Immigration Judges' Perceptions of Telephonic and In-Person Forensic Mental Health Evaluations

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Clinicians affiliated with medical human rights programs throughout the United States perform forensic evaluations of asylum seekers. Much of the best practice literature reflects the perspectives of clinicians and attorneys, rather than the viewpoints of immigration judges who incorporate forensic reports into their decision-making. The purpose of this study was to assess former immigration judges' perspectives on forensic mental health evaluations of asylum seekers. We examined the factors that immigration judges use to assess the affidavits resulting from mental health evaluations and explored their attitudes toward telehealth evaluations. We conducted semistructured interviews in April and May 2020 with nine former judges and systematically analyzed them using consensual qualitative research methodology. Our findings were grouped in five domains: general preferences for affidavits; roles of affidavits in current legal climate; appraisal and comparison of sample affidavits; attitudes toward telephonic evaluations; and recommendations for telephonic evaluations. Forensic evaluators should consider the practice recommendations of judges, both for telephonic and in-person evaluations, which can bolster the usefulness of their evaluations in the adjudication process. To our knowledge, this is the first published study to incorporate immigration judges' perceptions of forensic mental health evaluations, and the first to assess judges' attitudes toward telephonic evaluations.

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Across the United States, clinicians working in collaboration with medical asylum clinics and torture treatment programs conduct forensic evaluations of asylum seekers.[1–5] In such evaluations, clinicians investigate the physical and psychiatric sequelae of human rights abuses and document their findings in medico-legal affidavits that are submitted to the immigration judge as part of an individual's application for immigration relief.[1,6,7] The affidavits provide the evaluators' written testimony explaining to a judge the relevance of their findings (e.g., the impact of trauma on memory). Medical providers experienced in conducting forensic evaluations have worked in consultation with attorneys to establish and disseminate best-practice guidelines for evaluations.[6–10] Much of the best-practice literature reflects the perspectives of clinicians and attorneys, rather than the viewpoints of immigration judges who apply forensic reports in their decision-making. (One notable exception was a presentation of suggestions for writing medico-legal affidavits based on a qualitative study of a sample that included immigration judges, clinicians, and attorneys.[11]) As a result, forensic medical evaluators have limited insight into how immigration judges view the content of affidavits

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or how the documentation of forensic evaluations affects asylum cases.

In the context of the COVID-19 pandemic, medical human rights programs have transitioned to conducting forensic evaluations by telephone or video.[12,13] Forensic clinicians have also been using telehealth modalities to evaluate asylum seekers who have poor access to forensic services because they live in geographically remote areas of the United States, immigration detention centers, or Mexico border cities.[14] Mental health practitioners have reported both comfort with and concerns about the limitations of telehealth forensic evaluations.[15] Most literature on telehealth forensic evaluations has focused on evaluators' perceptions of video-teleconference, applied across multiple dimensions of forensic mental health.[16–20] Assessing the acceptability of remote evaluations to adjudicators of immigration claims and incorporating their perspectives into broader practice recommendations is particularly critical at this time, given that telehealth visits and telephonic interviews of asylum seekers have become standard as a result of both the COVID-19 pandemic and the increased number of asylum seekers in immigration detention facilities.

This study was to explore former immigration judges' perspectives on forensic mental health evaluations of asylum seekers. We examined the factors that immigration judges use to assess the medicolegal documents resulting from mental health evaluations. We also specifically identified participants' attitudes and perceptions toward telehealth evaluations. This study adds to existing literature by incorporating immigration judges' perceptions of forensic mental health evaluations and by assessing judges' attitudes toward telephonic evaluations. We specifically investigated telephonic rather than video-based evaluations because asylum seekers may have limited access to the internet, and immigration detention centers often restrict access to video conferencing platforms.[14] This study was approved by the Mount Sinai Institutional Review Board.

Methods

Recruitment

A total of nine participants, all former U.S. immigration judges, were eligible for inclusion in this study. Participants were recruited through peer recommendations of a nonparticipant former immigration judge and a physician active in medical human rights advocacy, as well through a snowball approach. Eligible participants included immigration judges with at least one year of experience, but who were no longer actively serving. Immigration judges who were familiar with the Mount Sinai Human Rights Program were not eligible to participate. Out of 11 prospective participants, two did not respond. Nine immigration judges participated in the interviews, consistent with the recommended range of eight to fifteen participants for a consensual qualitative research (CQR) study.[21]

Data Collection/Measures

Pre-Interview Preparation

In advance of interviews, we provided participants with two mental health affidavits; one was based on an evaluation performed telephonically and one based on an evaluation performed in person. All unique identifying information about the evaluator and asylum seeker was redacted, as was any mention of the modality by which the evaluation occurred (telephonic or in-person). These samples were intended primarily to prompt discussion of general strengths and weaknesses of affidavits. For example, participants were asked to rate the quality of the affidavits on a numeric scale. This was not done to quantitatively compare scores by modality, but rather so that participants could be asked to justify their overall assessments by pointing to the most salient pros and cons of each sample.

