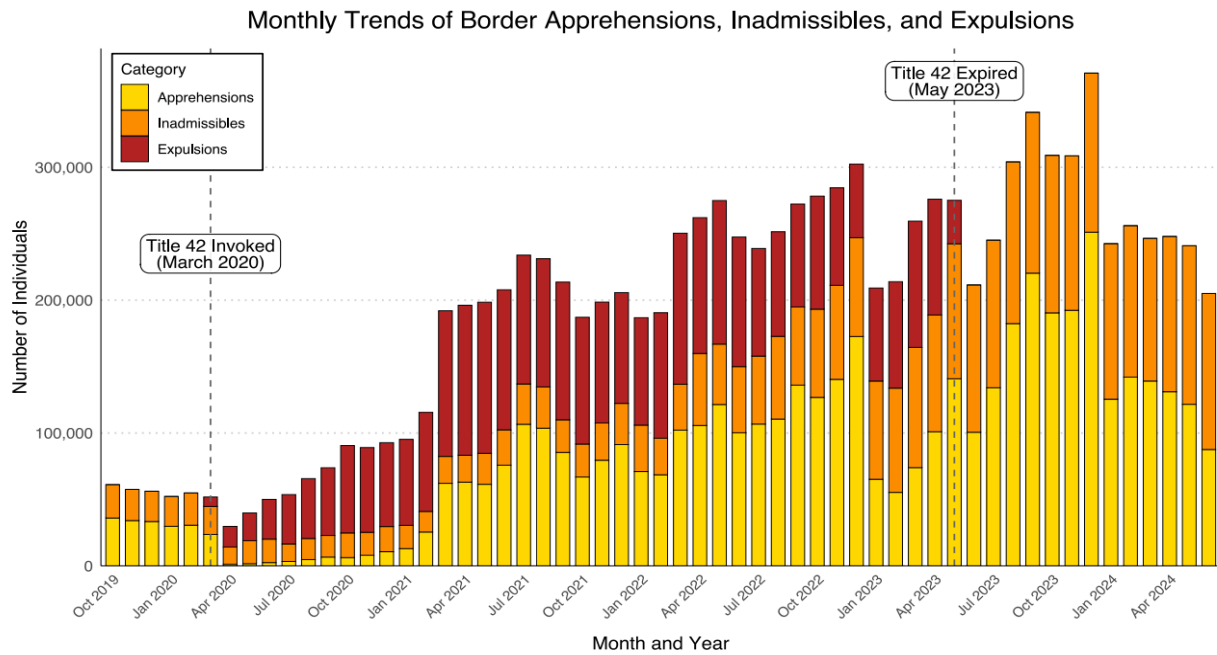
## Introduction

Humanitarian parole (HP) provides temporary entry into the United States for individuals who would otherwise be considered inadmissible. In recent years, HP has become an increasingly important legal mechanism for enabling asylum seekers to enter the country while awaiting processing of their asylum applications. HP requests are filed on Form I-131 (with Form I-134 if sponsor-based) with supporting evidence. The U.S. Citizenship and Immigration Services (USCIS) adjudicates HP to eligible applicants seeking entry into the U.S. prior to their transit to the country. When a foreign national seeks HP at a port of entry, however, the decision may rest with U.S. Customs and Border Protection (CBP). Both USCIS and CBP consider various factors when weighing HP determinations, including the urgency of the circumstances, the impact on the individual's well-being, and the potential suffering if parole is not granted (U.S. Citizenship and Immigration Services, 2023). Urgency can be demonstrated by presenting a compelling reason for immediate action, such as exigent medical treatment or the need to assist a family member in the final stages of illness (U.S. Citizenship and Immigration Services, 2023).

HP designation is granted sparingly and requires parolees to attend immigration appointments, with the expectation that they will leave the U.S. before the parole expires unless they obtain a more permanent status. To interpret published DHS parole statistics, it is essential to distinguish approvals from grants. Approvals are decisions on advance requests to authorise parole. Grants are parole events that effectuate parole, typically issued by CBP at a port of entry. These counts reflect events rather than unique individuals. Some grants occur without any prior USCIS or ICE approval, some individuals submit multiple requests or receive multiple grants, and some approved overseas applicants do not travel to the U.S. As a result, DHS aggregates should not be interpreted as a baseline approval rate for individualised HP. During FY2023, DHS received 2,709,092 parole requests and approved 782,716, yielding an overall approval-to-request proportion of 28.9% (USCIS:  $775,005/2,698,252 = 28.7\%$ ; ICE:  $7,711/10,840 = 71.1\%$ ). In the same period, DHS granted 1,340,002 paroles (CBP 1,244,348 [OFO 940,348; USBP 304,000], ICE 85,608,

USCIS 10,046) (Office of the Under Secretary for Management, 2024). The HP application process aims to prioritise the most vulnerable cases, such as individuals with significant health needs or vulnerabilities. HP has played a crucial role in providing temporary relief to asylum seekers facing challenging or potentially harmful conditions while awaiting entry to the U.S., enabling them to access essential medical care and reunite with family members already residing in the U.S. However, HP has received scrutiny across multiple branches of government.

