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Research Paper

Characteristics and scope of humanitarian relief forensic medical evaluations for immigrant children in the US

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ABSTRACT

According to US Customs and Border Protection, over 473,000 family units and 76,000 unaccompanied children were apprehended in 2019, a multi-fold increase from previous years. Thus, the number of children who may be eligible for humanitarian relief has increased significantly. For those claiming humanitarian relief, forensic medical evaluations performed by health professionals can provide critical evidence to bolster claims. In this cross-sectional, nationwide survey—in which we sought to characterize specialties, forensic training, capacity, and scope of humanitarian relief evaluations for immigrant children under eighteen-years-old—only 28 providers, half of whom were Child Abuse Pediatricians, reported performing humanitarian relief evaluations. The most common reported type of humanitarian relief evaluation conducted was for asylum. We found that the current training for forensic medical evaluations for humanitarian relief in pediatrics is likely varied not well-defined, and not pediatric-specific. In order to protect the rights of children who are eligible for humanitarian relief, pediatric and family medicine forensic medical evaluation training standards and curricula need to be developed; validated humanitarian relief screening tools need to be tested and utilized; and residents and attending physicians, including specialists with expertise in forensic evaluations, need to be actively recruited to perform these evaluations in collaboration with legal aid organizations.

1. Introduction

According to US Customs and Border Protection, over 473,000 family units and 76,000 unaccompanied children were apprehended at the US Southwest border in 2019, a multi-fold increase from previous years.[1] Many of these children are eligible for various types of humanitarian relief (HR), for which they can apply to obtain documented status to protect their right to reside in the US. These types of HR include, but are not limited to, asylum, a right guaranteed under the 1948 Universal Declaration for Human Rights.[2] Asylum can be granted to those seeking protection based on "persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion."[3] Children who are eligible for other forms of HR should have applications submitted concurrently to increase the likelihood of achieving lawful status; these include Special Immigrant Juvenile Status (for children who have suffered parental abuse, abandonment, or neglect), T-visas (for victims of human trafficking), or U-visas (for victims of criminal activity), and protection under the Violence Against Women Act.[4] Without HR, children may be forced to return to a home or intermediate country, where their lives may again be in danger.

For those claiming HR, forensic medical evaluations may be performed when a legal representative refers the client to a medical provider through professional contacts, academic asylum clinics, or organizations like Physicians for Human Rights. The client's attorney may suspect or is aware of physical or mental health morbidity related to past persecution, torture, abuse, or neglect. The attorney then requests the assessment to evaluate for objective clinical evidence. Asylum

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evaluators are typically licensed clinicians who may have obtained further training in performing forensic medical evaluations. These medical evaluations provide critical evidence to bolster immigrants' HR applications. In one evaluation of 1663 adult cases over four years, 89% of asylum seekers who had undergone a medical evaluation were granted asylum. This is in contrast to a national average grant rate of 37.5%.[5,6] Given the significant increase in children arriving at US borders seeking legal protections, there is a need for a HR workforce with expertise to perform both medical and mental health forensic evaluations in children.

Despite the recent staggering increase in immigrant children arrivals—including over 17,000 unaccompanied children per month apprehended in spring 2021 as COVID-19 restrictions loosened and the Biden Administration re-opened the southern border—many factors have limited children's ability to apply for and obtain HR.[7] According to the US Citizenship and Immigrant Services, between fiscal years 2016–2018, only approximately 5000 Special Immigrant Juvenile visas and 3600–6000 asylum claims were granted per year.[8–10] Furthermore, U-Visas and T-visas are capped at 10,000 and 5,000, respectively, per year.[11] In the US, there is currently a backlog of over 1.3 million cases, with wait times to adjudicate cases presenting to the legal system of over four years.[12] Even for those able to overcome wait time and quota obstacles, shortages of legal and medical professionals may further prevent immigrant children from receiving HR for which they may qualify. These shortages include, but are not limited to, (1) a lack of training of frontline medical, educational, and social work providers to appropriately identify children who may qualify for HR; (2) inadequate numbers of US immigration lawyers to represent all cases (of the 15,000 members of the American Immigration Lawyers Association, 2000 identified as specializing in asylum protection); (3) a shortage of trained medical providers to perform pediatric forensic medical evaluations.[13]

Although there are many known personnel shortages and obstacles to HR for children, little is known about the frequency in which pediatric medical asylum evaluations are performed or the number of generalists and subspecialists who perform these evaluations. In this cross-sectional, nationwide survey which targeted clinicians who work with immigrants as well as Child Abuse Pediatricians—subspecialists who focus on diagnosis and treatment of child abuse in collaboration with multidisciplinary teams and perform screening for mental health needs[14]—we sought to characterize specialties, forensic training, capacity, and scope of medical HR evaluations for immigrant children under eighteen-years-old.