Both sample affidavits had been written by a psychiatrist (CLK) who completed a fellowship in psychiatry and the law and had extensive experience conducting forensic mental health evaluations of asylum seekers both in person and by telephone. We considered the sample affidavits to reflect evaluations that were comprehensive to the extent possible given their respective modalities. In an effort to reduce bias, we did not formally assess the quality of specific elements of each sample affidavit. In other words, we did not intentionally select a sample telephonic affidavit that we felt was equal in quality to the sample in-person affidavit because this might obscure real differences in the average quality of an evaluation conducted by each respective modality.

We deliberately selected two sample affidavits that were similar in length (six to seven pages), region of origin (Central America), gender (cisgender women), protected status sought (asylum), and type of trauma (sexual violence).[22] The purpose of this selection was

to mitigate the possibility that differences in the type of trauma would become the focus at the expense of discussion of affidavit quality. Both evaluations were conducted with the aid of a Spanish language interpreter because the evaluating psychiatrist was not fluent in Spanish. Both affidavits included the following sections: evaluator credentials, overview of the case, relevant psychiatric and medical history, history of trauma, psychological examination, assessment of mental status, impressions, and conclusions. The sections of the sample affidavit that documented the evaluators' clinical impressions were structured differently, with one laying out diagnostic criteria and corresponding symptoms for a diagnosis of posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) in bullet-point form and the other providing a narrative description of diagnoses of panic attack and other specified trauma and stressor-related disorder or "sub-syndromal PTSD." These differences allowed analysis of participants' preferences for affidavit style in addition to any perceived differences in quality that may have resulted from the modality by which the evaluation occurred.

Participants received the two sample affidavits one week prior to the interview and were asked to consider "only the quality of the written affidavits and their conclusions based on their documented findings of the mental health evaluation," rather than any imputed legal merits of the asylum case. To guide their review, they were also provided with questions in advance related to their analysis of the affidavits' strengths and weaknesses, as well as perceived differences in quality.

Interviews

We piloted our interview protocol with a nonparticipant former immigration judge, an immigration attorney, and a psychologist who conducts forensic mental health evaluations of asylum seekers. We revised interview questions for clarity and based on their feedback. The semistructured interviews were conducted by phone by two of the authors (AG, SR) in April and May 2020 and were recorded on computer software (Audacity). After interviewers received participants' informed consent and demographic information, they confirmed that participants had read the sample affidavits thoroughly. Audio recording was then initiated with participant consent. The first part of the interview focused on general attitudes toward forensic mental health affidavits and evaluations, prompted by the two sample affidavits. For example, in addition to the questions provided in advance, participants were asked their opinion of the conclusions of the affidavit and whether the affidavit could affect the way they viewed the applicant's case. The second portion of the interview focused on attitudes toward forensic mental health evaluations conducted telephonically. For example, participants were asked how they think telephonic evaluations compare with in-person evaluations, and whether they would trust the conclusions of telephonic evaluations to the same extent as those from in-person evaluations. Interviews ranged in duration from one to two hours ($M = 85$ minutes). Four authors (AG, SR, BB, SW) transcribed the interviews and all transcripts were compared with the audio recordings by the two interviewers to ensure accuracy of transcripts.

Data Analysis

The transcripts were systematically analyzed using CQR, which provides a rigorous method for identifying themes across semistructured interviews of eight to 15 participants.[21] The coding team consisted of four medical students (AG, SR, BB, SW) who were trained in CQR by a faculty member with qualitative research expertise (KB). Training was approximately ten hours in length over multiple sessions and consisted of reading methods articles on CQR and examples of CQR manuscripts, attending didactic sessions with the supervising faculty member, and reviewing each step of the process before completion. At the start of the process, one transcript was set aside as a "stability check." All steps of the analysis began with the team coding the transcripts individually, before meeting as a group to argue all discrepant codes to consensus. First, the team developed a set of domains that reflected the broad topic areas that emerged from the transcripts. Next, they summarized all text associated with each domain into core ideas and created categories by identifying themes across participants' narratives. After reaching consensus on the initial eight cases, the team coded the final transcript and since no new domains or categories resulted, they determined that they had a stability of findings and the data had been analyzed effectively. An auditor with expertise in both CQR and the forensic psychological evaluation of asylum seekers reviewed the coding process and provided feedback to the team to reduce bias throughout each stage of

analysis. For example, the auditor suggested that the coders consolidate domains about participants' preferences for affidavit style and content, which were initially distinct.