In March 2024, a federal judge dismissed a lawsuit filed by Texas on behalf of 21 states challenging an HP program established by the Biden administration for Cubans, Haitians, Nicaraguans, and Venezuelans (Jordan, 2024; Lozano, 2024). Furthermore, during negotiations surrounding the bipartisan border security bill of 2024, the abolition or significant restriction of HP was discussed as a potential point of compromise during bilateral talks on border security and Ukraine funding (Diamante, 2024; Long et al., 2024). In the days following President Trump's inauguration in January 2025, the use of HP was further limited by executive order, with agencies instructed to broadly restrict humanitarian parole programs. Most recently, under the Trump Administration, the DHS narrowed the use of categorical parole pathways. In March 2025, the DHS published a Federal Register notice terminating the Cuba–Haiti–Nicaragua–Venezuela (CHNV) parole processes, with most existing CHNV parole ending 30 days after publication absent an individualized determination; following subsequent litigation, a Supreme Court stay on May 30–June 6, 2025 permitted DHS to proceed with termination notices in June 2025 (“Termination of Parole Processes for Cubans, Haitians, Nicaraguans, and Venezuelans,” 2025; U.S. Citizenship and Immigration Services, 2025a; U.S. Department of Homeland Security, 2025). Separately, on January 28, 2025, USCIS paused acceptance of Form I-134A pending review of all categorical parole processes, effectively suspending new sponsor-based applications under programs including Uniting for Ukraine (U4U), certain family reunification parole processes, sponsored Afghan parole, and Central American Minors re-parole (Montoya-Gálvez, 2025; “Securing Our Borders,” 2025; U.S. Citizenship and Immigration Services, 2025b). Notwithstand-

**Figure 1.** Impact of Title 42 policy on monthly border apprehensions, inadmissibles, and expulsions (2019-2024)

ing these administrative changes, humanitarian parole remains a discretionary, case-by-case tool for “urgent humanitarian reasons” or “significant public benefit” (U.S. Citizenship and Immigration Services, 2023).

In contrast, Title 42, a provision of U.S. health law, was enacted early on during the COVID-19 pandemic to immediately expel asylum seekers arriving at the U.S.-Mexico border without due process (such as a credible fear interview to screen for asylum eligibility), citing public health concerns and disease prevention, as outlined in 42 U.S.C. § 265. Although it has been part of U.S. law since 1944, Title 42 was not invoked until March 2020, after which it was used over 2.5 million times to expel migrants (Figure 1) (Gostin and Friedman, 2023; Santana, 2022). Initially implemented under the pretext of serving to curb the spread of COVID-19, Title 42 was criticised for lacking public health justification and violating international law by denying asylum seekers the opportunity to have their claims evaluated, leading to increased use of dangerous migration routes and resulting fatalities (Fabi et al., 2022; Rosenberg et al., 2022; Santana, 2022; Zard et al., 2022). Additionally, the policy was criticised for its poor scientific foundation, given the lack of existing evidence to suggest that singling out asylum seekers or migrants for exclusion would effectively prevent the spread of COVID-19, particularly alongside leni-

ent entry requirements for other foreign nationals, as was the case throughout the era in which it was enforced (Beckett et al., 2022; Durgun et al., 2023; Ulrich and Crosby, 2022). Following the lifting of the COVID-19 public health emergency on 11 May 2023, Title 42 automatically expired, and Title 8, the longstanding standard of immigration policy, was reinstated. During the period in which Title 42 was the status quo, non-citizens were allowed to apply for and receive exemptions to Title 42 on humanitarian grounds, largely related to ongoing negotiations alongside *Huisha-Huisha v. Mayorkas*, a case which challenged the invocation of Title 42 to restrict refugee and asylum entry.

In summary, HP is a discretionary, case-by-case authority under INA §212(d)(5). Individualised requests may be submitted in advance to USCIS on Form I-131 with supporting evidence, authorising travel. However, CBP makes the final parole determination at the port of entry. By contrast, “Title 42 humanitarian exceptions” were discretionary exemptions from the CDC public-health order that, when granted, permitted processing under Title 8; the Title 42 order ended on 11 May 2023. During that period, CBP used the CBP One application to schedule inspection appointments, and an appointment did not guarantee an exception or admission. HP remains available on a case-by-case basis, whereas Title 42 exceptions were

time-limited operational practices tied to the public-health order.

