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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Should Count as Best Practices of Forensic Medical and Psychological Evaluations for Children Seeking Asylum?

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Abstract

The process of being granted asylum is complex, often taking months and years. Asylum seekers face high risk of being denied asylum in the United States. As medical and psychological evaluations assist in achieving successful asylum outcomes, human rights asylum clinics are being established throughout the country to facilitate these types of evaluations. The Midwest Human Rights Consortium, a multi-institutional, interdisciplinary initiative, is working to streamline the referral process and increase the evaluator workforce through training and mentorship of practitioners. More work is needed to establish evidence-based, child-centered, and trauma-informed best practices in training evaluators and performing evaluations.

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Case

AA was 17 years old when his attorney referred him for a psychological forensic asylum evaluation. He is one of many such individuals interviewed during years-long processes of conducting such evaluations. He was born in a Central American country and arrived in the United States during the prior year. He left his home due to gang violence and believed his life would be in danger if he returned. He was transferred from a US Customs and Border Protection (CBP) detention center to a shelter under contract with the US Department of Health and Human Services Office of Refugee Resettlement (ORR), which aims to assist and provide resources to refugees, asylum seekers, and newly arrived immigrants to the United States. Following eventual release to a sponsor, who must be a US citizen or legal permanent resident who agrees to offer food, shelter, health care, and other necessities for at least 6 months,[1] and who, in this case, is a trusted friend of AA's family, AA awaits a response to his asylum application.

When AA was 9, his mother's boyfriend beat him severely and frequently. Despite numerous calls, police did not intervene, and his mother was unable to protect him. AA left home several times to escape and experienced intermittent homelessness. At age 14, while staying with a friend, AA was threatened with a machete and money was

extorted from him by Mara Salvatrucha (MS-13) gang members. After defending himself against attack by one of the gang members, AA was severely wounded. In danger and without protection, AA journeyed to the United States.

Commentary

The story of AA mirrors that of thousands of other asylum seekers from the Northern Triangle (El Salvador, Guatemala, and Honduras) who travel thousands of miles to reach the US southern border to escape the threat of MS-13, one of the 2 largest gangs in the Northern Triangle.[2] MS-13 is a transnational gang considered to be a byproduct of civil war, a complex history of US immigration policy, and ongoing Northern Triangle country policies.[3] MS-13 is notorious for its brutality and use of extreme violence.[4] A history of political unrest, corruption, easy access to US-made weapons, the transnational US drug trade, and instability have rendered the Northern Triangle governments unable to protect their citizens from widespread gang violence.[5] AA applied for asylum, a form of protection for anyone who is unable or unwilling to return to their home country and cannot obtain protection in that country due to past persecution or a well-founded fear of being persecuted in the future on account of "race, religion, nationality, membership of a particular social group or political opinion."[6]

The United States currently has a record number of asylum-seeking youth arriving along the Mexican border.[7] Obtaining asylum is an involved process that includes multiple governmental agencies (eg, CBP, Department of Homeland Security, ORR) and other entities (eg, the immigration court system, community resettlement agencies, shelters for unaccompanied minors). Notably, rates of asylum denial have reached record highs, with judges denying close to 74% of asylum cases in fiscal year 2020.[8] The process itself can take years. Illinois, for example, has one of the longest wait times (1404 days on average as of October 2021).[9] Although authorized to stay, asylum seekers are left in limbo without legal status while their cases are pending.

The Midwest Human Rights Consortium (MHRC), a multi-institutional, interdisciplinary initiative, is working to streamline the referral process and increase the evaluator workforce through training and mentorship of practitioners. Drawing from the work of MHRC, the following discussion outlines the complexity of medical and mental health forensic evaluations and the need for establishing clearer guidelines for best practices.