Results

Participants ranged in age from 46 to 71 years old ($M = 62$). Forty-four percent of participants identified as male ($n = 4$) and 56 percent identified as female ($n = 5$). Participants had served in immigration courts both in the community and in immigration detention centers across the United States. Five judges served in jurisdictions in the Southern United States, three in the West, three in the Northeast, and one in the Midwest. Participants reported between 1.5 and 24 years of experience as immigration judges ($M = 16$), while collectively serving in the courts from 1994 to 2020. The study resulted in the creation of five domains that emerged from the interviews: general preferences for affidavits; roles of affidavits in current legal climate; appraisal and comparison of sample affidavits; attitudes toward telephonic evaluations; and recommendations for telephonic evaluations. The domains contained categories that further described the perspectives of the former immigration judges. A list of the domains, categories, and their accompanying frequencies is presented in Table 1.

Table 1 Domains, Categories, and Frequencies of Participants' Attitudes

Domain and Category	No. of Participants
General preferences for affidavits	
Format affidavits for easy readability	9
Provide evidence to support conclusions	9
Include malingering assessment	8
Avoid advocacy and legal language	8
Detail evaluator qualifications	7
Provide therapeutic recommendations	5
Describe interview conditions	4
Roles of affidavits	
Provide evidence	8
Explain manifestations of trauma	8
Exist in unfair legal system	7
Streamline court proceedings	5
Appraisal of sample affidavits	
Viewed both affidavits positively	9
Rated in-person affidavit as stronger	8
Attitudes toward telephonic evaluations	
Concern about limitations of modality	9
Better than no evaluation	9
Unfamiliar with modality	6
Judge's background informs attitudes	6
Recommendations for telephonic evaluations	
Disclose modality and explain rationale	9
Describe strategies to overcome limitations	8

General Preferences for Affidavits

Format Affidavits for Easy Readability

All participants emphasized the importance of structuring affidavits in an organized fashion to ensure that the information presented is easy to review. Judges specifically highlighted the use of bullet points, numbering, and section heading as useful tools for enhancing readability. One participant found it particularly helpful when evaluators provided a brief overview of the trauma narrative, diagnoses, and conclusions at the beginning of an affidavit. Some of the judges noted that well-structured affidavits were especially necessary given the current time pressures placed on the courts. As one participant explained, "style helps when you're trying to explain . . . to a busy judge what is going on in this person's psychological life."

Provide Evidence to Support Conclusions

Nearly all participants stated that clinicians should explain the process by which they arrived at their conclusions, including use of assessment measures, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) criteria, or structured interview techniques. Participants recommended that evaluators explain which, if any, diagnostic criteria were met, describing in detail what symptoms, behaviors, or aspects of the narrative support their clinical findings. Judges urged clinicians to "assume the judge knows nothing about psychology" and to avoid using jargon when outlining clinical symptoms or diagnoses. One participant articulated why judges find the description of the assessment process to be so useful: "It's not that I understand what the specific DSM sections are or what these tests are; I don't. In fact, that's why I need your evaluation. But I like seeing the bones, I like seeing why the doctor came to the conclusion that he or she came to."

Include Malingering Assessment

Nearly all participants suggested that clinicians assess for malingering and document their findings in the affidavit. Several participants recommended

that evaluators describe what they look for when making a determination of malingering and whether they relied on any tools or testing to make their assessment. A few participants tied the need for a malingering assessment to a skepticism among some colleagues who feel that "psychologists just always believe everything they're told." One participant noted that clinicians could explore parts of the narrative that are less clear as a way to demonstrate that they are concerned with the veracity of the client's reported history. A few participants noted that evaluators should explain inconsistencies in the applicant's narrative or demeanor when making a determination of truthfulness.

Avoid Advocacy and Legal Language

Nearly all of the participants strongly advised against using technical legal terminology (e.g., "credible") or opining on legal aspects of the case (e.g., that respondent meets criteria for asylum). Participants cautioned that judges view affidavits negatively when they "usurp the judge's judicial fact-finding role." Participants also cautioned that both government counsel and immigration judges will question evaluators' objectivity if evaluators appear to assume the roles of advocates, which could discredit or diminish the weight given to an otherwise useful affidavit. To mitigate this, one participant suggested qualifying statements that might otherwise appear to draw subjective conclusions; for example, the participant suggested that an evaluator add the word "perceived" to the phrase "her perceived lack of protection from the authorities" to demonstrate the evaluator's commitment to objectivity.

