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Assessing the efficacy and experience of in-person versus telephonic psychiatric evaluations for asylum seekers in the U.S.

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A B S T R A C T

Psychiatric evaluations of asylum seekers in the U.S. play an important role in asylum cases; however, there are significant barriers to assessing asylum seekers' psychological trauma. Telephonic psychiatric evaluations provide an opportunity to access important resources to bolster their case. In this retrospective study, we considered the efficacy of telephonic psychiatric evaluations and assessed their potential as a solution to meet the needs of asylum seekers. Ten affidavits produced from telephonic evaluations were compared to twenty produced from in-person evaluations using a standardized scoring rubric. Providers who conducted telephonic evaluations also completed a structured interview and a qualitative assessment of themes was conducted. Overall, there was a small, but non-significant difference in overall score. The presence of descriptions of cognitive complaints, appearance, motor activity and use of checklists were, however, all significantly lower in telephonic compared to in-person affidavits. Providers agreed that despite limitations, the ability to diagnose and advocate for asylum seekers is equivalent regardless of format. This study identifies that telephonic psychiatric evaluations produce comparable results to in-person evaluations with the benefit of reaching a hard to reach population. Evaluators, lawyers, and judges should consider these results in weighing the risk-benefits of a telephonic evaluation of an asylum seeker.

1. Introduction

In recent years, asylum seekers have become an increasingly vulnerable population in the United States, as immigration reform has introduced barriers to the process of applying for asylum. As of October 2019, there were over 1,000,000 pending immigration cases in the United States (TRAC Reports, Inc. 2019). Meanwhile, in 2017, only 26,568 were granted asylum by either the Department of Homeland Security or the Department of Justice (Kerwin, 2012; Statistics, 2019). A number of those seeking refugee status are forcefully kept in detention centers or are ultimately resettled in remote areas of the US, both subsets isolated from a number of essential asylee services. This article explores the efficacy of telephonic psychiatric evaluations of asylum seekers, a tool that may be used to increase the accessibility of asylee support for hard to reach populations.

In order to qualify for refugee or asylee status in the United States, one must be unable or unwilling to return to his or her country of nationality because of persecution or a well-founded fear of persecution on account of race, religion, membership to a particular social group, or political opinion (8 USC 1101 (1952)). The weight of proof of "credible fear" rests on the asylum seekers and how well they and their lawyers can make this case in immigration courts. Mental health professionals often play a crucial role in this process by providing diagnostic information that can support asylum seekers' claims (Scruggs et al., 2016)

Psychiatric evaluations by medical professionals allow for a more holistic consideration of asylum cases and often result in greater positive outcomes for clients. In particular, individuals seeking asylum have suffered abuses in their countries of origins and often suffer ongoing mental health illnesses. Much like scars or bruises, mental health diagnoses can provide important evidence substantiating an asylum seeker's claims of torture or abuse. In addition, psychiatric disorders can impact a clients' ability to express themselves throughout asylum proceedings, and should be considered during proceedings.

After performing psychiatric evaluations of asylum seekers, medical professionals submit medical-legal affidavits to immigration courts on the client's behalf. These documents are frequently the determining factor in whether asylum is granted or other relief from deportation is obtained (Meffert et al., 2010). Physicians for Human Rights reports that 90 percent of asylum outcomes that include an evaluation performed by a PHR Asylum Network volunteer for either psychological or medical purposes are successful, compared to a national average of barely 30 percent (Lustig, 2007).

There are significant barriers to assessing the psychological trauma of asylum seekers, including limited availability of providers performing evaluations (Thomas et al., 2009). In particular, providers are

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often based at academic medical centers in metropolitan areas, inaccessible to many asylum seekers living in remote areas or detained in detention centers. For these individuals, telephonic psychiatric evaluations, which are conducted via telephone between provider and client often with the help of an interpreter, provide an opportunity to access important services to bolster their case.

Considerable evidence on telephonic psychiatric care suggests both quality and efficacy are similar to in-person psychiatric evaluations for patient and provider (McKenzie et al., 2019). A 2016 literature review of 452 published research articles on the subject of telepsychiatry using video conferencing concluded that overall, patients and providers are generally satisfied with telepsychiatry services.