2. Methods

2.1. Survey instrument development

The cross-sectional survey was developed with input from key medical and legal stakeholders using cognitive interviews and the "think aloud" approach for survey development. The study was deemed exempt by the Yale Institutional Review Board (exemption ID # 2000027343) and the final Qualtrics survey was reviewed by psychometric expert prior to dissemination (Appendix).

2.2. Listserv selection

In order to track distribution, the survey was administered to six listservs with instructions not to disseminate more widely. The six listservs were identified through discussions with experts in immigrant, refugee, and asylee health and in Child Abuse Pediatrics (Fig. 1). One of the lists was compiled from a prior scoping survey previously administered by co-author KW, which identified providers of pediatric asylum medicine who agreed to be contacted for future correspondence. While there was likely overlap between listservs, the maximum number of possible respondents was 1069.

2.3. Inclusion criteria

Listserv members were asked to participate (a) if they had performed an HR evaluation on a child <18, or (b) if they were a Child Abuse Pediatrician. Child Abuse Pediatricians were included specifically because of their skillset in forensic medical evaluations and interactions with children who may be eligible for HR.

Responses were excluded from analysis if they (a) did not meet inclusion criteria or (b) key inclusion criteria questions were unanswered (Fig. 1).

2.4. Survey distribution

The survey was distributed to each of the six listservs and was open for two months (April–June 2020), with one reminder email sent halfway through the study period. Additionally, preliminary results were presented at a virtual pediatric asylum medicine conference, and these attendees were asked to also complete the survey. However, zero of the attendees completed the survey, most likely because most were members of one of the six listservs.[15]

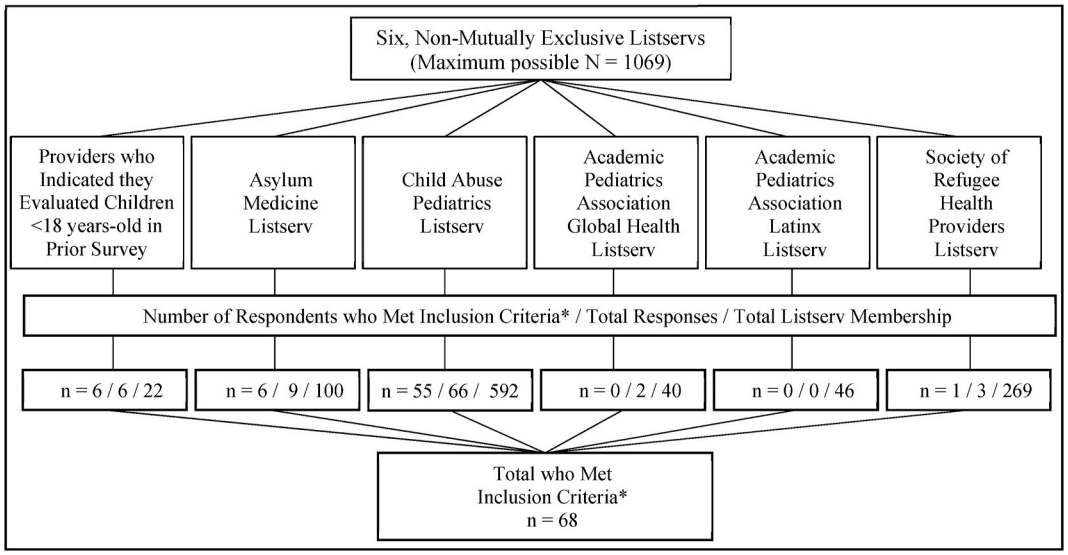

Fig. 1. Listserv respondents who met inclusion criteria.

2.5. Analysis

Data were exported from Qualtrics and descriptive statistics were analyzed in Stata.[16]

3. Results

3.1. Respondent characteristics

A total of 86 responses were collected (minimum response rate given overlap of listservs = 7.5%); 68 met inclusion criteria for analysis, and 28 of those (41.1%) reported completing an HR evaluation for a child under eighteen years old. The remaining 40 respondents who had not completed an HR evaluation (58.8%) were Child Abuse Pediatricians (Fig. 2).