Detail Evaluator Qualifications

Nearly all participants reported that evaluators should detail their relevant qualifications in the written affidavit, and the majority recommended including a curriculum vitae with their reports. A few judges suggested that evaluators consider outlining any prior experience in the role of expert witness, including the number of times they have evaluated clients, whether and in which contexts they have provided oral testimony, and whether they were compensated. A few participants noted that evaluators' explanations of their practice experiences can be helpful in establishing their objectivity as expert witnesses. For example, participants suggested that evaluators state that they assess truthfulness as part of routine clinical practice. Participants also suggested that evaluators explain to the court that they do not always find clients believable or assign formal medical diagnoses.

Provide Therapeutic Recommendations

Most participants suggested that evaluators who document clinically significant psychological symptoms provide prognoses and recommendations for treatment. One participant noted that the inclusion of treatment recommendations "supports the diagnoses" and reduces perceptions of clinician bias by demonstrating "that the evaluator is focused on the person's mental health and not on the person's asylum case." A few participants suggested that evaluators comment on the feasibility of their clinical recommendations, because a judge or the opposing counsel may be skeptical if a client did not pursue the clinician's proposed referrals.

Describe Interview Conditions

Most participants recommended that evaluators detail the circumstances under which they elicited information. Participants suggested that clinicians describe the interview setting, level of privacy, and individuals present. A few participants specifically recommended stating whether an interpreter was used and including their qualifications. Participants also encouraged evaluators to clearly distinguish between what the client reported during the interview versus information provided by the attorney or other collateral documentation. One judge suggested including phrases such as "based on what the respondent related to me" to identify the source of the information.

Roles of Affidavits

Provide Evidence

Most participants stated that affidavits can provide evidence that is seemingly more objective than just the applicant's testimony to justify their decision to grant asylum. A few participants noted that medical affidavits can assist attorneys as they build a record for appeal, particularly in cases where the judge failed to address the mental health evidence. Nearly all participants also felt that the affidavits' documentation of the client's narrative and psychological sequelae

provide evidence that supports statutory requirements for protected status, such as credibility, ill treatment rising to the level of persecution, or extenuating circumstances related to a client's inability to meet the one year limit for applying for asylum. As one participant described, an affidavit would "give me something to hang my hat on in a decision . . . if I had enough evidence . . . to grant asylum anyway—even though her testimony might not have been fully credible, this would give me an explanation of why it may not have been fully credible. So it would give me a boost up to be able to do what I thought was right in the case."

Explain Manifestations of Trauma

Nearly all participants noted that effective affidavits can describe the ways psychological symptoms might manifest and influence a respondent's behavior in the courtroom. They explained that this is particularly important when respondents exhibit behaviors that immigration judges may not expect and that may be otherwise interpreted as deceptive (e.g., not maintaining eye contact, or demeanor inconsistent with traumas described). Nearly all participants also indicated that affidavits can explain respondents' difficulties providing oral testimony (e.g., memory lapses) and suggest "what kind of support might allow the respondent to testify more appropriately in a courtroom setting."

Exist in Unfair Legal System

Most participants reported that the current immigration legal system creates structural or intentional biases against affidavits and asylum seekers. They noted that judges are under time pressure and case completion quotas and may dislike the addition of evidence that increases their workload. One participant reported that some colleagues did not review medical affidavits in advance of hearings due to time limitations.

In addition, participants indicated that judges may be hostile to testimony from expert clinician-evaluators because they perceive it as threatening their role as fact-finders or may assume that mental health professionals are biased and find clinically significant symptoms of psychological distress in all their evaluations. Finally, a few participants stated that in some instances, the role of an affidavit was inherently limited because more judges are being appointed who they believe are "presumptively going to deny the case anyway" and are operating within a system committed to "maximizing deportations" rather than seeking "accurate and consistent results."

Streamline Court Proceedings

Most participants indicated that medico-legal affidavits simplified court proceedings by reducing the need for oral testimony from asylum seekers or clinician-evaluators. A few participants noted that affidavits may help avoid "re-traumatization" of respondents by not requiring the client to provide detailed testimony of experiences of violence.

