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# Characteristics and Guardianship Status of Children Undergoing Forensic Medical and Psychological Evaluation for Asylum in Miami

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## Abstract

To add to the limited evidence on forensic medical and psychological evaluations of children experiencing distress migration and seeking asylum in the United States, this paper describes the sociodemographic characteristics, nature of human rights violations, and guardianship status of the children served by the Human Rights Clinic of Miami from 2010 to 2021. Through a retrospective study of affidavits, we identified trends among sociodemographic characteristics and types of human rights violations and used bivariate analysis to determine factors associated with guardianship. Children constituted 17% of all evaluations conducted during this period. Approximately half were male, and two-thirds were aged 15–17 years. Honduras was the most common country of origin, and physical violence was the most reported human rights abuse, followed by gang violence. Most children reported being detained at the United States–Mexico border. Only a third had a guardian present during the evaluation, with guardianship significantly more likely for younger children. This study provides insight into the health needs of children affected by distress migration. It underscores how children's experiences of forced migration and the barriers they face in accessing essential safeguards illustrate critical gaps in protecting their right to health.

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## Introduction

In 2023, there were 6.9 million asylum seekers—individuals seeking international protection from conflict or persecution—globally, including approximately 2 million children.[1] Particularly concerning from a human rights perspective is the sharp increase in the number of migrant children arriving in the United States. In 2022, over 300,000 children were apprehended at the United States–Mexico border, a five-fold increase since 2008.[2] The number of unaccompanied children—those most at risk of exploitation, violence, and neglect—also rose seventeen-fold between 2008 and 2019.[3] These children are often fleeing systemic violence, extreme poverty, and other conditions that constitute severe breaches of their human rights. These circumstances are characteristic of distress migration, or migration that "stems from desperation, vulnerability, and need, from living circumstances that are experienced as unbearable or deeply unsatisfactory and that precipitate serious obstacles to a reasonable or tolerable life."[4] Thus, their access to protection and care and their right to health are urgent global concerns.

The rights of asylum seekers are firmly established in international law as a cornerstone of human dignity and justice. While article 14 of the Universal Declaration of Human Rights proclaims that everyone has the right to seek and enjoy asylum from persecution in other countries, this article is aspirational and nonbinding, meant to set a global standard of rights that inspired later legally binding agreements. In contrast, the 1951 Refugee Convention, a binding international treaty, mandates that individuals seeking asylum must not be expelled or returned to situations where their lives or freedoms would be in danger.[5] Children, as particularly vulnerable individuals, are afforded further protections under the Convention on the Rights of the Child, including appropriate protection, humanitarian assistance, and family reunification.[6] In the United States, the Department of Justice's 1998 Guidelines for Children's Asylum Claims state that "the harm a child fears or has suffered may be relatively less than that of an adult and still qualify as persecution" and that "it is generally unrealistic to expect a child to testify with the precision expected of an adult."[7] These protections reflect a global commitment to safeguarding the rights of those displaced by violence, persecution, and severe adversity, especially those most vulnerable.

Despite the well-established human rights basis for asylum, political and legal systems have often undermined the timely and fair realization of these rights. In the United States, where the right to seek asylum is also articulated in the law, the backlog of immigration cases has surged over the past decade.[8] As of 2024, there are more than 3.3 million pending cases, with an average wait time of 762 days in 2023.[9] Further, asylum outcomes in the United States are heavily influenced by access to quality legal representation and the discretion of immigration judges.[10] Data from 2017–2022 for Miami, Florida, for example, show a stark contrast in outcomes, with asylum grant rates varying from 0.9% to 27.9%, depending on the judge presiding over the case.[11] This variability raises concerns about the consistency and fairness of asylum adjudications and highlights the importance of supporting fair asylum judgments through legal and medical interventions.

