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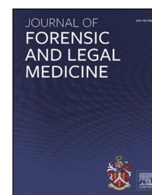

Research Paper

Conducting remote medical asylum evaluations in the United States during COVID-19: Clinicians' perspectives on acceptability, challenges and opportunities

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ABSTRACT

Background: Due to the COVID-19 pandemic, medical evaluations for asylum are being performed predominantly remotely. We sought to describe these evaluations and identify barriers.
Methodology: This study utilized an online survey to assess clinician perspectives and experiences regarding remote asylum evaluations.
Results: Clinicians reported positive experiences regarding remote interpretation (85%, 51/60), history taking (82.4%, 61/74), rapport building (81.3%, 61/75), and conducting the psychiatric exam (65.7%, 44/67). Concerns were more frequently reported with performing remote physical examinations (83.3%, 15/18). Although the majority denied challenges with technology (62.5%, 45/72), internet (60.8%, 45/74) or clients having difficulty acquiring technology (58.6%, 41/70) or finding private spaces (54.2%, 39/72), these aspects did represent barriers.
Discussion: Remote evaluations were relatively easy to perform and acceptable to clinicians. This may facilitate easier access for asylum seekers beyond the pandemic.

1. Background

The COVID-19 pandemic has forced the cessation of nearly all non-essential clinical encounters in most of the United States.[1] Asylum evaluations – the process during which a trained clinician reviews the history and performs a physical or psychological evaluation of a person seeking asylum or other forms of humanitarian relief – have had to be cancelled or postponed, with a likely negative impact on clients' abilities to obtain forensic evaluations for their case. As clinicians have adapted to remote clinical work, asylum evaluations have increasingly been performed remotely as well, although there is scant published research regarding the logistic barriers and diagnostic efficacy of remote clinical evaluations for this specific purpose and population.[2–4]

Asylum evaluations are highly specialized clinical medico-legal encounters that seek to evaluate and document evidence to corroborate asylum seekers' allegations of persecution, torture or ill-treatment. Asylum evaluations can focus on physical evidence collection, mental health evidence collection (in the form of psychiatric signs, symptoms or diagnoses related to the alleged trauma), or both. This process can be used for a variety of medico-legal situations, but when applied to a legal asylum procedure, is used to support claims that the person has a well-founded fear of returning to their home country. The international standard for such evaluations is the UN Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, also known as the "Istanbul Protocol" (IP).[5] Most often, these evaluations take place in the community, where asylum seekers reside while awaiting their immigration proceedings. There is limited formal research to suggest that these evaluations increase the chance of gaining asylum, but anecdotal and programmatic data from programs which provide these evaluations regularly indicate that the evaluations are helpful in these legal cases.[6]

The need to conduct asylum evaluations remotely preceded the COVID-19 pandemic, owing to policies which seek to geographically isolate asylum seekers, whether through prolonged confinement in remote, rural detention centers in the United States or through new policies at the U.S. southern border. The drastic asylum policy changes

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enacted by the Trump administration between 2016 and 2020 have resulted in increased numbers of clients residing in immigration detention or made to wait for their asylum hearing across the border in Mexico.[7] As a result of the challenges of accessing this population, limited funding for services, and the limited number of clinicians who perform these types of evaluations, only a small fraction of the estimated 300,000 individuals seeking refugee or asylum status in the US every year have access to clinicians who can perform evaluations to aid in the legal process, which has been further exacerbated by the requirement for physical distancing due to the COVID-19 pandemic.[8] Conducting remote asylum evaluations could enable clinicians and legal representatives to provide such services to clients who otherwise would not have access to an expert evaluation.

Telepsychiatry and remote tele-mental health services have recently been an expanding field of practice due to inadequate access and insufficient mental health workforce in rural areas of the United States.[9,15] There is considerable evidence showing similar outcomes (diagnostic accuracy, care quality, efficacy, patient satisfaction) between in-person and tele-mental health services in the general population.[2–4] Although the majority of clinical assessments performed remotely have been seen to have similar reliability to in person assessments, the results have been mixed when the assessment requires a visual component.[2–4] Concerns have also been expressed regarding the implications of telepsychiatry on building therapeutic rapport, as well as privacy-related concerns, technological challenges, and an impaired ability to respond to psychiatric emergencies.[2–4] Phone interviews have been used and found to be a reliable method to assess individuals for posttraumatic stress disorder and major depressive disorder,[10] which suggests that similar methods can be used to support such assessments in the context of asylum evaluations.