The complex nature of asylum claims and the traumatic experiences many applicants have undergone necessitate a comprehensive understanding of the impact of forensic medical evaluations (FMEs) in various immigration contexts, including applications for HP and exemptions under Title 42 in the United States. However, there is a dearth of literature regarding the specific impact of medico-legal evaluations in the context of applying for HP and/or seeking exemption under Title 42. This study seeks to address this gap by conducting the first analysis of cross-border medico-legal evaluations and letters of medical vulnerability for individuals applying for HP and/or seeking Title 42 exemption in the United States. Our aim was to characterise the role of Istanbul Protocol-informed FMEs in support of humanitarian parole and Title 42 exemption requests in the United States, and to describe associated clinical, psychosocial, and procedural features. Our specific objectives were to: (1) summarize client demographic characteristics (age, gender, origin, primary language), location at the time of evaluation, and modality (remote vs in-person); (2) delineate the reasons for application and the typical components of affidavits produced; (3) systematically categorize reported forms of mistreatment during migration; and (4) describe documented psychological sequelae among psychological cases and key medical indications among medical cases. The research will focus on exploring the demographic characteristics, lived experiences, and grounds for application of clients who have undergone FMEs through the HEAL Refugee & Asylum Collaborative (hereinafter, "HEAL Collaborative").

In light of the growing number of displaced individuals globally, with an estimated 123.2 million forcibly displaced people worldwide by the end of 2024, there is an urgent need for more trained clinicians to conduct trauma-informed FMEs to support applicants for immigration relief (UNHCR, 2025). Forensic evaluations are pivotal in immigration proceedings by providing corroborative evidence of trauma and persecution experienced by asylum seekers (Franceschetti et al., 2019; Hanna et al., 2021; Lustig et al., 2008; Peart et al., 2016). FMEs are not required but are often included when medical or psychological risk is relevant, consistent with USCIS evidence guidance encouraging detailed medical documentation and with the Istanbul Protocol's medico-legal standards (U.S. Citizenship and Immigration Services, 2022). FME content typically includes a trauma-informed history; physical examination or structured observation when indicated; psychological assessment where clinically appropriate; review of available records and photographs; and a consistency analysis linking findings to reported

events, culminating in a medico-legal affidavit provided to the legal team in support of the client's application. These evaluations have been shown to significantly impact the application process, with success rates ranging from 82% to 89% for individuals who undergo FMEs in conjunction with legal services compared to the national average of 37.5% (Atkinson et al., 2021; Lustig et al., 2008; Peart et al., 2016). This finding highlights the critical role that FMEs can play in providing essential support and credibility to asylum seekers' accounts, potentially spelling the difference between securing legal status and being deported to face further persecution.

## Study Data and Methods

### *Data Sources*

This study utilised data from the HEAL Collaborative, programmatically based at Johns Hopkins University, with a mission to expand access to responsive health care and supportive services for immigrant survivors of torture and trauma seeking refuge in the U.S. The HEAL Collaborative provides pro bono FMEs to clients in the greater Baltimore area and beyond for the purposes of use in immigration proceedings. For this study, all evaluators were physicians with M.D. licensure specialising in internal medicine, paediatrics, emergency medicine, or nephrology. Evaluators completed FME training through the Physicians for Human Rights Asylum Network and/or the Asylum Medicine Training Initiative (DeFries et al., 2025). Abbreviated FMEs were conducted for a majority of cases involving reported human rights abuses and entailed the use of an Istanbul Protocol-based standardised approach, following a structured format for the medical and psychological assessments linking clinical findings to specific allegations of abuse (United Nations Office of the High Commissioner for Human Rights, 2022). The results of these concise FMEs were summarised in structured letters that were designed to be a maximum of 2–3 pages, reflecting the limited time DHS officials have to review submitted materials relative to asylum adjudicators. HP requests for non-torture cases were related to medical necessity and did not follow the Istanbul Protocol methodology.