Of the 28 who reported completing an HR evaluation for a child under 18 years-old, 17 (68.0%) were female, the median age was 52-years-old (range 31–72 years-old), and all four regions of the US were represented. Of those who had completed an HR evaluation, half (50%) were Child Abuse Pediatricians, followed by Pediatricians (21.4%) (Fig. 2). Median years of practice was 17.5 (range 2–41), and median years of performing HR evaluations was 7 (range 2–29) (Table 1).

Table 1
Respondent demographics (n = 68).

	Respondents who Performed HR Evaluations (n = 28)	Child Abuse Pediatricians who had not Performed HR Evaluations (n = 40)
Female, n (%)	17 (60.7%)	26 (76.5%)
Age in Years, Median (range)	52 (31–72)	48.5 (31–75)
Years of Practice, Median (range)	7 (2–29)	14 (2–47)
Type of Provider, n (%)		
Resident/Fellow	1 (3.6%)	3 (7.5%)
Practitioner/ Provider	24 (85.7%)	25 (87.5%)
Retired Practitioner/ Provider	3 (10.7%)	2 (5%)
Degree, n (%)		
MD, DO or Equivalent	25 (89.3%)	40 (100.0%)
PhD	3 (10.7%)	0 (0.0%)
Currently Licensed, n (%)	27 (96.4%)	40 (100.0%)
Regions of US, n (%)		
Northeast	9 (32.1%)	7 (17.5%)
Midwest	5 (17.9%)	12 (30.0%)
Southeast	3 (10.7%)	6 (15.0%)
Southwest	3 (10.7%)	5 (12.5%)
West	5 (17.9%)	4 (10.0%)
Referred *to* Legal Aid Organization for HR	17 (60.7%)	8 (20.0%)

HR = Humanitarian Relief.

3.2. Referral to legal aid organizations

Of those who reported performing HR evaluations, 60.7% reported that they had referred children to a legal aid organization for evaluation for HR. By contrast, 20% of the 40 Child Abuse Pediatricians who had not performed an HR evaluation had referred children to legal aid organizations (Table 1).

3.3. Training for humanitarian relief evaluations

Reported training for HR evaluations varied greatly. Non-mutually-exclusive training reported by respondents included Physicians for Human Rights (39.3%), individual mentorship (35.7%), training from legal colleagues (25.0%), listserv advice (17.9%), HealthRight International (71.%), Child Abuse fellowship training (7.1%), university-based training (3.6%), and no formal training (3.6%) (Table 2).

3.4. Total evaluations performed

Respondents were asked to estimate the number of evaluations they had performed over the course of the past year and over the course of a year five years prior. Not all respondents completed this part of the survey, but of those who did, nine stated they had performed at least one HR evaluation in the past year (with a median of four evaluations per year) and eight stated they had performed evaluations five years prior (with a median 2.5 evaluations per year) (Table 2).

3.5. Setting of evaluations

The most common setting for HR evaluation was reported to be academic institutions (53.6%), and 32.1% of respondents reported performing evaluations in an asylum clinic and 25.0% indicated that the

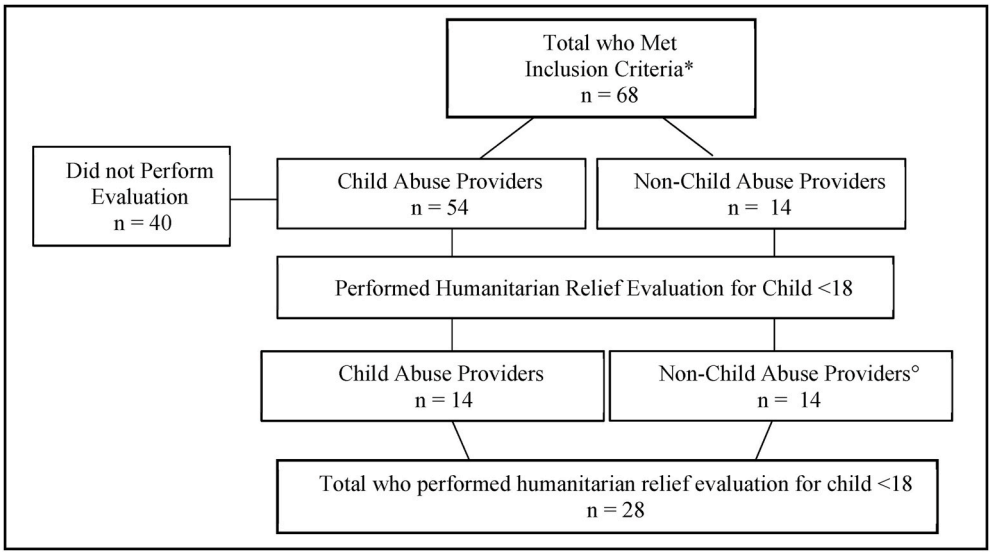

Fig. 2. Characteristics of respondents who met inclusion criteria.