When it comes to competency assessment as part of a legal process, a few articles and resources suggest that it may be an acceptable alternative to an in-person encounter[11,12]

There has been limited research to date regarding the comparison between remote versus in-person clinical forensic evaluations as they apply specifically to the asylum process. A recent study found that telephonic and in-person asylum psychiatric evaluations were equally efficacious in obtaining a history of torture, obtaining a psychiatric history, and formulating a differential diagnosis.[4] Clinicians reported that they did not find a difference in their ability to accurately diagnose in comparison with in-person evaluations. At the same time, they reported challenges with building rapport, and found that checklists and cognitive tests were logistically more challenging to conduct over the phone. Specifically, they reported that the mental status exam was less comprehensive, since they could not accurately assess the clients' visual and physical cues, such as motor activity, appearance and facial expressions.[4]

Another study of remote forensic mental health evaluations of asylum seekers noted that "that concerted coordination of forensic mental health evaluations by telephone or video improves access to forensic evaluations and provides a feasible alternative for asylum seekers unable to obtain in person evaluations."[3]

Studies looking at the challenges and potential of the physical forensic evaluation done remotely are scarce, although there is growing evidence that clinicians have adapted quickly to conducting remote clinical encounters, as part of routine clinical care, including in specialties that traditionally benefit from in-person, physically oriented clinical encounters.

Research suggests that clinicians consider telehealth visits reliable even for the highly visual and tactile field of Dermatology, finding that "teledermatology is a useful alternative […] and has generally been accepted by patients and practitioners alike".[13] This finding could suggest that remote evaluations of scars and lesions from traumatic injuries and torture – an important part of forensic medical asylum evaluations – is also possible.

This study builds on the current research to further assess clinicians' experiences of remote asylum evaluations through use of a retrospective online survey, aimed at describing the current status of remote asylum evaluations – both physical and mental health – and identifying barriers in the remote evaluation process.

2. Methods

2.1. Participants

Surveys were distributed to 1437 licensed clinicians in a convenience sample identified and recruited through the Physicians for Human Rights (PHR) Asylum Network. Physicians for Human Rights is a US-based non-governmental organization that matches volunteer health professional with asylum seekers and their legal representatives for Medico-Legal evaluation purposes. One hundred and seventy-two of the asylum network members were known to have carried out remote asylum evaluations between March 15th and October 5th, 2020. Inclusion criteria for this study included subjects being health professionals of any discipline, over 18 years old, and having experience conducting in-person asylum evaluations. The research team also distributed the survey to 20 medical-school based PHR asylum clinics and 20 non-PHR-affiliated clinics for distribution among their independent clinician networks (some of whom are also members of the PHR Network).

2.2. Data collection

We distributed the survey twice, once in September and once in October 2020 by email and collected responses through October 2020.

2.3. Measures

The research team designed an online survey that contained logistic questions regarding remote asylum evaluations as well Likert-scale questions gauging clinician experiences. The survey included a free response section to allow for general written feedback. Not all data fields in the survey were mandatory, so there were inconsistencies in the number of responses for different questions, however this allowed for flexibility in cases where not all questions were applicable to every respondent.

2.4. Analysis

Survey answers were de-identified and stored in a secure online database. Statistical analysis was descriptive and graphing of the survey data were performed using JMP software. Free responses were qualitatively analyzed for themes.

Institutional Review Board approval was obtained from Georgetown University.