While the use of telepsychiatry in other underserved communities has been extensively researched, no published studies to date have examined the use of remote interviews in evaluation of asylum seekers. To our knowledge, there are currently no studies that examine why providers may not offer telephonic evaluations and no studies comparing the efficacy of telephonic evaluations compared with in-person evaluations for asylum seekers in particular. Here, we investigate the use of telephonic asylum assessments, as telephonic evaluations (rather than webcam or other means) are an existing, though uncommon practice in detention centers and asylee communities. In this study, we created a gold-standard criteria to assess psychiatric medico-legal affidavits using the Istanbul Protocol, an international guideline for evaluating survivors of torture (OHCHR, 2004). We then evaluated the efficacy of both telephonic and in-person psychiatric evaluations and compared them based on these criteria.

2. Methods

Our aim was to evaluate the efficacy of telephonic versus in-person asylum evaluations through comparison of affidavits and standardized interviews with providers. This involved four key stages:

2.1. Data collection

Affidavits from both in-person and telephonic asylum evaluations were provided by The Mount Sinai Human Rights Program (MSHRP) as a control group. MSHRP, affiliated with the national organization Physicians for Human Rights (PHR), provides pro-bono, trauma-informed medical assessments, mental health evaluations, access to social services, and referral for medical care to U.S. asylum seekers who are survivors of torture and human rights abuses. All affidavits (approximately 300) were initially deidentified to ensure anonymity. All MSHRP clients had previously consented to the use of their affidavits for research purposes.

Voluntary interviews were conducted with providers who have conducted telephonic interviews at Mount Sinai Human Rights Clinic and snowball sampling was used to recruit providers from similar organizations around the country. Potential participants were contacted via email and interviews were completed in person or over the phone. Participants were also invited to submit any de-identified affidavits written from telephonic interviews. All interviewed participants were board-certified psychiatrists or psychologists with previous experience conducting asylum interviews.

In total, 10 telephonic affidavits were collected, a combination of those provided by the MSHRP and those submitted by interviewees.

2.2. Interviewing of providers

Providers ($n = 3$) were asked open-ended questions that assessed the following topics: experience with asylum seeking work, provider and client perception of the telephonic interview process, tools utilized during the interview, and ability to advocate for the patient after telephonic interviews (interview questions available upon request). Participants were asked to reflect on each of these areas in comparison to their experiences conducting in-person psychiatric evaluations. Recordings with providers were transcribed for qualitative analysis.

2.3. Assessment of affidavits

We developed a rubric to assess the quality of affidavits based off standards outlined in the Istanbul Protocol.

We randomly selected two affidavits produced by the Mount Sinai Human Rights Program to evaluate the reproducibility and reliability of the criteria. We then and met to discuss and adjust the criteria based on results. Next, the 10 telephonic affidavits we collected were matched to 20 in-person affidavits based on the two possible types of evaluations: Credible Fear Interview, which takes place when the client is in a detention center, or Asylum Case, which takes place after their case for asylum has been initiated. Each affidavit was then assessed individually by three coders and assigned a score 0–30 based on its adherence to the Istanbul protocol. For each criterion that was present, one point was awarded, creating a binary coding system. If disagreement occurred, the 2/3rd majority opinion was considered.

2.4. Statistical analysis

We conducted a quantitative analysis to assess frequencies of observed criteria from affidavits. Fisher's exact test was used to determine if the distribution of each criteria and diagnoses were different between telephonic and in-person affidavits. A student's *t*-test was used to determine if there was a difference between mean criteria scores, with a *p*-value less than 0.05 considered significant. All analyses were done using SAS 9.4 (Cary, NC).

A qualitative thematic analysis of the transcripts proceeded using 4-level open coding methods (Strauss, 1987). Each team member individually reviewed all transcripts for themes, after which the team met together to arrive at consensus. We generated a list of recurrent themes and recorded salient quotations that exemplified them.

This study was approved by the Icahn School of Medicine at Mount Sinai Institutional Review Board.

3. Results

Our approach to assessing the efficacy to telephonic evaluations vs. in-person involved two study arms. The primary arm was a quantitative evaluation of the efficacy of affidavits based on these criteria we developed using the Istanbul Protocol. We acknowledged, however, that a quantitative analysis would not fully capture the experience of conducting telephonic evaluations. Therefore, we added a second qualitative study arm to add nuance to our quantitative data.