Forensic medical and psychological evaluations play a critical role in asylum claims, particularly those involving human rights abuses. During these evaluations, impartial and unbiased health professionals identify physical or psychological signs of trauma and determine the degree of consistency between these signs and the individual's history. They document their evaluation in an affidavit that is submitted as a component of the individual's asylum application and, in some cases, provide expert testimony in immigration courts. Finally, they identify medical or psychological needs for follow-up care. If the medical evidence matches the asylee's history, medical evaluations increase an individual's likelihood of being granted asylum.[12] For example, one analysis determined that 89% of individuals seeking asylum in the United States whose application included a forensic evaluation were granted asylum, compared to the national average of 37.5% among those whose applications did not include such an evaluation.[13]

While a limited body of evidence exists on the characteristics of adult asylum seekers receiving such forensic medical and psychological evaluations, even less is known about the characteristics of children receiving such evaluations. Likewise, while a handful of guidance documents and training materials are available that provide specific guidance on conducting forensic evaluations for children, there remains a lack of consensus on several issues, such as how to address guardianship (or lack thereof) and best practices for minimizing re-traumatization during the evaluation process.[14] Thus, to improve our understanding of the characteristics and health needs of children seeking such evaluations, this paper describes the sociodemographic characteristics, nature of human rights violations, and guardianship status of the children served by the Human Rights Clinic of Miami from 2010 to 2021. In examining these factors, we seek to shed light on the complex vulnerabilities of children navigating distress migration and underscore the urgent need to address gaps in safeguarding their right to health within the asylum process and beyond.

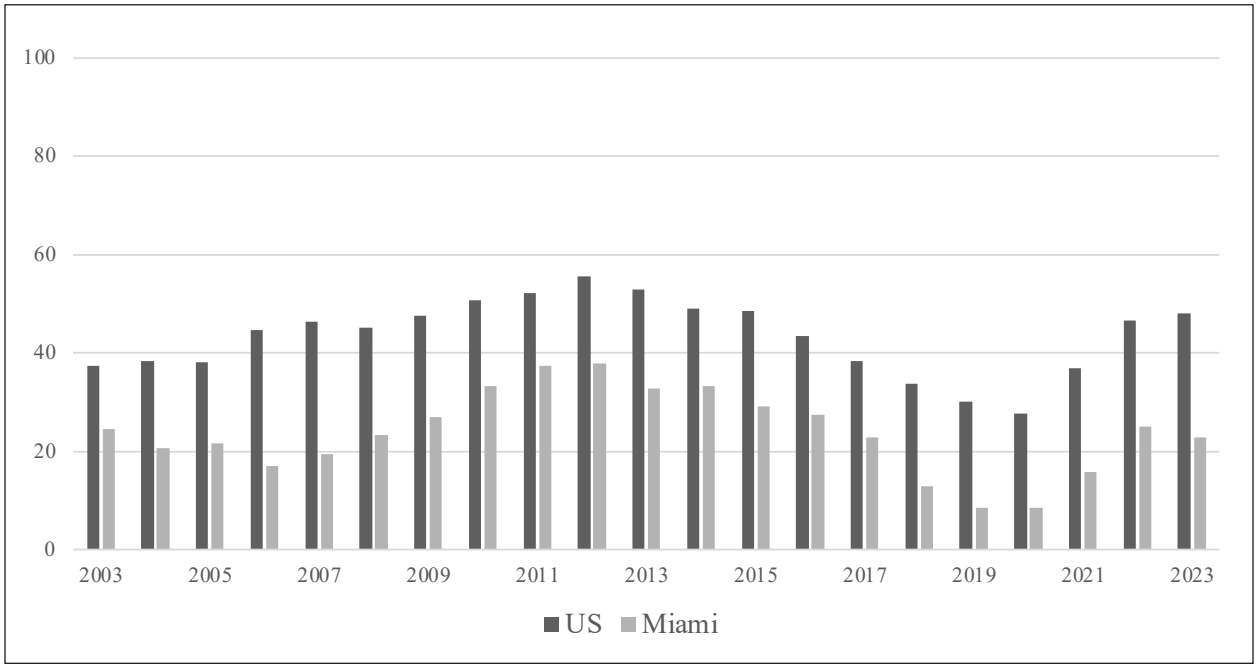
## Methods

### *Study setting*

As of August 2024, Miami-Dade County had the most pending immigration court cases in the United States, totaling over 325,000, with an average of 567 days pending.[15] The percentage of applications granted asylum in Miami is consistently below the national average; it decreased from a high of 37.9% in 2012 to a low of 8.4% in 2019, and has since increased again to 22.8% in 2022 (Figure 1).[16]