All clients were referred to the HEAL Collaborative by the International Refugee Assistance Project (IRAP), a global non-profit organisation that provides legal aid and advocacy to refugees and displaced persons. Referring immigration attorneys provided a provisional recommended focus for each evaluation (e.g., suspected PTSD), but the evaluators were ultimately responsible for determining the focus areas based on the history elicited and their clinical judgment. Most of the clients referred by IRAP were served by their U.S.-Mexico Border pro-

gram, which offers remote legal counsel, community outreach, and legal advocacy to individuals forcibly displaced and pursuing asylum in the United States through the Ciudad Juárez/El Paso port of entry. As part of their legal support services, IRAP partnered with the HEAL Collaborative to conduct evaluations and write medico-legal support letters summarising any relevant clinical findings. Assessment duration ranged from approximately 30 to 120 minutes (most >60 minutes), with flexibility based on clinical/legal need. All evaluations were performed with a certified bilingual interpreter or language-concordant physician. In-person assessments occurred in private rooms at a community-based organisation in Ciudad Juárez, Mexico. Since FMEs do not constitute clinical care, evaluators are generally permitted to take on cases from jurisdictions outside their state or country of licensure, including virtual FMEs (Physicians for Human Rights et al., 2025). The study was approved by the Johns Hopkins Medicine Institutional Review Board (IRB00370039) and followed in accordance with the Declaration of Helsinki.

### Methods

This retrospective qualitative study examined all FMEs and letters of medical vulnerability submitted by the HEAL Collaborative between February 2021 and March 2024. We analysed a subset consisting of 21 evaluations, which represented all HP and Title 42 exemption cases referred to our centre over the designated period. To maintain confidentiality, the evaluations were de-identified before being imported into NVivo, version 1.7.1, for qualitative analysis. Initial codes were developed based on the research objectives, resulting in a comprehensive codebook. Subsequently, multiple rounds of data review were conducted to identify similarities among codes and to refine or subdivide categories, ensuring that nuanced data were captured effectively. Coding was performed by two independent coders (A.L. and O.F.S.) with relevant clinical experience, yielding excellent interrater reliability (Cohen's kappa = 0.905).

In our analysis, we employed frequency labels to categorise forms of mistreatment and psychological sequelae observed across the cases. Specifically, we used four descriptors: "general" (all or nearly all cases), "typical" ( $\geq 50\%$ ), "variant" (4–8 cases), and "rare" (2–3 cases) (Hill et al., 2005). These labels facilitated a systematic approach to understanding and interpreting the prevalence and variation of mistreatment and psychological sequelae within our dataset. Intimate partner violence was defined as physical, sexual, or psychological abuse perpetrated by a current or former domestic partner.

### Limitations

Several limitations are present in this study that warrant consideration. Firstly, the cohort primarily comprises clients of IRAP in Ciudad Juárez, Mexico. Consequently, these findings may not fully capture the diverse experiences of all applicants seeking HP and Title 42 exemptions, given the inherent geographic limitations of our sample. Additionally, the written reports conducted within this study were not uniformly standardized, given the need for conciseness for written reports in this setting (while FMEs for traditional asylum cases can result in affidavits that are often >10 pages, HP reports must be kept to 2–3 pages maximum given that they are not being reviewed by an asylum officer or immigration judge but rather by a CBP or USCIS official with limited time/capacity). This lack of standardisation poses a risk of underestimating the actual prevalence of mistreatment and psychological sequelae within this cohort, as variations in report structure could impact the identification and documentation of such issues. However, this did not limit the reports' focus, as deemed necessary by the evaluator. Moreover, qualitative coding was carried out by only two individuals, which introduces the potential for bias. While efforts were made to maintain objectivity, the subjective interpretation inherent in qualitative analysis may have influenced the results. These limitations underscore the need for caution when generalising findings and emphasise the necessity for future research endeavours to employ larger, more diverse cohorts, utilise standardised evaluation protocols, and incorporate multiple coders to enhance the robustness and reliability of conclusions drawn.

### Results

#### Demographics

The cohort was predominantly female (61.9%) with an average age of  $24.5 \pm 10.2$  (range 6–36) years. Of these clients, six (28.6%) were under 18 years old, three (14.3%) were aged 18–24, nine (42.9%) were aged 25–34, and three (14.3%) were 35 or older. The majority hailed from the Northern Triangle (33.3% from Honduras, 14.3% from Guatemala) or Mexico (23.8%). Additionally, there were clients from Haiti (two), Iraq (two), and one each from Ecuador and Ethiopia. The primary language spoken was Spanish (76.2%), while the remaining clients spoke Haitian Creole, Amharic, or Arabic. Demographic characteristics are shown in Table 1.