3. Results

One hundred fifty-five clinicians responded to the survey. The majority were women (79%, 121/153) and behavioral health specialists, including psychologists (18.2%, 28/154), psychiatrists (17.5%, 27/154), and therapists or social workers (16.9%, 26/154). Table 1 describes the demographics of the clinician cohort. Out of these respondents, 104 had received referrals for remote evaluations, and of those individuals 72.1% (75/104) had completed at least one of these referrals. The most cited reason for not completing a remote evaluation was not having time (53.8%, 14/26), followed by concerns about familiarity with technology (25.9%, 7/27). Several respondents noted concerns about privacy (15.4%, 4/26), legal issues (11.5%, 3/26), or not having a medical student scribe during the evaluation (12%, 3/25) (Fig. 1).

For those who did complete evaluations, most remote asylum evaluations were psychiatric (79.7%, 59/74), although several were

Table 1
Demographic information for all survey respondents.

Age	Years
Mean	53.4
Gender	**% (N/Total)**
Female	79.1% (121/153)
Male	20.9% (32/153)
Specialty	**% (N/Total)**
Psychologist	18.2% (28/154)
Psychiatrist	17.5% (27/154)
Therapist/Social Worker	16.9% (26/154)
Family Medicine	12.3% (19/154)
Internal Medicine	11.7% (18/154)
Emergency Medicine	5.8% (9/154)
Pediatrics	5.8% (9/154)
Obstetrics/Gynecology	1.9% (3/154)
Other	9.7% (15/154)
Years of Experience Conducting Asylum Evaluations	**Years**
Mean	7.1

combination psychiatric and physical (10.8%, 8/74) or physical exams alone (without gynecologic evaluations) (8.1%, 6/74), with one physical evaluation that included a gynecologic exam (1.4%, 1/74). Mean length was 2.24 h (±1.04 h), with a range of 0.75–6 h. The majority were completed by the clinician at home (87.5%, 63/72), followed by in the office (11.1%, 8/72), or a detention facility (1.4%, 1/72). Clients were also usually located at home (65%, 39/60), followed by at an office (13.3%, 8/60), in a detention facility (11.7%, 7/60), in a shelter or group home (8.3%, 5/60), or in a car (1.7%, 1/60). Evaluations were usually completed by clinicians on computers (74.0%, 54/73), followed by mobile phones (16.4%, 12/73), tablets (5.5%, 4/73), and landlines (4.1%, 3/73). For those who used applications, the platform used most commonly was Zoom (77%, 47/61), followed by What's App (9.8%, 6/61), Doxy.me (6.6%, 4/61), Google Meet (3.3%, 2/61), Microsoft Teams (1.6%, 1/61), and Facetime (1.6%, 1/61) (Table 2).

The majority of clinicians (80%, 60/75) had access to video throughout the entire clinical encounter. Most clinicians included a disclaimer in the written affidavit that stated that the evaluation was carried out remotely (91.9%, 68/74).

The vast majority of clinicians agreed that the overall experience of the remote evaluations, by and large, went well. Over 75% of the cohort agreed that they were able to remain engaged and focused for the entire encounter (92%, 69/75), that remote interpretation was effective (85%, 51/60), that the history taking went smoothly (82.4%, 61/74), and that they were able to build rapport with the client despite the evaluation being remote (81.3%, 61/75). They also reported that their clients were able to remain engaged and focused for the entire encounter (78.7%, 59/75) and that clients were not concerned about confidentiality issues (71.6%, 53/74).

A majority of the clinicians denied having issues related to technology platforms (62.5%, 45/72) or internet connectivity (60.8%, 45/75). They also rejected the notions of clients having difficulty acquiring the needed technology (58.6%, 41/70), or clients having difficulty finding a private space for the evaluation to take place (54.2%, 39/72).

Regarding conducting the psychiatric evaluation, the majority reported that they were easily able to assess mental status and affect through the client's webcam/phone camera (74.3%, 52/70), that the psychological examination was easy to conduct (65.7%, 44/67), and that there was no significant difference in their ability to obtain the history compared to an in-person evaluation (58.9%, 43/73).

However, regarding conducting the physical examination, the majority reported it was not easy overall (83.3%, 15/18), and specifically noted that it was not easy to assess physical findings through the client's webcam/phone camera (83.3%, 15/18). They rejected the notion that there was no difference in their ability to conduct a physical examination remotely compared to an in-person evaluation (80%, 16/20). Nevertheless, the majority did not arrange for an in-person visit (90.5%, 19/21).