Table 2
Characteristics of HR evaluators (n = 28).

Years of Performing Evaluations, Median (Range)	7 years (2–29 years)
Types and Ages of Evaluations Performed,[a] n (%)	
Medical Evaluations for Children <18-year-old	15 (53.6%)
Medical Evaluations Ages 18-26 years-old	7 (26.9%)
Medical Evaluations Age >26 years-old	7 (25.0%)
Mental Health Evaluations for Children <18 years-old	7 (25.0%)
Mental Health Evaluations Ages 18-26 years-old	6 (21.4%)
Mental Health Evaluations Age >26 years-old	6 (21.4%)
Types of Humanitarian Relief Evaluations Performed,[a] n (%)	
Asylum	23 (82.1%)
Female Genital Mutilation/Cutting	13 (46.4%)
Special Immigrant Juvenile Visa	12 (42.9%)
Violence Against Women Act	7 (25.0%)
U-Visa	7 (25.0%)
T- Visa	5 (17.9%)
Convention Against Torture	4 (14.3%)
Type of Training Received,[a] n (%)	
Physicians for Human Rights	11 (39.3%)
Individual Mentorship	10 (35.7%)
Training from Legal Colleagues	7 (25.0%)
Advised by Listserv	5 (17.9%)
HealthRight International	2 (7.1%)
Fellowship Training (Child Abuse Pediatrics)	2 (7.1%)
University-Based Training	1 (3.6%)
No Formal Training	1 (3.6%)
Setting of Evaluations,[a] n (%)	
Academic Institution	15 (53.6%)
Asylum Clinic	9 (32.1%)
Trainee-Organized Clinic	7 (25.0%)
Office of Refugee Resettlement Shelter or Detention Center	6 (21.4%)
Independent Clinic	5 (17.9%)
By TeleVideo	2 (7.1%)
By Telephone	1 (3.6%)
Private Practice	1 (3.6%)
Child Advocacy Center	1 (3.6%)
Volunteer Free Clinic	1 (3.6%)
Trainees Involved in Clinic	16 (57.1%)
Receive Compensation for Evaluation	2 (7.1%)
Youngest Client Evaluations	
Youngest Medical Evaluation Completed, Median (Range),	5.5 years-old (2-15 years-old)
Youngest Medical Evaluation *would* complete, Median	<1 year-old
Youngest Mental Health Evaluation Completed, Median (Range)	6 years-old (5-15 years-old)
Youngest Mental Health Evaluation *would* complete, Median	7-9 years-old
Estimated Number of Evaluations Performed *in Past Year*, Median (IQR)	
Medical Evaluations (n = 7)	2 exams (1–4 exams)
Mental Health Evaluations (n = 4)	4 exams (1–7 exams)
Combined Medical/Mental Health Evaluations (n = 3)	3 exams (1–3 exams)
Total Evaluations (Medical, Mental Health, and/or Combined) (n = 9)	4 exams (2–14 exams)
Estimated Number of Evaluations Performed *Five Years Ago*, Median (IQR)	
Medical Evaluations (n = 6)	3.5 exams (1–5 exams)
Mental Health Evaluations (n = 1)	2 exams (2-2 exams)
Combined Medical/Mental Health Evaluations (n = 2)	1.5 exams (1–2 exams)
Total Evaluations (Medical, Mental Health, and/or Combined) (n = 8)	2.5 exams (2–3 exams)

[a] Non-Mutually Exclusive.

clinic was student- or trainee-organized. Other settings, among others, included detention centers (21.5%), independent clinics (17.9%), and televideo (7.1%). Over half (57.1%) of clinics involved trainees or students, and two respondents (7.1%) reported that they received compensation for their evaluations (Table 2).