#### Evaluation characteristics and outcomes

The majority of evaluations (85.7%) were conducted remotely, with most clients situated in Ciudad Juárez, Mexico (76.2%) during the evaluation period. Evaluations occurred in 2021

**Table 1.** Demographic characteristics of all clients

	Number ( <i>n</i> = 21)	Percent
<b>Age</b>		
<18	6	28.6
18–24	3	14.3
25–34	9	42.9
35–44	3	14.3
<b>Gender</b>		
Female	13	61.9
Male	8	38.1
<b>Country of origin</b>		
Honduras	7	33.3
Mexico	5	23.8
Guatemala	3	14.3
Haiti	2	9.5
Iraq	2	9.5
Ecuador	1	4.8
Ethiopia	1	4.8
<b>Language</b>		
Spanish	16	76.2
Haitian Creole	2	9.5
Arabic	2	9.5
Amharic	1	4.8

(33.3%), 2022 (61.9%), and 2024 (4.8%). Two clients required disability accommodations: one for post-stroke hemiparesis and aphasia, and the other for cognitive impairment from traumatic brain injury. Neither condition constrained the evaluation: in the aphasia case, collateral history was provided by the patient's mother and primary caregiver. The adult with traumatic brain injury provided sufficient history to support a DSM-5–consistent diagnosis.

In terms of reasons for application, nearly half of the applications addressed both physical and psychological concerns, with 38.1% exclusively targeting psychological issues and 9.5% focusing solely on physical matters. Additionally, 9.5% aimed to prevent first-degree family separation. During evaluation, two clients were enrolled in the Migrant Protection Protocols (MPP) program, a U.S. immigration policy requiring certain asylum seekers to remain in Mexico while their cases are processed (American Immigration Council, 2025). All of the 13 known application outcomes resulted in either an HP or a Ti-

**Table 2.** Evaluation characteristics and outcomes

	Number ( <i>n</i> = 21)	Percent
<b>Evaluation modality</b>		
Remote	18	85.7
In-person	3	14.3
<b>Location at time of evaluation</b>		
Ciudad Juárez, Mexico	16	76.2
Monterrey, Mexico	1	4.8
Celaya, Guanajuato, Mexico	1	4.8
Ethiopia	1	4.8
Jordan	1	4.8
Iraq	1	4.8
<b>Year of evaluation</b>		
2021	7	33.3
2022	13	61.9
2024	1	4.8
<b>Reasons for application</b>		
Medical and psychological	10	47.6
Psychological only	8	38.1
Family separation	2	9.5
Medical only	2	9.5
<b>Outcome</b>		
Granted Title 42 exemption	7	33.3
Granted HP	5	23.8
Unknown outcome*	4	19.0
Pending	4	19.0
Granted HP with subsequent removal <sup>†</sup>	1	4.8

\* Contact with the client was lost.

† One client was granted HP but was unable to get to the border, and HP was subsequently revoked due to the order of removal.

tle 42 exemption. One of these clients was granted HP based on the submitted letter of medical vulnerability, but HP was revoked after the client could not safely reach the U.S.-Mexico border from their existing location in the interior of Mexico. Evaluation characteristics and outcomes are detailed in Table 2.

#### *Forms of ill treatment*

*General forms of mistreatment:* Among clients whose applications centred on psychological reasons, common forms of mis-

**Table 3.** *Mistreatment and psychological sequelae in clients applying for psychological reasons*

	Frequency label	Number (n = 18)	Percent
<b>Forms of mistreatment</b>			
Physical assault	Typical	9	50.0
Sexual assault	Typical	9	50.0
Threats of death or harm	Variant	7	38.9
Robbery	Variant	5	27.8
Racial/ethnic discrimination	Variant	4	22.2
Forced confinement	Variant	4	22.2
Intimate partner violence	Rare	3	16.7
Family separation	Rare	3	16.7
Verbal assault	Rare	2	11.1
<b>Psychological sequelae</b>			
Symptoms of PTSD	General	17	94.4
Diagnosed PTSD*	Typical	16	88.9
Symptoms of depression	Typical	13	72.2
Diagnosed MDD*	Typical	12	66.7
Symptoms of anxiety	Variant	5	27.8
Diagnosed GAD*	Variant	4	22.2
Suicidality	Rare	3	16.7

\* Based on DSM-5 criteria

treatment reported in their histories included physical and sexual assault, each occurring in 50.0% of cases (Table 3). Physical assault often coincided with other types of abuse, such as intimate partner violence and robbery. Perpetrators of physical

violence varied, ranging from close relationships like intimate partners or family members to strangers such as local gang members or unknown assailants. Several clients disclosed experiences of sexual abuse, often perpetrated by distant family members during childhood. Noteworthy are two instances of sexual assault occurring at the U.S.-Mexico border where clients sought humanitarian protection. One client from Haiti was bound, forced into a car, and sexually assaulted by two men in Ciudad Juárez. Another client was sexually abused and raped by a former employee at her shelter.