Despite these difficulties, most clinicians did not feel that the remote nature of the evaluations affected their ability to formulate a diagnosis (72.6%, 53/73), and nearly 60% were not concerned about the admissibility of an affidavit based on a remote evaluation (58.7%, 44/75).

Overall, more than 60% of respondents noted that conducting a remote evaluation was "easier than I thought" (64.9%, 48/74) and that it was a "time saver" (60.8%, 45/74). Over half agreed they would like to continue to do remote asylum evaluation even after the COVID-19 pandemic (53.3%, 40/75), and slightly less than half felt that they were more likely to conduct more asylum evaluations if they were able to do them remotely (42.7%, 32/75). Fig. 2 provides more detail about these questions.

Clinicians were also given the opportunity to submit free responses

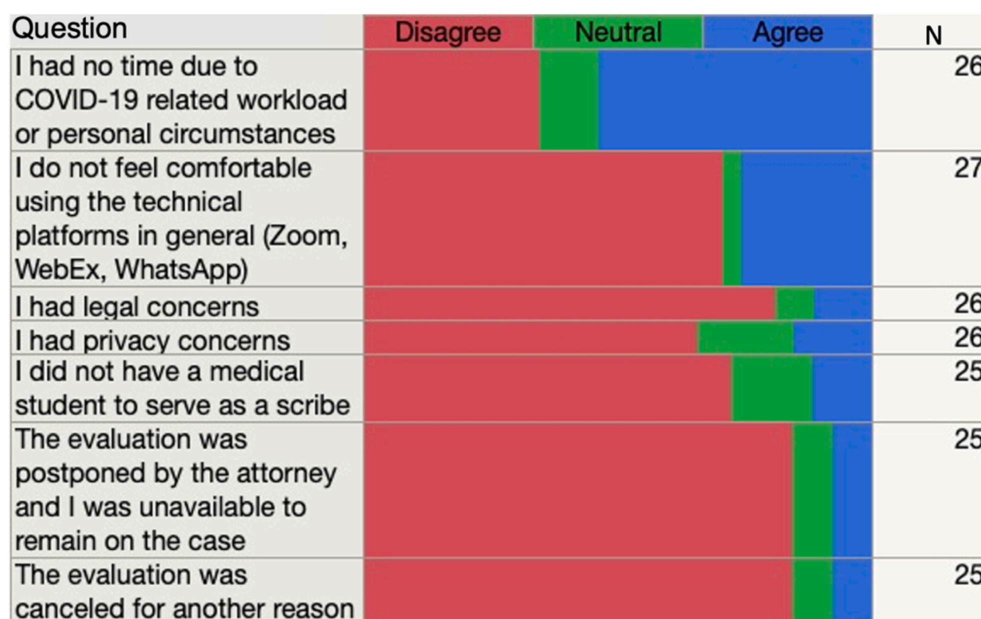

Fig. 1. Clinician reasoning for not completing a remote asylum evaluation (N = total number of respondents to each question). *Figure should include color. (For interpretation of the references to color in this figure legend, the reader is referred to the Web version of this article.)

Table 2
Type, logistics and technology of remote asylum evaluations.

Type of Evaluation	% (N/Total)
Psychiatric Only	79.7%, (59/74)
Combination Psychiatric and Physical	10.8% (8/74)
Physical Only (no gynecologic exam)	8.1% (6/74)
Physical Only (with gynecologic exam)	1.4% (1/74)
Length	**Hours**
Mean	2.24 (±1.04)
Minimum	0.75
Maximum	6
Clinician Location	**% (N/Total)**
Home	87.5% (63/72)
Office	11.1% (8/72)
Detention Facility	1.4% (1/72)
Client Location	**% (N/Total)**
Home	65% (39/60)
Attorney's Office	13.3% (8/60)
Detention Facility	11.7% (7/60)
Shelter/Group Home	8.3% (5/60)
Car	1.7%, (1/60)
Technology Used	**% (N/Total)**
Computer	74% (54/73)
Mobile Phone	16% (12/73)
Tablet	5.3% (4/73)
Landlines	4.1% (3/73)
Platform Utilized	**% (N/Total)**
Zoom	77.0% (47/61)
What's App	9.8% (6/61)
Doxy.me	6.6% (4/61)
Google Meet	3.3% (2/61)
Microsoft Teams	1.6% (1/61)
Facetime	1.6% (1/61)