3.6. Types of humanitarian relief evaluations

The most common reported type of HR evaluation conducted was for asylum (82.1%); other HR evaluations included female genital mutilation/cutting (46.4%), Special Immigrant Juvenile Visas (42.9%), Violence Against Women Act (25%), T-Visas (sex or slave labor trafficking) (17.9%), U-Visa (US crime victims) (25%), and Convention Against Torture (14.3%) (Table 2).

3.7. Youngest humanitarian relief evaluations

Respondents were asked to report the youngest age of children that they had evaluated. For medical evaluations, the median reported youngest age was five-and-half-years-old, with a range of two-to fifteen-years-old. For mental health evaluations, the median reported youngest age was six-years-old, with a range of five-to fifteen-years-old. When asked about the youngest age for which a respondent would agree to perform an evaluation, the median age for medical evaluations was under one-year-old and for mental health evaluations was the range of seven-to nine-years-old (Table 2).

4. Discussion

This study assesses the current national scope of pediatric forensic medical evaluations for HR. Despite a multi-fold increase in both unaccompanied minors and family units who may be eligible for HR, in this targeted, national survey, we received responses from only 28 providers, who reported performing HR evaluations, and 14 (50%) were Child Abuse Pediatricians.

We found that the current training and settings for forensic medical evaluations for HR in pediatrics are varied. Recently, standards and best practices for adult evaluations and a guide for pediatric asylum evaluations have been published.[6,17] However, most asylum evaluation training programs—including the programs reported by respondents such as Physicians for Human Rights and HealthRight International—are not pediatric-specific, highlighting a need to institute such training. Training curricula need to address pediatric developmental stages and their impact on clinical manifestations of traumatic stress.[17] Curricula and training also are needed to ensure that principles of trauma-informed care are followed to minimize re-traumatization and to ensure children's safety and well-being.[17,18] Thus, there are opportunities for future directions in this field related to training, collaboration, advocacy, and research, which we discuss below and summarized in Table 3.

Results of this study point to opportunities for engagement and collaboration with health providers, including and beyond the Child Abuse Pediatrician work force. The Child Abuse Pediatrics specialty, an Accredited Council for Graduate Medical Education specialty since 2006, trains fellows in multiple skills relevant to HR and forensic medical evaluations. Training requirements include, "performance of age-appropriate examinations and forensic evidence collection" and "knowledge of epidemiology of childhood injuries, biomechanics of childhood trauma; anatomy and pathophysiology as they relate to the effects of child abuse, including normal variants and conditions that mimic findings of child abuse; forensic pathology; laws and legal procedures related to child maltreatment."[14] However, there are currently only 350 boarded Child Abuse Pediatricians practicing in the US.[14] It is clear that they cannot fill the gap of performing all pediatric medical forensic examinations for immigrant children alone. There is an opportunity to address the gap in care by standardly engaging medical providers, including Child Abuse Pediatricians and subspecialists from across disciplines and backgrounds with expertise in trauma-informed and/or forensic care, to collaborate with, mentor, and train pediatric providers to perform forensic medical evaluations.

Many children may present to front-line providers in emergency rooms, clinics, and inpatient units with histories that support the need

Table 3
Next steps to improve identification of at-risk children and linkage to pediatric humanitarian relief evaluations.

1. Standardize training curricula	Develop, formalize, and share pediatric medical and mental health forensic evaluation training materials with organizations, individuals, and specialty mentors who train evaluators. Materials should address pediatric developmental stages and impact on clinical manifestations of traumatic stress.
2. Expand engagement and collaboration with specialists for mentorship, training, and consultation	Expand existing networks of providers and create standard processes to engage specialists from across disciplines and backgrounds with expertise in trauma-informed and/or forensic care
3. Establish "legal triage" for medical, mental health, and social work providers.	Develop and standardize validated tools for health care providers to appropriately identify children needing legal supports.
4. Advocate to improve access to both legal and medical representation for children	Health care and legal providers should advocate at individual, organizational, and systems levels for policies to ensure both legal representation and trauma-informed medical evaluations are available for children seeking legal humanitarian relief.
5. Establish bidirectional, streamlined medical-legal referral networks	Expand immigrant-focused medical-legal partnerships and outreach to ensure that both medical and legal providers are aware of (1) the value of forensic evaluations and (2) local, national, and international resources for humanitarian relief evaluations.[19–22]
6. Conduct longitudinal research	Harness partnerships to coordinate and track pediatric legal humanitarian relief cases to expand the knowledge base related to outcomes and to disseminate emerging best practices.
7. Expand access to specialty listservs	Reduce barriers and gating that currently exist to reach certain listservs for recruitment and knowledge sharing across specialties.

for consultation with an immigration attorney. However, currently, there is no training available for medical staff to perform "legal triage" to appropriately identify children needing legal supports. Our study demonstrates that few providers currently refer undocumented immigrant children to legal counsel. To improve access to HR, education, training and streamlined legal linkage must be made available to individual providers to help identify children in need of legal services. This can include the development of validated screening tools to identify children who may qualify for HR. Health systems should develop capacity and operationalize legal supports and referrals by formalizing medical-legal partnerships that focus on legal status supports.