Medical and Psychological Forensic Evaluations

There is strong evidence that medical and psychological forensic evaluations aid in providing critical evidence of trauma, torture, or abuse that can significantly affect the outcome of unaccompanied children's asylum cases[10,11,12] and increase the likelihood of being granted asylum.[13,14] The evaluation can also serve to document and raise awareness of issues that necessitate specific resources and services to support the child (eg, mental health treatment and resources, educational supports, and medical care). Despite the inarguable benefits of these evaluations, there is no permanent infrastructure in place to ensure that children have access to them. Although Chicago is a major metropolitan area with numerous immigrant-serving organizations and shelters where unaccompanied children are placed, there was, until recently, no formal system facilitating the critical interdisciplinary collaboration required to offer such evaluations.

To address this need, we established and developed the MHRC. Housed within the Illinois chapter of the American Academy of Pediatrics, this multi-institutional, interdisciplinary initiative has developed a formal referral process that connects

attorneys to evaluators on behalf of their asylum-seeking clients. MHRC also engages in efforts to train and build a workforce of professionals to perform the evaluations and support the establishment of asylum clinics throughout the Chicagoland area.

Establishing Standards for Evaluations

If MHRC is to appropriately evaluate AA, standards should be established in the areas of (1) evidence-based best practices employed in the evaluation process, (2) systematized training, and (3) resources to competently and ethically perform the evaluation.

Evaluation process. While the field of asylum medicine is expanding and there are broad guidelines, such as Physicians for Human Rights guidelines[15] and the Istanbul Protocol[16]—both of which deal with evaluating asylees for torture and ill treatment—there is no universal standard of specific assessment criteria when evaluating asylum seekers whose trauma does not fall under the strict definition of torture. In particular, there is a limited framework for evidence-based best practices when working with unaccompanied immigrant children whose claims generally fall outside traditional categories qualifying for asylum. For example, in the absence of state-sanctioned torture and scars, should the court rely on psychological instruments and tools to draw out objective information or information that can be codified?

Working with children also brings up the importance of informed consent. As with all clinical interactions, it is essential to obtain informed consent for performing a forensic evaluation.[17] For children, informed consent requires the approval of the legal representative of the child.[18] However, undocumented, unaccompanied immigrant children are not automatically assigned legal guardians. Who is responsible for providing consent for an unaccompanied child under the age of 18 to participate in a forensic evaluation? Who protects their story and how it is used by the court system or government? Who decides how the child's story should be shared? It is critical to develop an explicit process for gaining a child's consent, regardless of age.

Such questions also raise concerns around data security. The process of conducting the assessment, as well as exchanging information with the attorney and others involved, is fraught with data ownership and security concerns, privacy considerations,[19] and risks of overlooking implications (eg, involving language or communication barriers or manifestations of mental illness). Thus, potentially damaging notes written by a therapist who is not culturally sensitive and who is employed by a governmental shelter may remain in AA's file, affecting the outcome of his case.

The issue of health information privacy as it applies to unaccompanied children is being debated in our legislature.[20] Given rapidly changing technology and commonly used modes of electronic communication, explicit guidelines concerning record protection and information sharing (eg, referral information, drafts of the evaluation) will help protect the privacy of the asylum applicant. Guidelines about the level of detail documented in the file, as well as honoring asylum seekers' wishes concerning whom their file can be shared with and how much information can be shared, should inform best practice standards.

The interview process poses its own challenges. For example, memory distortion[21] due to severe trauma can affect not only applicants' ability to provide a coherent narrative but also their credibility. Memory distortion is particularly a risk for young children who have experienced trauma and disrupted attachments that might affect their neural

development and their social and emotional capacity.[22] In such instances, best standards should require supporting interviews from the child's teachers and caretakers and documentation from their home country if available. Moreover, best practice standards for interviewing children and asylum seekers who share their narratives must incorporate a trauma-informed lens, with special attention to how they tell their story and a nuanced understanding of how trauma can impair memory. The kind of information retained in an affidavit also needs to be standardized.