A majority of asylum seekers whose affidavits were evaluated for this study were from El Salvador, Guatemala, and Honduras, reflecting the demographics of the Mount Sinai Human Rights Program population.

3.1. Quality of written affidavits

Overall, we found a small, but not statistically significant difference in the quality of affidavits reflected by the total criteria met (19.7/30 telephonic versus 22.1/30 in-person; $p = 0.093$). In 26 clinically relevant areas, telephonic and in-person evaluations were equally efficacious, including general summary of history of torture ($p = 0.5$), psychiatric history ($p = 0.7$), and diagnoses considered ($p = 0.4$), among others listed in **Table 1**.

Individual criteria that were more frequently missing in telephonic affidavits included: a description of cognitive complaints relevant to psychiatric history, notes on appearance and motor activity in the mental status exam, and the use of checklists as screening tools for diagnoses.

Table 1
Comparison of In-person vs. Telephonically Produced Affidavit Quality

Topic	Criteria	Frequency (%) In Person (n = 20)	Telephonic (n = 10)	p-value
Cultural Context	Description or acknowledgement of native country culture	65	60	0.2
Introduction	Referreal Source (psychiatric, legal, medical document)	20	30	0.7
	Collateral sources/documents (references, interviews)	60	80	0.06
History of Torture	General summary	90	100	0.5
	Review of legal documents (to set context)	35	60	0.1
Pretorture History	Descriptions of childhood and growing up	85	100	0.5
	Descriptions of education and occupation history	75	90	0.6
	Description/acknowledgement of past trauma	75	100	0.1
	Description of cultural and religious background	60	70	0.7
	Comparison of pre and post trauma history	85	90	1.0
Medical History	Summary of medical history	80	90	0.6
Psychiatric History	Previous diagnoses, therapy or prescription drug use	70	80	0.7
Substance Use	Patterns of use	75	90	0.6
Current Psychiatric Complaints	Affective	95	100	1.0
	Cognitive	95	60	0.02
	Behavioral symptoms	90	100	0.5
	Frequency/examples of nightmares and hallucinations	95	100	1.0
Mental status exam	Appearance/hygiene	70	0	<0.001
	Motor activity	60	0	0.002
	Speech	85	90	1.0
	Cognitive examination	90	40	0.2
Checklists and Questionaires	Use of	65	0	0.01
Assessment of Social Function	Daily activities	55	50	1.0
	Social role	50	50	1.0
	Recreational activities	20	30	0.7
	Perception of health status	55	40	0.7
	Chronic fatigue	70	50	0.4
Clinical Impression	Diagnosis Considered	95	90	0.4
	Malingering considered	85	100	0.5
	Resiliency considered	45	30	0.7
Overall	Average Total Score (30 possible)	22.1	19.7	0.09

Table 2
Distribution of Diagnoses Considered by Interview Format

		Diagnosis PTSD	MDD	Anxiety Disorder	None
Format	In Person	17 (45)	14 (37)	5 (13)	2 (5)
	Telephonic	6 (50)	2 (17)	2 (17)	2 (17)

Presented as n (%); PTSD = Post-traumatic Stress Disorder; MDD = Manic Depressive Disorder

The diagnosis(es) of each affidavit was also noted during analysis. Table 2 shows that there was no difference in the distribution of post-traumatic stress disorder (PTSD) or major depressive disorder (MDD) diagnoses between telephonic and in-person cases (*p-value* = 0.43)

3.2. Provider experiences

The results of significant themes in provider interviews are summarized in Table 3 with representative quotes from each and largely align with our quantitative findings.

All providers (n = 3) repeated that there was “no difference” in their ability to accurately make recommendations or diagnoses on the client's behalf when compared to in-person evaluations. One provider stated, “the recommendations that I made for her based on the telephonic interview wouldn't have been different than the ones I would have made in person.”

The providers offered consistent descriptions of challenges encountered while performing telephonic evaluations. All providers mentioned that building rapport with the client was more difficult, but that they were able to overcome this challenge over the course of the evaluation. All interviewed providers also noted that the use of checklists or cognitive tests to facilitate diagnoses proved to be logistically challenging, consistent with our quantitative findings above. A final limitation noted by all providers is their inability to perceive the clients' motor activity, appearance, and facial expressions during the telephonic interview, again consistent with our quantitative analysis.