*Variant forms of mistreatment.* Variant mistreatment forms encompassed threats of harm (38.9%), robbery (27.8%), forced confinement (22.2%), and racial or ethnic discrimination (22.2%). Threats of death or harm typically originated in the client's country of origin. Perpetrators' relationships with the clients varied. For instance, a Honduran client and her husband, who owned a stall, faced extortion and death threats from gang members demanding "taxes." Another client received "threatening text messages from her ex-partner and her family, taunting her and referencing her HIV diagnosis." In yet another case, an alleged rapist persistently "harassed, intimidated, and threatened [the client] and her mother with death due to [the client's] parents' determination to bring him to justice." Despite seeking police intervention, the threats persisted in all cases, with some clients explicitly advised by the police to leave the country for their own safety. Regarding robbery cases, four out of five clients were robbed in Mexico while en route to the U.S. border, with two incidents occurring in Ciudad Juárez, where clients sought shelter. Among the noted cases of forced confinement, two Honduran clients were kidnapped and held hostage in Mexico (kidnappings of migrants by cartels are commonplace on the border). Another client from Haiti reported being kidnapped with her son and sexually assaulted in her country of origin, while her son was deprived of food and water. In instances of racial or ethnic discrimination, all three clients housed in Ciudad Juárez experienced verbal abuse at the border. The ethnic backgrounds of these clients were Garifuna, an Afro-indigenous ethnic minority; Quechua, an indigenous ethnic minority; and Haitian. The client from Haiti explicitly stated that this discrimination prevented him from finding work or accessing health care.

*Rare forms of mistreatment:* Rare instances of mistreatment included intimate partner violence (16.7%), separation from family (16.7%), and verbal abuse (11.1%). Intimate partner violence was documented in three cases: one involving repeated head trauma inflicted by a prior domestic abuser, resulting in "loss of consciousness and subsequent concussive symptoms on at least three separate occasions," one case where a "former

partner purposely drove over her foot with his motorcycle, requiring surgical intervention,” and another of physical assault by a first cousin, whom the client was compelled to marry in return for land. Singular occurrences of mistreatment involved property seizure, police intimidation, coerced marriage, and attempted abduction.

#### *Psychological sequelae*

Among clients seeking humanitarian protection on psychological grounds ( $n = 18$ ), symptoms of post-traumatic stress disorder (PTSD) were prevalent in nearly every client, with all but one provisionally diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria (Table 3) (American Psychiatric Association, 2013). Symptoms often manifested as intrusion, as seen in one client who, after experiencing threats from a local gang, reported feeling “afraid and unsafe when her husband is not around...[and] fearing a repeat kidnapping when she hears footsteps near her.” Other frequently noted symptoms included negative mood changes (low self-esteem, guilt, negative affect, feelings of isolation) and avoidance of reminders of the trauma. Depression symptoms were typical, affecting 72.2% of clients; of these, all but one were diagnosed with major depressive disorder (MDD). One 15-year-old client with MDD expressed feeling as if “something must be wrong with him to be the target of so many attacks from his peers and his teachers.” Anxiety symptoms varied, occurring in 27.8% of clients, with generalised anxiety disorder diagnosed in all but one of these cases. One client’s anxiety was exemplified by his need “to leave his job at a car repair shop only two weeks after starting due to his fear that something dangerous would happen to him, and because his difficulty breathing from his anxiety was exacerbated by wearing a mask at work.” Instances of suicidal thoughts were noted infrequently, with an occurrence rate of 16.7% in the evaluations. Of these three cases noting suicidality, two involved active suicidal ideation and one a history of suicidality in adolescence; plans and intent were not documented in the affidavit (of note, based on one’s interpretation of the Immigration and Nationality Act [INA], suicidality can be considered grounds for inadmissibility) but were addressed following the evaluation in collaboration with the referring attorney and local organizations. Mistreatment and psychological sequelae are depicted in Table 3.

#### *Medical reasons for seeking humanitarian protection*

In cases where clients applied for humanitarian protection due to inadequate access to care in their current country of residence, a variety of diagnoses spanning multiple body systems were observed. These evaluations revealed unique medical justifications,

each noted in singular cases across the cohort. Diagnoses included atrial myxoma, cerebral palsy, developmental delay, gastritis, gastrointestinal bleed, human immunodeficiency virus (HIV), hypertension, kidney failure requiring transplant, lung disease, unrepaired umbilical hernia, and one case of a congenital urologic disorder. All these clients sought HP to access treatment in the U.S., which was unavailable in their country of current residence. Two applications were solely on medical grounds. In one case, a mother was granted HP as the primary caregiver for her son, a U.S. citizen requiring specialised care due to repeated strokes caused by atrial myxoma. The other case involved an 18-year-old woman with kidney failure receiving inadequate dialysis and awaiting a transplant.