Training. MHRC and similar initiatives can increase the evaluator workforce by supporting different evaluation models. Each asylum evaluation model (eg, medical school, academic center, or individual community-practitioner based) presents a unique set of challenges. Ideally, training new forensic assessment evaluators involves opportunities for trainees to observe how evaluations are conducted. However, clients are often unwilling to have observers present. Moreover, there are multiple risks of retraumatization when evaluators ask children to provide the details of their narrative, especially in settings where multiple trainees are involved. While medical school-based clinics are designed to process evaluations expediently, they necessitate the presence of trainees and observers during interviews and examinations of an intimate, emotionally intense, and potentially traumatic nature.

The need for an asylum applicant to disclose sensitive trauma narratives and physical scars to multiple people in a nontherapeutic setting for training purposes should be made transparent, and the evaluation should be structured in the least intrusive way. What guidelines should be incorporated that engage a trauma-informed approach and consider the best interests and rights of the child? Guidelines originally developed for asylum and immigration officers can inform best practice standards that utilize a trauma-informed interview approach, including child-friendly opening statements, building rapport to help the child feel secure, nonadversarial questioning, active listening, and assessing the child's comfort level when speaking with others (eg, parent or family member, observer) in the room and the child's level of fear during the interview.[23] Given the traumatic content of the child's narrative, the evaluator is at risk of experiencing vicarious trauma and thus needs critical self-awareness, self-reflection, and support through mentorship and consultation. This type of support, however, is not always available. Finally, clinicians might be formally trained in forced migration, immigration policy, mental illness, child abuse, or forensic documentation. Training in these areas is not required or regulated, but lack of training can affect an affidavit's quality and client-evaluator interactions.

Resources. There is variability in the resources (eg, time, institutional support and funding, physical spaces for the forensic interview, mentorship) available to clinicians to conduct evaluations, which affects systemic capacity to meet the wider demand for evaluations. Depending on the complexity of the case, it can take up to 10 to 20 hours to complete the assessment and write-up. For a community-based practitioner, these labor and time-intensive assessments are usually conducted pro bono or outside normal clinic hours, whereas medical student-run clinics and clinics operating within an academic setting have protected time and infrastructure to offset cost. Academic clinics operating within medical centers and universities that are not student run might offer more experienced clinicians without trainee requirements. However, academic clinics can accommodate only a limited number of clients.

Conclusion

Aside from the years 2016 to 2020, asylum seekers have been allowed to enter the United States while their claims are being processed.[24] The United States anticipated over 300 000 new asylee and refugee claimants in fiscal year 2021,[25] a number likely to be influenced by—despite efforts to end it—the recently reinstated "Remain in Mexico" policy (ie, Migrant Protection Protocols), whereby asylum seekers wait in Mexico for their cases to be heard in US immigration courts. As of October 2021, a backlog of over 1.4 million immigration cases remains,[26] each requiring legal, social, and health services for asylees and training for officers, health evaluators, attorneys, and judges in trauma-informed care. While the number of US asylum clinics has increased, the field of asylum medicine also continues to grow and evolve.[17]

As MHRC works to strengthen its network and develop best practice standards, it must continue its collaboration with the various professionals and players involved with the asylum evaluation process and continue to use a transdisciplinary lens in gaining consensus on what should be standard best practices in conducting asylum evaluations. While there is evidence that asylum success rates have increased under the current administration,[27] understanding what factors have contributed to these success rates can inform the broader practices of attorneys and evaluators who work with asylees. More specifically, understanding what elements contribute to a stronger forensic asylum evaluation should inform best practices.

Increased dialogue through round tables, conferences, and trainings that involve medical and mental health practitioners, attorneys, judges, and asylees or refugees themselves is critical to promoting a better understanding of the immediate and long-term effects of complex trauma in children who have experienced danger in their home country and are experiencing an ongoing sense of fear. Furthermore, advocating for legislative and structural support and funding to enable increased legal representation, evaluator workforce capacity, and implementation of best practices will also be critical. There is much state, national, and international work to be done collectively.

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