A topic not identified by our quantitative analysis was provider's experience with translators, which was noted a number of times during our interview portion. Some providers suggested using the interpreters, who are typically in the room with the client, to gain useful observations or ask the client explicit questions like, “Are you crying?” that may offer better insight into the clients' live reactions. Providers unanimously agreed their experience was not markedly changed when working with a remote interpreter: “When I've worked in hospitals and you have to work with an [in-person] interpreter, it's equally complicated.”

Importantly, providers noted a number of advantages of using telephonic evaluations. They emphasized the convenience and a sense of satisfaction in participating in immigration work.

4. Discussion

This study compared telephonic psychiatric evaluations of asylum seekers to those conducted in-person, demonstrating similar quantitative and qualitative efficacy and experience between the two formats. The results of this study provide a potential solution to address the unmet need for psychiatric evaluations of asylees in remote areas and detention centers. Telephonic evaluations are a tool to provide comparable, practical alternatives to in-person asylum evaluations.

As substantiated by our quantitative analysis, the written evaluations from telephonic evaluations produced equally robust accounts, per our gold-standard criteria. Our results demonstrate that providers can comparably obtain a complete history, diagnose, and make recommendations for clients following a telephonic evaluation. For example, both psychiatric and in-person evaluations were able to equally obtain a complete pre-torture and torture history, both of which are

Table 3
Summary of Provider Experiences Comparing In-person and Telephonic Formats

Theme	Quote
Difficulty in Rapport Building	*"A lot of them say that they've never spoken to mental health professional before. So, there was this disembodied voice in a far-off place asking them a lot of personal questions."*
	"We can only use encouragement in the telephonic interview. But how we look at them, how we behave when they are very distressed, these [missing] elements of body language, it can affect the rapport."
Telephonic interviews had a comparable affidavit writing process compared to in-person	*"I don't see any difference. It's the same process."*
	"I don't think the writing is any different, except for the mental status."
The client appeared trusting and appreciative	*"They are welcoming during the interview, and appreciated the way this would be helping. So, I don't think it reflects any discomfort on their side.*
	"She was grateful for the opportunity to do it. I think it actually provided her a sense of comfort that maybe it would strength her case with the immigration courts."
	"They just don't seem to have much hesitation. They are just so trusting. It's kind of remarkable. And you get plenty of information; they talk."
There was a comparable ability to diagnose, advocate and testify for the client after a telephonic evaluation	*"I felt it was as comfortable as in person."*
	"I didn't actually find it to be that different. My ability to find out her cognitive-emotional-behavioral consequences of those experiences weren't inhibited by this telephonic experience."
	"The recommendations that I made for her based on the telephonic interview wouldn't have been different than the ones I would have made in person."
Convenience of the telephonic interview was emphasized by all providers	*"I feel good doing this. You know I did. Find in some sense a very timely. I don't have to travel anywhere. I can do it at my desk, so they actually saved me a lot of time. I'm sort of kind of lucky to be able to do that."*
	In general, I am happy to do this because I would not be able to travel to see these clients otherwise.
	"I am happy to do it because I would not be able to travel to see these clients. So, I think this is more convenient."
Lack of visual, social, and physical cues create a less comprehensive mental status exam	*"I think the mental status exam [was more challenging] because you cannot comment on the appearance, or eye contact, or behavior…. It's one of the main challenges in conducting telephonic interviews."*
The translator creates a barrier (in time and "layer") but this is comparable to in-person evaluations.	*"It was more difficult to get information, in part because of working with an interpreter. That said, I don't necessarily know that working with an interpreter in the room would have been any different. When I've worked in hospitals and you have to work with an interpreter, it's equally complicated."*
	"I didn't find it any different. Let's put it this way, I find it equally awkward."
	"It's another layer between you and the evaluee. It takes a lot more time, but it is actually a distinct advantage. One of course is if they are in the same room with the person, then you can ask for their observations. The other good thing is that while they're talking you can be taking notes."

essential in the psychiatric evaluation of asylees. Our data also showed that evaluators were not hindered in their ability to make a clinical diagnosis or offer a clinical impression, even when not physically in the presence of the client. Overall, based on these findings, we believe evaluators should feel confident that a telephonic interview is an efficacious way to evaluate an asylum seeker.