There are also opportunities for the development of streamlined regional referral networks of both medical and mental health providers trained to perform pediatric asylum examinations as well as immigration attorneys able to take on cases. The recently-established US-based Society for Asylum Medicine is an example of one such network, whose mission is to, "create a community of physicians, mental health providers, and other caregivers, as well as legal and human rights professionals who work with individuals seeking asylum.[19]" Such networks, especially those with pediatric asylum training, could improve access for referring providers as well as for children and families seeking expert representation for HR and for other forms of legal protection, including for victims of human trafficking within the US.

This study had several limitations. Overall, only 86 responses were collected, and of those, only 68 met inclusion criteria and only 28 respondents reported having performed an HR evaluation. Thus, there is concern for low response rate and generalizability. However, this was a targeted survey that harnessed responses from a prior, broader scoping survey of asylum medicine providers. The study was also specific to the US, and while all regions of the continental US were represented, no additional respondents were recruited from a specialized medical conference specifically addressing pediatric medical asylum evaluations. Thus, the small *n* likely reflects and confirms our hypothesis that few providers have conducted HR evaluations, and, although we cannot make broad generalizations from these data, there clearly is a need to expand this workforce to serve the human rights and needs of the hundreds of thousands of immigrant children in the US who may be eligible for HR. Another limitation is that this survey mainly targeted medical pediatric providers, and likely mental health providers and other allied health professionals who already may be providing these evaluations may have been excluded. The Child-Abuse Listserv, for example, only targeted physicians and did not include other advanced practice providers. Additionally, several of the respondents did not fill out sections of the survey about the estimated number of children they had seen and the respective age groups, which further limits generalizability around these data. Finally, we could not analyze data related to unaccompanied minors. Although we asked questions related to unaccompanied minors, respondents indicated through free-text comments that they were unclear of the definition of "unaccompanied minor" and we chose to exclude these data for concerns about question validity. The low response rate and difficulty accessing closed listservs (e.g., listservs representing adolescent medicine providers, mental health professionals, and allied health professionals), limited the ability to delineate the national scope of the current pediatric HR landscape. Expanded access to specialty listservs could help to improve response rates and scope for future studies.

5. Conclusions

Although the number of children who may be eligible for HR evaluations has increased multi-fold, this nationally-distributed survey of medical providers indicated that few are performing forensic medical evaluations for HR. Although this survey did not capture all HR evaluators, especially certain mental health providers and allied health professionals, for the 28 providers who reported performing forensic medical evaluations for HR, training was variable and non-standardized. Few reported that they identify and refer immigrant children, *de novo,* to legal aid organizations for HR evaluations. The right to asylum and legal protection may be undermined when few medical providers are trained in evaluation practices or the rights of asylum-seekers. Those who are trained to perform forensic medical evaluations, such as Child Abuse Pediatricians, could be more frequently involved, both directly and indirectly, with HR evaluations for immigrant children. In order to protect the rights of children who are eligible for HR, pediatric forensic medical evaluation training standards and curricula need to be developed, validated HR screening tools need to be tested and utilized, and residents and attending physicians, including subspecialists with forensic expertise, need to be actively recruited to perform these evaluations in collaboration with legal aid organizations.

CRediT author statement

Julia Rosenberg: Conceptualization, Methodology, Formal analysis, Investigation, Resources, Data curation, Writing – original draft, Visualization. Emily Edwards: Conceptualization, Formal analysis, Data curation, Writing – review & editing. Karen H Wang: Conceptualization, Methodology, Resources, Writing – review & editing, Supervision. Katherine C McKenzie: Conceptualization, Methodology, Validation, Writing – review & editing. Andrea G Asnes: Conceptualization, Resources, Writing – review & editing, Supervision. Janine Young: Conceptualization, Methodology, Formal analysis, Writing – review & editing, Supervision.

Declaration of competing interest

None declared.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.jflm.2021.102221.

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