The Human Rights Clinic of Miami is affiliated with the University of Miami Miller School of Medicine and provides forensic medical and psychological evaluations for asylum seekers in Miami, Florida. It was established in 2010 and is the only medical student-run asylum clinic in Miami-Dade County. The clinic flow is as follows: the student scheduling director receives requests for medical or psychological evaluations from an individual seeking asylum in the United States or their lawyer; they then identify an available physician, student scribe, and translator (if needed) from the clinic's staff. The physician seeks consent from the individual seeking asylum (or their guardian in the case

FIGURE 1. Percentage of applications granted asylum in the United States as a whole vs. Miami, 2003–2023



of individuals less than 18 years of age) for (1) the collection of basic sociodemographic information for research purposes (importantly, the collection of this information is not required for the evaluation to take place) and (2) for the evaluation itself. If consent for the former is provided, a short survey is administered to collect basic sociodemographic information from the individual. If consent for the latter is provided, the physician then conducts the evaluation, while the student scribe documents the encounter. The student scribe prepares a draft affidavit, which is revised and finalized by the physician and shared with the individual or their lawyer for use in their asylum case. To maintain impartiality, the clinic does not directly provide medical or psychological services for needs identified during the evaluation; instead, a team of client navigators supports the individual in accessing relevant services after the evaluation.

### *Data collection*

A retrospective chart review was conducted of all affidavits prepared by the Human Rights Clinic of Miami for individuals less than 18 years of age between 2010 and 2021. As described above, consent for the collection of basic sociodemographic information for research purposes was sought from the children's guardians, and assent was sought from the children themselves. Given the limitation that asylum seekers often lack formal guardianship documentation, we defined guardian as the adult appointed by the lawyer to accompany and consent for the child's evaluation. Before 2020, this consisted of written consent. In 2020 and 2021, this consisted of oral consent because evaluations were conducted via Zoom due to restrictions related to the COVID-19 pandemic; oral consent was witnessed and documented by at least two other staff members of the Human Rights Clinic of Miami. The consent process (as well as the evaluation itself) was conducted in the child and their guardian's language of choice either by the physician directly or via a staff translator.

Data were accessed from the clinic's database in January and February 2022 and were extracted using REDCap electronic data capture tools hosted at the University of Miami. During data extraction, the study team had access to information that could identify individual clients; however, efforts were made to ensure client confidentiality, and identifiable information was not extracted from the database.

### *Data analysis*

Descriptive statistics were used to describe the sociodemographic characteristics and nature of human rights abuses of the children who received services from the Human Rights Clinic of Miami. Because a qualitative analysis of the nature of human rights abuses was beyond the scope of this analysis, this study used the categories recorded in the clinic's administrative data, namely physical violence, gang violence, sexual violence, political violence, and other. Bivariate analysis was used to compare children with and without a guardian present during the evaluation using Fisher's exact test for categorical variables. All statistical analyses were performed using SAS (OnDemand for Academics).

## Results

From 2010 to 2021, the Human Rights Clinic of Miami conducted forensic medical or psychological evaluations for 64 children less than 18 years of age, constituting 17% of all evaluations conducted by the clinic during that time (Table 1). Just over half of the children were male (56%). The median age was 16 years (IQR 13–17); no children were less than 5 years old. Honduras was the most common country of origin (53%), followed by Guatemala (28%) and El Salvador (11%). The majority of children reported achieving some primary (i.e., elementary) school in their country of origin (64%), while 29% reported achieving some secondary (i.e., high) school, and 8% reported receiving no education.