describing their overall experiences regarding the remote evaluation process. Thirty-five clinicians (22.6%, 28/154) provided free text responses and the responses were reviewed for illustrative quotes. Five respondents noted the challenge of the visual examination portion of the evaluation (5/35, 14.3%). Representative quotes include: *"in-person examinations allowed much more impressive photography of lesions and abnormalities than could have been obtained remotely,"* and *"the psychiatric exam by zoom lacks the ability to assess body language."* Seven of those who responded to this portion of the survey reported experiencing challenges with the client's internet or technology access (20%, 7/35), saying, *"[t]here have been various times when I could do phone only and not video because of their phone connection and because demands more of their data to do video;" "[c]lients technology was limited. Very difficult to accurately assess psychological issues,"* and *"[i]f the client had better connectivity the interview would have been fine."* Two clinicians also described challenges regarding the logistics of coordinating a remote evaluation for a client location in detention (7.1%, 2/28), stating, *"I had to go to the jail myself and use a computer in a cubicle in the lobby of the jail to conduct the video conference"* and *"[t]he challenges typically come from the detention facility - having a private location and access to phone/internet."*

Four clinicians raised concern about the distance created by the combination of a virtual evaluation and a translator (8.6%, 3/35), and referred to this as a *"double problem,"* and an *"extra layer"* of separation from the client.

4. Discussion

The COVID-19 pandemic forced the shifting of clinical care globally from in-person encounters to technologically-enabled remote format. In a similar fashion, forensic asylum evaluations had to shift to remote platforms. In the midst of the pandemic, between March 15 and October 5th, 2020, Physicians for Human Rights placed 289 cases with clinicians meant to be carried out remotely. This is the first study of its kind to evaluate clinicians' experiences with the provision of US-based remote clinical evaluations as part of the US legal asylum process. A previous study by our team explored the provision of remote mental health forensic assessments across the US-Mexico border and showed the process was acceptable to the clinicians conducting the clinical encounters.[2]

Similarly, the vast majority of clinicians performing remote asylum evaluations had positive experiences, although many experienced challenges related to performing physical evaluations. Although the majority denied having problems with internet connectivity or technology platforms some did endorse experiencing at least some technological barriers, especially with regard to client access to technology, privacy and internet. Use of virtual translators was predominantly deemed effective, although several clinicians felt that the combination of virtual evaluations with remote translators created a personal sense of distance that impeded the evaluation.

A large majority gave positive feedback regarding their ability to build rapport virtually, which has been a concern voiced commonly about telehealth in general, and also specifically related to asylum evaluations.[10] Previous studies have noted that virtual rapport building is more commonly a concern among clinicians than patients, and again this may reflect a cultural shift to clinicians gaining comfort performing sensitive evaluations remotely, or with virtual interactions in general.[11]

Importantly, clinicians largely felt that the remote experience was a "time saver" and they would like to continue doing remote evaluations even after the pandemic, further cementing the viability of this method of performing these evaluations even when in-person clinical work can be resumed. Their acceptability of using remote platforms for asylum evaluations is important because, even after the COVID-19 crisis subsides, clinicians may be called upon to perform asylum evaluations remotely for migrant populations that are geographically isolated or held in detention.

There was significant heterogeneity in the way that these exams were performed, ranging from devices and platforms used to locations they were performed in. This reflects how evaluators and legal teams have been adapting to situations where technology may have been limited, particularly with detention centers, or other locations with limited internet access. Work needs to be done to ensure that asylum seekers have the necessary technology and space to engage in these evaluations. Obtaining access to technology may be especially challenging for clients in detention and in refugee camps, who represent the populations most likely to benefit from access to remote evaluations.