#### **Discussion**

Previous studies have highlighted shifts in the demographic composition of U.S. asylum seekers supported by asylum clinics. While historically dominated by male individuals fleeing political persecution in Africa, the current trend shows a prevalence of female victims from the Northern Triangle escaping domestic and gang violence (Cuneo et al., 2021; Gallagher et al., 2022; Zero et al., 2019). Our findings corroborate these trends, with a majority of our cohort being female (61.9%), and nearly half originating from Honduras or Guatemala.

In our study, the primary basis for seeking HP or Title 42 exemption was a combination of physical and psychological reasons. Usually, these medical needs would develop independently and become exacerbated due to a lack of accessible medical and/or psychiatric care in the client’s country of origin and residence. For example, one client exhibited PTSD and MDD due to a history of physical, psychological, and sexual abuse by a former partner, and years later developed an abdominal hernia at the U.S.-Mexico border that required urgent surgical intervention. However, the interplay of physical health and mental health cannot be overstated, and unmet medical needs may play a role in the development and worsening of psychological distress in this context (a lack of perceived safety can also contribute significantly to this). Notably, psychological reasons accounted for the majority (85.7%) of applications, underscoring the profound impact of trauma and mental health issues in this vulnerable population and the subsequent need for sufficient and accessible mental health services. It is important to note that the inaccessibility of mental health services is not exclusive to asylum seekers but extends to the general population in Mexico. This shortage is exacerbated by a surge in mental health challenges, including a high prevalence of mental disorders, insufficient funding for support systems, and low utilisation of available services due to stigma from the general population and

from psychiatrists (Lagunes-Cordoba et al., 2021). Neglecting psychological needs during the asylum process could have both immediate and long-term repercussions. These may include worsening mental health among individuals and greater economic costs for host countries, driven by increased healthcare utilisation and reduced workforce participation (Trautmann et al., 2016). Hence, early intervention and comprehensive mental health support are crucial for both the well-being of asylum seekers and the interests of the countries of transit.

Our findings regarding the psychological impact on clients seeking humanitarian protection are consistent with existing literature, which consistently reports high rates of PTSD, depression, and anxiety symptoms (Cuneo et al., 2021; Emery et al., 2022; Lasowski et al., 2023; Wikholm et al., 2020). Particularly noteworthy is the prevalence of PTSD in our cohort, with almost all clients seeking protection based on psychological grounds exhibiting some symptoms of PTSD, which may be particularly pronounced in this setting due to isolation and a perceived lack of safety at the border. Importantly, traumatic events triggering PTSD were not confined to pre-migration but also occurred in transit and post-migration, including experiences of physical and sexual assault, robbery, and confinement (Andisha and Lueger-Schuster, 2024; Atrooz et al., 2022; Carlsson and Sonne, 2018; Goodkind et al., 2021). Of the seven clients who shared experiences of trauma outside their home countries, five mentioned incidents in Ciudad Juárez. These included two cases of sexual assault, racial discrimination, and robbery, as well as one case of verbal abuse and forced confinement. Four clients reported trauma from another Mexican city before reaching the border. This included three cases of forced confinement, two cases of physical assault and sexual assault, one case of verbal abuse, and incidents of robbery and forced separation. One client experienced trauma in Panama, involving physical assault and witnessing a sexual assault, while another client experienced robbery in Guatemala. Thus, our findings demonstrate the perilous conditions migrants face while seeking humanitarian protection, especially during transit and after migration, indicating the need for greater support for migrants at every stage of their journey.

Our findings also suggest that protracted transit settings, such as areas on the U.S.-Mexico border, fall short of providing adequate protection for refugees and asylum seekers, evident in the risks of kidnapping, disappearance, sexual assault, trafficking, and other grave harms faced by migrants. Such risks are affirmed in a 2017 report by Doctors Without Borders, which found that 68.3% of migrants and refugees entering Mexico from the Northern Triangle reported being victims of violence during their transit towards the United States, and 31.4% of