Regarding the human rights abuses that the children experienced in their country of origin, physical violence was most reported (72%), followed by gang violence (53%), sexual violence (22%), and political violence (3%). Political violence is defined as the deliberate use of power and force to achieve

political goals; it can include physical or psychological acts aimed at injuring or intimidating individuals or populations.[17] More boys reported experiencing gang violence than girls, while nearly all those who reported experiencing sexual and political violence were girls (Figure 2). Physical violence was reported by roughly the same number of boys and girls. Children aged 5–10 years reported experiencing physical violence most commonly, followed by gang violence; no children in this age group reported experiencing sexual or political violence (Figure 3). Most of those reporting sexual violence were 15–17 years of age.

The majority of children (87%) reported being

TABLE 1. Characteristics of children who received medical or psychological evaluations from the Human Rights Clinic of Miami, 2010–2021

| Characteristic | Total sample | n |
|---|---|---|
| Age (median, IQR) | 16 (13–17) | 64 |
| Age (n, %) | | 63 |
| <5 | 0 (0) | |
| 5–10 | 4 (6.2) | |
| 11–14 | 17 (26.6) | |
| 15–17 | 43 (67.2) | |
| Gender (n, %) | | 63 |
| Female | 28 (43.8) | |
| Male | 36 (56.2) | |
| Ethnicity (n, %) | | 64 |
| Hispanic | 62 (95.4) | |
| Non-Hispanic | 3 (4.6) | |
| Country of origin (n, %) | | 62 |
| Honduras | 34 (53.1) | |
| Guatemala | 18 (28.1) | |
| El Salvador | 7 (10.9) | |
| Haiti | 1 (1.6) | |
| Highest level of education in country of origin (n, %) | | 51 |
| None | 4 (7.7) | |
| Some primary (elementary) school | 33 (63.5) | |
| Some secondary (high) school | 15 (28.8) | |
| Type of human rights abuse (n, %) | | 63 |
| Physical violence | 46 (71.9) | |
| Gang violence | 34 (53.1) | |
| Sexual violence | 14 (21.9) | |
| Political violence | 2 (3.1) | |
| Other | 1 (1.6) | |
| Detained at the border (n, %) | 32 (86.5) | 36 |
| Number of people in house (n, %) | | 49 |
| <5 | 32 (64.0) | |
| 5–10 | 17 (34.0) | |
| >10 | 1 (2.0) | |
| Currently in school (n, %) | 48 (96.0) | 49 |
| Guardian present during evaluation (n, %) | 18 (31.0) | 57 |
| Guardian relationship (n, %) | | 18 |
| Mother | 15 (83.3) | |
| Father | 1 (5.6) | |
| Sibling | 2 (11.1) | |

detained at the border upon entry into the United States. Regarding their current conditions in Miami, 64% reported living in a home with fewer than five people, while 34% reported living in a home with five to ten people. Nearly all the children (96%) were currently attending school.