This study reinforces that there is a need for additional training and resources for clinicians who perform these evaluations to increase the comfort and ease of the process. Furthermore, as one of the most significant barriers to performing these evaluations was discomfort with the technology and virtual platforms required, training that increases familiarity with these aspects has the potential to increase clinician willingness to participate.

Our study has several limitations. First is the low response rate, with a total of 155 responses to the survey. However, given that at the time of the survey a total 289 PHR of cases had been placed among 172 clinicians, the number of respondents actually represents 90% of the total number of clinicians who took on remote evaluations from PHR. Additionally, our respondents are a self-selected and highly experienced and motivated group of clinicians. Their experiences may not be generalizable to the broader community of forensic evaluators. Among respondents, the vast majority were behavioral health experts who generally do not perform physical evaluations. This fact may have blunted the negative experiences reported by clinicians of conducting physical evaluations remotely and it is highly likely that our percentage of those reporting this as a challenge would be much higher. Further, our survey was not designed to assess the suitability of remote asylum evaluations for particular client groups, including children. Importantly, this survey only assessed clinician perspectives and was limited to US-based clinicians, and to the US asylum process specifically.

The legal perspective must be explored, specifically regarding legal admissibility in the context of US asylum adjudicators and immigrations courts in the US, privacy concerns and the use of remote evaluation disclosures. Some scholars are rightfully concerned about legal