women and 17.2% of men had been sexually abused during their transit through Mexico (Médecins Sans Frontières, 2017) and other reports (Cuneo & Janeway, 2020). Notably, an unsafe environment can lead to exacerbation of PTSD symptom burden, which could partially explain the very high prevalence of PTSD in our sample. Although the United States does not maintain a Safe Third Country Agreement with Mexico, certain U.S. policies, including the Migrant Protection Protocols, have functionally presumed that Mexico could provide complementary protection while claims proceed. In general, the “safe third country” concept presupposes access to a full and fair procedure for determining an asylum claim or to an equivalent form of temporary protection (U.S. House of Representatives, 1952). However, an Amnesty International report found that 75% of individuals passing through migration detention centres in Mexico were not informed of their right to seek asylum (Amnesty International, 2018). Given the dangers faced by migrants seeking humanitarian protection at the U.S.-Mexico border and the inadequacies in Mexico’s refugee protection system, it is imperative to be critical when considering whether a country can provide adequate protection to ensure that asylum seekers are not subjected to further harm or mistreatment in transit. Strengthening support to build an effective refugee protection system in countries of transit and addressing the risks faced by migrants at borders are essential steps to ensuring the safety and well-being of those seeking humanitarian protection.

Lastly, the use of remote modalities in conducting medico-legal evaluations for asylum seekers has emerged as a valuable and accessible tool for individuals seeking protected immigration status (Bayne et al., 2019; Green et al., 2020; Mishori et al., 2021; Pogue et al., 2021; Simeon and Cuneo, 2023). These evaluations have empowered clinicians to conduct thorough assessments of the psychological consequences stemming from human rights violations, playing a pivotal role in bolstering asylum claims and guiding immigration adjudicators. This study’s findings add to existing data supporting the utility of remote medico-legal evaluations in immigration proceedings, as all cases that were known to have been granted HP and Title 42 exemption were conducted remotely. Because this consecutive case series lacks a valid comparison group, we cannot infer that reports associated with known grants differed from others, and we avoid benchmarking our outcomes against system-wide DHS figures, which aggregate heterogeneous parole pathways and count events rather than unique individuals. Constructing a valid counterfactual cohort would require cases matched on key drivers of parole decisions and outcomes, including pathway (USCIS, CBP, or ICE), custody status, legal posture, urgency or medical severity, country conditions, and

timing or port practices. Many of these factors are unobserved, not publicly available, or discretionary. In the context of a rapidly evolving landscape where remote activities are becoming increasingly prevalent across various sectors, the acceptance and integration of remote forensic evaluations for asylum seekers hold significant promise for improving access to critical assessments for vulnerable populations. Further exploration of potential action plans for the risk of remote evaluations, such as responding to active suicidal ideation in a client, alongside a comparative analysis of outcomes between remote and in-person evaluations, will be crucial in solidifying the efficacy, safety, and comparability of remote forensic evaluations in supporting claims for humanitarian protection.

FMEs can carry risks of psychological distress or re-traumatisation during recounting; this requires trauma-informed interviewing, explicit consent, strict confidentiality, and referral pathways for clients exhibiting acute stress reactions during the encounter. They may also entail privacy and data security vulnerabilities, especially when conducted remotely in unstable settings, and communication risks when working through interpreters. Remote modalities can limit nonverbal observation and physical examination, and uneven access to trained evaluators can create evidentiary inequities. We mitigated these risks by adhering to ethical principles consistent with the Istanbul Protocol (do no harm, consent, confidentiality), using secure channels, pre-briefing, supporting interpreters, working with legal organisations to identify appropriate referral pathways in cases of acute distress, and limiting detail to what is necessary for medico-legal purposes.

Although the Title 42 public-health order ended on 11 May 2023, processing reverted to Title 8 authorities. HP remains a discretionary, case-by-case tool under INA §212(d)(5), and adjudicators across parole, asylum, and Convention Against Torture proceedings continue to consider medical and psychological evidence. FMEs therefore remain pertinent for documenting trauma-consistent findings, clinical needs, and risk, and for supporting lawful-pathway submissions (including HP) and protection claims under current policy.

### Conclusion

Our study adds critical evidence to the existing body of literature on the significant impact of trauma and mental health challenges on migrants and asylum seekers. Of note, we report several cases that reveal numerous forms of mistreatment faced by migrants in countries and towns of transit toward the U.S.-Mexico border, drawing attention not only to the personal suffering endured but to the systemic challenges and human rights violations encountered by individuals seeking safety and asylum.

Hence, our study contributes to the political discourse of what constitutes a “safe third country,” indicating the necessity for enhanced protections, advocacy, and policy interventions to safeguard the rights and dignity of migrants. The significance of our findings becomes especially apparent in light of the “transit” bans by both the Trump and Biden administrations. These policies penalise asylum seekers who do not seek humanitarian protection in countries they transit through on their way to the U.S., despite the lack of safe conditions many clients described while in transit. Lastly, our findings affirm the utility of remote cross-border medical evaluations in assisting individuals seeking HP or Title 42 exemption, offering a practical solution to extend protection to those in need.

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