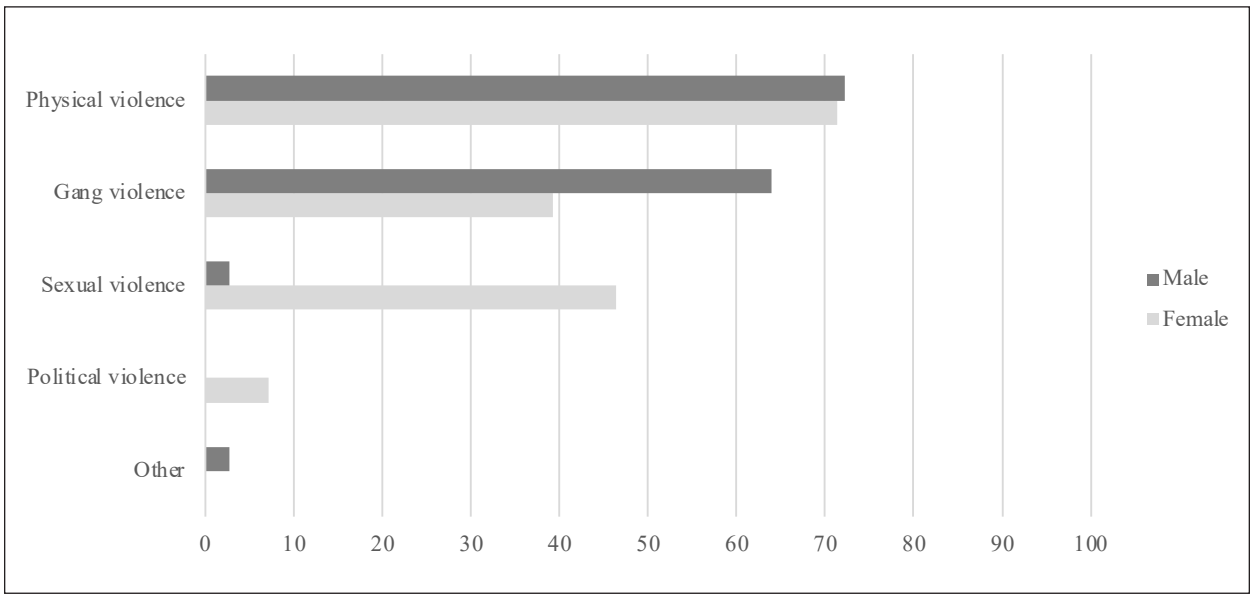
Only one in three children (31%) had a guardian present during the forensic medical and psychological evaluation. Of the guardians present, the majority were mothers (83%), followed by siblings (11%) and fathers (6%). When disaggregated by age (Figure 4), the percentage of children with a guardian present decreased from 100% of 5- to 10-year-olds, to approximately half of 11- to 14-year-olds, to only 20% of 15- to 17-year-olds. On bivariate analysis (Table 2), younger children and children with lower levels of education in their country of origin were significantly more likely to have a guardian present during the evaluation. There were no significant differences across gender, country of origin, or types of human rights abuse categories.

## Discussion

This study describes the sociodemographic characteristics, nature of human rights violations, and guardianship status of children served by the Human Rights Clinic of Miami from 2010 to 2021, contributing several significant findings to the limited available data on who these children are and why they are seeking asylum. First, children constituted nearly 20% of the patients served during the study period by the Human Rights Clinic of Miami, the only student-run asylum clinic in Miami-Dade county, which is home to the highest number of pending immigration court claims in the United States. This figure was surprisingly high, considering that children receive derivative asylum when their parents receive asylum and thus often do not require independent asylee claims. A possible explanation is that many of our pediatric clients enter the United States as unaccompanied minors. Regardless, this finding underscores the critical need for specialized resources and tailored care for pediatric asylum seekers.

Second, the reasons for seeking asylum for children are notable: physical violence was the most common form, followed by gang-related, sexual, and political violence. The data indicate important gender differences: boys were more likely to experience gang violence, while girls reported higher levels of sexual and political violence. These findings highlight the need to approach forensic evaluations with a lens of gender equality, ensuring that gender-specific experiences, particularly sexual violence against girls, are adequately accounted

FIGURE 2. Percent of children reporting different human rights abuses, by gender



for. In addition, they highlight the crucial role of such clinics in connecting these children with health and social services that safeguard their right to health as migrants in the United States, including trauma-informed mental health support and medical services. It is important to note that many