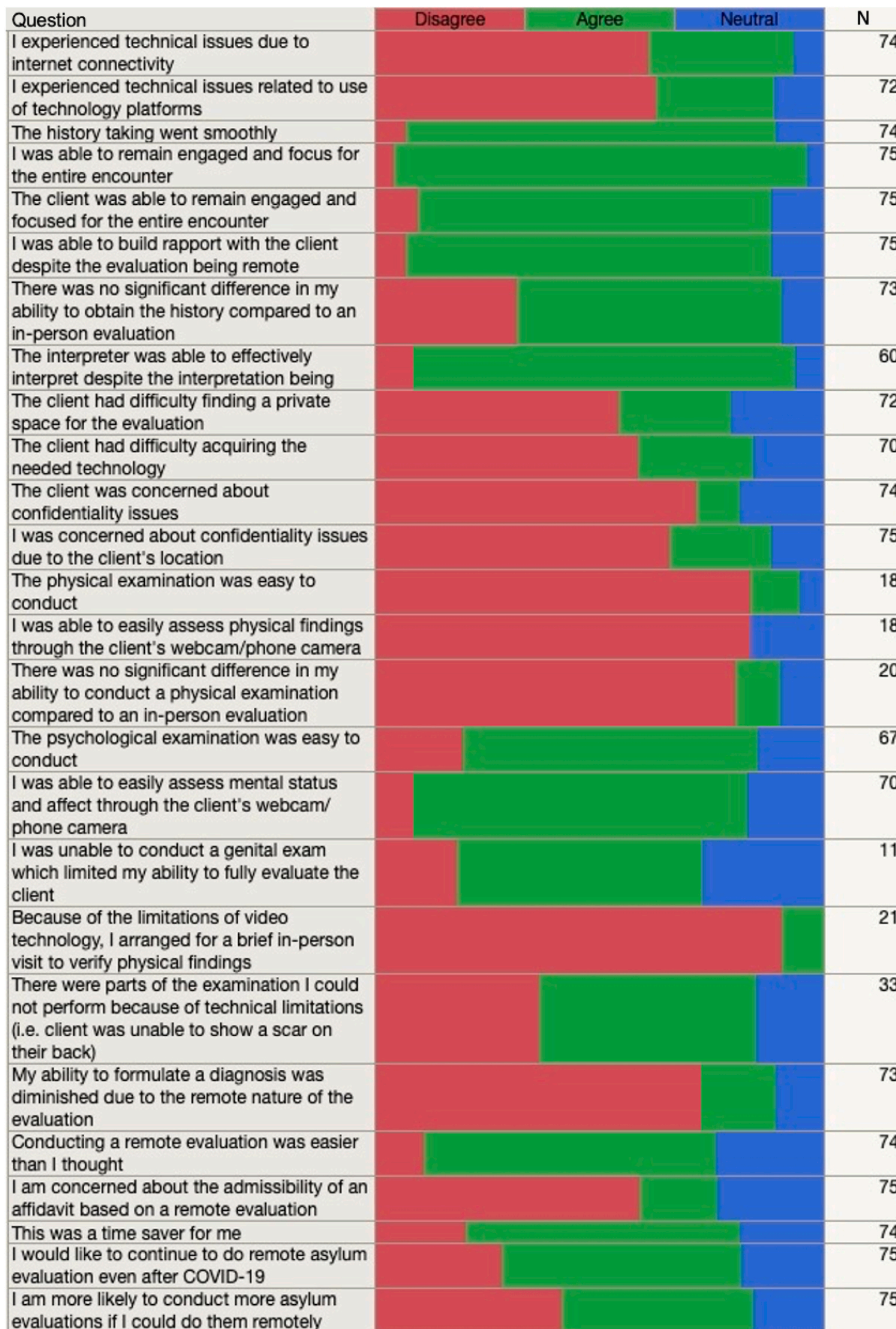

Fig. 2. Overall clinician experiences of remote asylum evaluations. (N = total number of respondents to each question). *Figure should include color. (For interpretation of the references to color in this figure legend, the reader is referred to the Web version of this article.)

challenges that might arise as the number of remote forensic assessments increases.[14] How it might play out in the context of forensic asylum evaluations is too soon to tell.

As of this writing, it appears all medico-legal affidavits generated following a remote evaluation have been admitted as part of the case materials. Comparison of affidavits and outcomes produced by remote and in person evaluations is necessary to establish true equivalence of these practices. Unfortunately, the backlog in US immigration courts will likely impact our ability to study the outcomes of cases in the near future, where an asylum seeker received a remote evaluation.

Our findings may be relevant in the global arena and not only in the US context, especially in countries where asylum evaluations are being conducted, including the UK, Italy, France, and the Netherlands, among others.[16–19]

Additional questions that should be explored further include whether and how remote evaluations affect clients' credibility; what, if any, regulatory and licensing barriers exist across US domestic State lines as well as across international borders.

The emerging literature on the potential benefits of remote clinical forensic assessments may factor into global efforts to conduct remote

evaluations in support of hard-to-reach populations who may benefit from such evaluations in a variety of legal processes (including torture and human trafficking, for example), and in a variety of physical settings such as in detention, refugee and migrant camps, as well as in locations where experienced clinicians are scarce.

With this practice clearly on the rise, US and international organizations working with torture survivors, asylum seekers and other justice-affected individuals have begun publishing best practices for practitioners[20–23] but such guidance is limited to expert advice. A more systematic and multi-sectoral approach to the creation of practice guidelines is necessary.

Lastly, the perspectives of asylum seekers themselves must be sought and explored regarding their preference for one format vs. the other, factoring in questions such as access to spaces that offer privacy and confidentiality, safety concerns, their comfort with the use of technology, their perceptions about building trust with the examiner via digital interfaces, among others.

5. Conclusion

As we continue to generate best practices, conducting asylum evaluations remotely represents a great opportunity to increase accessibility to and efficiency of asylum evaluations, possibly increasing the number that may be performed each year and helping speed up the often-lengthy process of adjudication.

At least one US-based asylum adjudicator believes that medico-legal affidavits produced following remote forensic evaluations would be viewed positively. According to Susan Roy, a former US immigration judge who participated in a recent training on remote evaluations declared: “online evaluations, if they’re conducted with the same sort of protection of privacy and objective measures, would be given the same weight as in-person evaluations by immigration judges”.[24]

Author contribution

Megan Pogue: Formal analysis; Writing-original draft. Elsa Raker: Conceptualization; Methodology; Formal analysis; Project administration; Writing - review & editing. Kathyrn Hampton: Conceptualization; Data curation; Methodology; Formal analysis; Writing - review & editing. May-Lorie Saint Laurent: Data curation; Methodology; Formal analysis; Writing - review & editing. Ranit Mishori: Conceptualization; Data curation; Methodology; Formal analysis; Writing - review & editing.

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Declaration of competing interest

To the best of our knowledge, no conflict of interest, financial or other, exists.

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