The quantitative arm also highlighted a few challenges encountered during a telephonic psychiatric evaluation. Most notably, elements of the mental status exam were significantly absent in telephonic as compared to in-person evaluations. This is an expected barrier and should be considered a limitation of telephonic evaluations. Other areas where telephonic evaluation was limited were use of checklists as diagnostic tools and ability to assess cognitive complaints. Notably, these did not hinder the providers' abilities to make a diagnosis, suggesting that there were strategies to overcome these challenges within the context of a telephonic interview.

The qualitative findings of this study largely supported the quantitative findings. Like in the quantitative results, providers said they were able to obtain complete histories and formulate diagnoses. In the qualitative arm, providers added that the affidavit writing process was equivalent, and emphasized the convenience of conducting telephonic interviews, which has been established in other studies on telephonic psychiatry (Hajebi et al., 2012). Likewise, our results replicate previous studies of telephonic psychiatric evaluations where providers did speak to the challenge of conducting a mental status exam telephonically, due to their inability to observe visual, social, and physical cues, such as smiling, frowning, and crying. Additionally, providers reported impaired rapport with their patients and that assessments requiring objective observations (i.e., the Brief Psychiatric Rating Scale) may be more difficult to conduct via telepsychiatry (Hubley et al., 2016). As a result, providers relied more on the client's tone of voice and relevant history.

Another possible solution to this problem offered in the qualitative interviews was to utilize the translator as an in-person objective observer. The translator may be is useful in offering observations of the client's affect and rapport. While this suggestion was offered by a number of providers, we want to be cautious in encouraging providers to use translators as data collectors during an evaluation. Translators are intended to act as objective parties to facilitate conversation between providers and interviewees. To ask a translator to offer any subjective observations of the interviewee may compromise their ability to otherwise translate objectively. However, as this was suggested by providers with considerable experience conducting these evaluations, we chose to report it objectively as a qualitative finding of this study.

Importantly, our study replicates the findings of several other studies examining the use of telepsychiatry services for underserved populations. US veterans represent a high-risk population with a significant unmet need for high quality mental health care (Hubley et al., 2016; Richardson et al., 2010). Previous studies have demonstrated significant agreement in diagnosing both PTSD and MDD, using Clinician-Administered PTSD Scale (CAPS) and Hamilton Rating Scale for Depression (Ham-D) respectively, when in-person and telephonic evaluations were compared (Aziz and Kenford, 2004). Our study replicates these findings in a population with similar vulnerabilities to both disorders (Kronick, 2018).

Our study had a number of limitations. Many providers are reluctant to conduct telephonic psychiatric evaluations for fear they may not be able to offer a holistic evaluation if conducted over the phone. As a result, very few mental health providers have ever conducted these types of evaluations. This limited both our ability to recruit providers for interviews and limited the number of affidavits we were able to evaluate. While this is a significant limitation of this study's methodology, it also highlights the need for further research evaluating the

efficacy of telephonic evaluations as the practice expands, which could in turn guide providers interested in participating in this work. Yet, a more rigorous research study will only be possible if more providers participate.

Further research could explore teleconference (video) interviews as a potential new avenue to allow interviews to be conducted remotely while allowing the interviewer to observe the client. Our study demonstrates that providers face challenges associated with not seeing the patient, specifically an inability to conduct a thorough mental status exam and observe the clients' body language, which may be mitigated by using video. In addition, further research might explore the strengths and weaknesses of telephonic evaluation from the perspective of other stakeholders, including clients and attorneys.

In conclusion, we believe telephonic interviews can play an essential role in increasing the availability of psychiatric evaluations to asylum seekers without immediate access to a provider. These individuals are often some of the most vulnerable, either in detention centers or isolated in rural communities. We believe remote telephonic interviews would offer them an invaluable resource to bolster their immigration case and are hopeful these research findings might encourage more providers to engage in this type of work.

Declaration of Competing Interest

The authors declare no conflict of interest.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.psychres.2019.112612.

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