FIGURE 3. Percent of children reporting different human rights abuses, by age

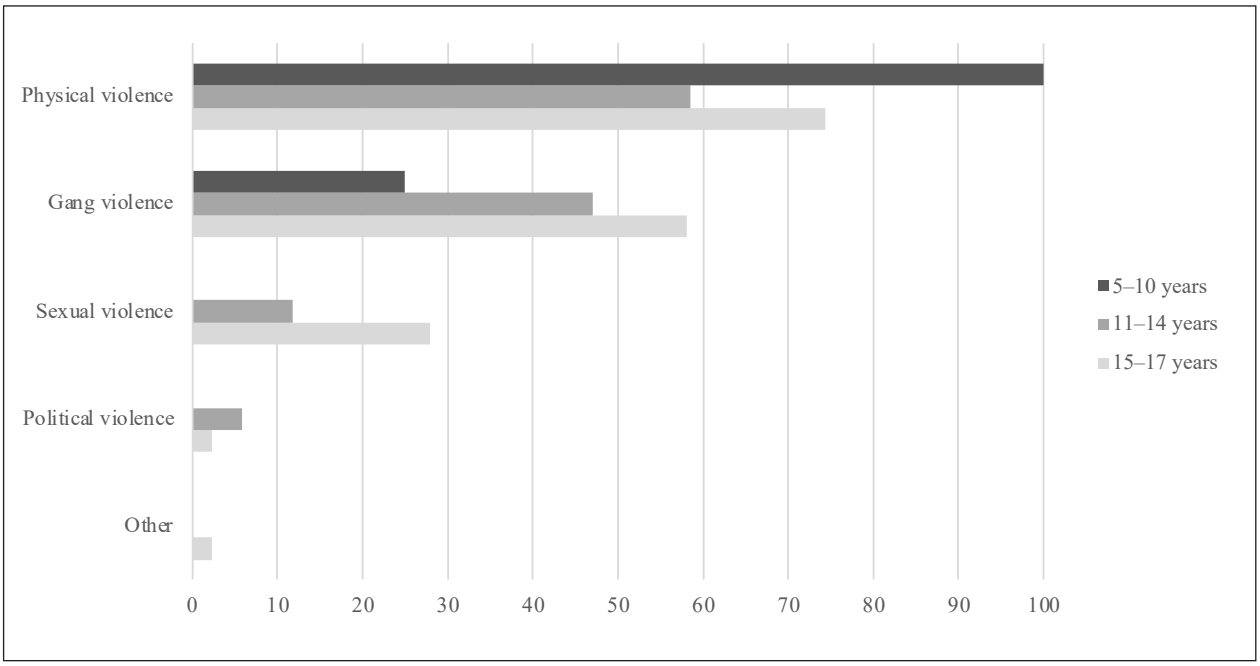


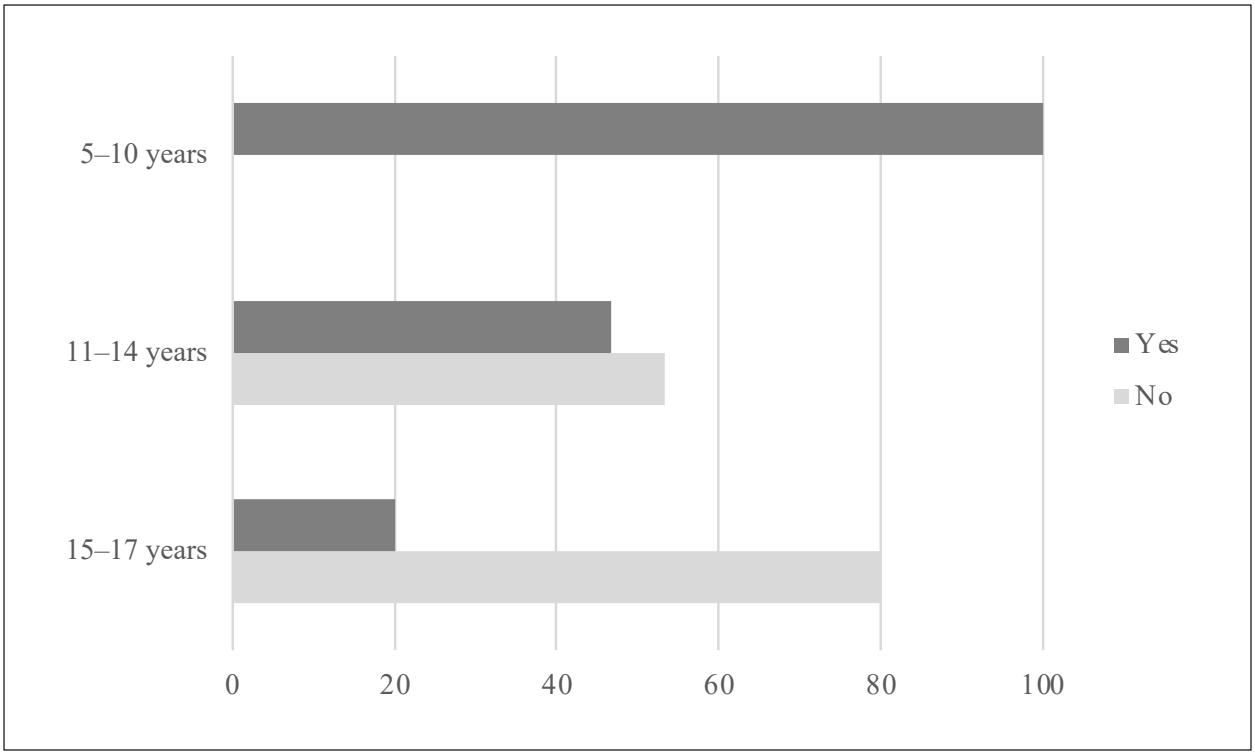

TABLE 2. Comparison of characteristics of children between those with and without a guardian present during their evaluation

| Characteristic | | Guardian present | Guardian not present | p value |
|---|---|---|---|---|
| Age (n, %) | | | | 0.005 |
| | 5–10 | 3 (100) | 0 (0) | |
| | 11–14 | 7 (46.7) | 8 (53.3) | |
| | 15–17 | 8 (20.0) | 32 (80.0) | |
| Gender (n, %) | | | | 0.256 |
| | Female | 8 (24.2) | 25 (75.8) | |
| | Male | 10 (40.0) | 15 (60.0) | |
| Country of origin (n, %) | | | | 0.557 |
| | Honduras | 10 (33.3) | 20 (66.7) | |
| | Guatemala | 5 (27.8) | 13 (72.2) | |
| | El Salvador | 2 (25.0) | 6 (75.0) | |
| | Haiti | 1 (100) | 0 (0) | |
| Highest level of education in country of origin (n, %) | | | | 0.006 |
| | None | 4 (100) | 0 (0) | |
| | Some primary (elementary) school | 10 (32.3) | 21 (67.7) | |
| | Some secondary (high) school | 2 (14.3) | 12 (85.71) | |
| Type of human rights abuse (n, %) | | | | |
| | Physical violence | 10 (24.4) | 31 (75.6) | 0.122 |
| | Gang violence | 10 (33.3) | 20 (66.7) | 0.780 |
| | Sexual violence | 6 (54.5) | 5 (45.5) | 0.079 |

children also flee their home country due to inadequate medical and legal infrastructure. In cases such as the violence documented in these affidavits, limited access to health care compounds trauma and underscores that returning to their country of origin may endanger their health and well-being. Children's right to health, integral to the asylum process, includes access to safe environments where they can live, learn, and play—essential factors in mitigating adverse childhood experiences, which are linked to chronic disease and early mortality.[18] Thus, the forensic evaluation process itself serves as a pathway to protecting the health rights of these vulnerable children.

Third, this study found that only a third of the Human Rights Clinic of Miami's pediatric patients had a guardian present during their evaluation, with older children significantly less likely than younger children to have a guardian present. This finding highlights the importance of addressing the issue of guardianship during forensic evaluations and the associated legal and ethical considerations of performing evaluations without a guardian present. In formal medical practice, the general standard is to not provide medical care without a guardian or proxy adult present. However, state laws and even individual clinics can vary in their exact rules and regulations regarding unaccompanied minors seeking medical care, and this is likely true for medical professionals who perform forensic asylum evaluations. Further, forensic evaluations for children seeking asylum have their own unique considerations. Evaluations commonly involve distressing discussions of violence, abuse, and trauma; thus, the presence of a guardian is crucial for supporting the child's emotional well-being. It is also considered normal for pediatric patients to not remember or be able to accurately describe relevant details about their experiences, especially those that occurred when they were very young; in such cases, a guardian can help by providing supplementary information. While the absence of a guardian provides the opportunity to screen for the child's safety, this can be accomplished with a guardian present by asking them to leave the room for part of the interview, and the benefits of their presence far

FIGURE 4. Percent of children with a guardian present during the evaluation, by age



outweigh the disadvantages. Although guardianship presents logistical challenges, especially in the case of unaccompanied minors at various stages in the process of receiving a court-appointed guardian, addressing this issue is essential to ensuring access to justice for these children and upholding their rights, including their right to health and well-being. Our clinic stresses the importance of a guardian being available during and after the interview for emotional support and clarifying questions; however, given the social complexity of this population, we practice on a case-by-case basis. Because our clinic does not provide medical or psychiatric treatment, we have a robust referral system in place to link patients to appropriate care. Likewise, because all the children we evaluate have legal representation that requested the interview, we continue with evaluations without a guardian present, if necessary, particularly with older children 16 years and up. Nonetheless, future protocols should prioritize securing guardianship, whether through remote consent, legal coordination, or alternative forms of support so that evaluations can take place in the legal time frame of their asylum cases. In the case that securing a guardian is not possible, unaccompanied minors would particularly benefit from the establishment of consensus guidelines to ensure that evaluations are appropriate and evidence based, given that they are an especially vulnerable population at risk for harm and misrepresentation.

The increase in children seeking asylum in the United States, and particularly unaccompanied minors, over the past decade has raised concerns regarding how best to address their distinct physical and psychological needs during forensic medical and psychological evaluations.[19] Unfortunately, there are still very few tailored resources to guide health professionals in evaluating the claims of pediatric asylum seekers, despite evidence demonstrating the importance of such evaluations in determining asylum outcomes.[20] As the number of children continues to rise, we are concerned by this lack of research and evidence-based guidelines for several reasons: (1) evaluations may miss important findings or may report findings inconsistently; (2) the objectivity of these evaluations is at a greater risk of being questioned if there is limited supportive research or consensus on practice guidelines; and (3) it will continue to be difficult to recruit pediatric trained health professionals to perform forensic evaluations in the absence of formal and standardized training. The resulting "de-professionalization" of our expertise will limit access to this important service and will widen the large inequity gap already faced by children seeking asylum. We hope that this study can serve as a launching point for further research to strengthen the field's understanding of the needs and circumstances of children seeking asylum and to maintain our high professional standard of upholding justice, equity, and the duty to do no harm.

This study's primary strength lies in its focus on children seeking asylum, a vulnerable population that is often underrepresented in legal literature, clinical practice, and research. The data gathered from the Human Rights Clinic of Miami provide valuable insights into the experiences and needs of these children. However, there are notable limitations. First, the study was conducted at a single asylum clinic with a relatively small sample size and in a particular geographic location with most individuals originating from Central and South America; therefore, the findings may not be generalizable to the broader US asylum-seeking population. Additionally, the categories of human rights abuses—physical violence, gang violence, sexual violence, political violence, and other—were limited to those recorded in the clinic's administrative data, which may not capture broader systemic issues such as socioeconomic deprivation and violations of basic rights, including the right to health, that can drive migration. Finally, while a standardized REDCap form was used to reduce variability, inconsistencies in data input, due in part to annual staff turnover, may have affected data completeness and consistency. Future research should expand this work by gathering more comprehensive data across multiple regions and asylum clinics and by further investigating the impact of guardianship and other protective factors on asylum outcomes.

## Conclusion

This study sheds light on the sociodemographic characteristics, nature of human rights violations, and guardianship status of children served by the Human Rights Clinic of Miami between 2010 and 2021. The findings emphasize the need for pediatric-specific forensic evaluation protocols that address the unique vulnerabilities of child asylum seekers. The findings of this study contribute to the broader literature on distress migration and the right to health: children seeking asylum, especially those who are unaccompanied, often experience severe trauma, and their right to health—both physical and psychological—is central to their asylum claims. By applying human rights principles, such as substantive equality, gender equality, and access to justice, the field can better protect children's rights and well-being throughout the asylum process. Future research may investigate whether factors such as guardianship affect the outcome of asylum cases, and future programmatic efforts may include the development of pediatric-specific guidelines for conducting forensic medical and psychological evaluations of children seeking asylum.

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## Ethics Approval

This study received ethics approval from the University of Miami Ethics Review Committee (IRB study number 20140865).

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