Appraisal of Sample Affidavits

Both Affidavits Positively Viewed

Nearly all participants stated that both the telephonic and in-person sample affidavits were comparable with or stronger than the mental health affidavits they had reviewed during their careers. When participants were still unaware of the modality of the evaluation, they described the telephonic sample as, "right in the middle," "above average," "good," and "quite sophisticated;" they remarked that the in-person affidavit was "a B+", "does what it needs to do," "did a great job," and "did everything extremely well." Participants reported that they trusted the conclusions of both affidavits and felt that the affidavits could help the respondent by serving their respective legal purposes.

Rated in-Person Affidavit as Stronger

When participants were still unaware of the modalities of the evaluations, nearly all participants preferred the in-person affidavit to the telephonic affidavit; one judge rated them as equivalent. When asked to rate the affidavits on a scale from 1 (*weakest*) to 5 (*strongest*), participants rated the in-person affidavit with a range of 4.0–4.5 ($M = 4.3$), compared with a range of 2.0–4.5 ($M = 3.2$) for the telephonic affidavit. Most participants rated the affidavits within one point of each other. Nearly all participants explained their preference for the in-person sample affidavit was largely because they believed it had clearer diagnostic analysis and was more objective. In one participant's words, "[the evaluator included] the diagnostic criteria for PTSD and MDD, and they then related it back to what the person went through. I think I like this and I identify with it because it's very much what lawyers do, right? We cite." A few

participants reported that they found the evaluator in the telephonic sample more credible as an expert witness, because the evaluator appeared to be objective. They indicated that the evaluator acknowledged other potential medical causes of the respondent's symptoms, assessed the possibility of malingering, provided treatment recommendations, and used language that was perceived as less legally conclusory.

It should be noted once they were informed that one evaluation was conducted in person and the other by telephone, most participations speculated that the telephonic modality might explain some of the differences in quality they noted between the two affidavits. The participants suggested that the telephonic modality might have affected the affidavit, by decreasing the comfort of the clinician conducting the evaluation; limiting "sense of interaction" with the asylum seeker; forcing the evaluator to rush through an inherently more complex narrative; or posing particular challenges related to interpretation. A few participants noted that visual observations were not possible in the telephonic sample. In particular, several participants identified the same sentence, that the client was "fidgety . . . and picked at her nails and at a wad of tissue paper," as being a compelling piece of information that was feasible to observe during the in-person evaluation.

Attitudes toward Telephonic Evaluations

Concern about Limitations of Modality

All participants voiced concerns about the limitations of conducting forensic medical evaluations over the telephone. They noted that telephonic evaluations may miss visual cues that are important for making an assessment. Specifically, participants were concerned that evaluators would not be able to perceive indicators of malingering, behaviors, or affects that inform diagnoses, or make the behavioral observations needed to guide the interview effectively. A few participants also worried that telephonic evaluations could be hindered by a lack of rapport between evaluator and respondent, difficulties administering tests, miscommunications with the interpreter, and technological complications.

Better than No Evaluation

Despite their concerns, all participants reported that although they prefer in-person evaluations, a telephonic evaluation is better than no evaluation. As one participant explained, "I think that while in-person communication is always preferred, I think that with some agility the telephonic interviews can be done professionally. It's not perfect, but adequate to the need." All participants recognized that the use of telephonic evaluations is particularly understandable in certain contexts. Nearly all mentioned that telephonic assessments may be necessary for respondents who are detained and unable to access in-person evaluations. Participants also suggested additional circumstances under which "it becomes too onerous to do an in-person evaluation," including geographic distance, childcare or work responsibilities, lack of transportation, and social distancing measures during the COVID-19 pandemic. Most participants stated that the weight or credence they would give to a telephonic evaluation depends on the explanation of why it was necessary and whether the affidavit adequately addressed their concerns about potential limitations of the modality. Most participants further noted that they would be more forgiving of weaknesses in an affidavit if they knew that the evaluation was conducted by telephone. While every participant preferred telephonic evaluations to no evaluations, a few participants stated that they would generally ascribe less weight to the conclusions of a telephonic evaluation than those of an in-person evaluation regardless of context. One participant was particularly critical, remarking that telephonic psychiatric interviews are "inappropriate" and may "border on unethical."

Unfamiliar with Modality

Most participants stated that they had no prior experience reviewing telephonic evaluations and were not aware that forensic evaluations are conducted by telephone. A few participants suggested they may have reviewed affidavits resulting from telephonic evaluations but could not point to a specific case or example.

Judge's Background Informs Attitudes

Most participants noted that their personal and professional experiences affected their perceptions of telephonic evaluations. For example, one participant noted his experience presiding over a geographically large jurisdiction made him understand the need for telephonic evaluations. A few other participants explained that their negative experiences with conducting videoconference immigration hearings made

them believe it would be difficult to perform mental health evaluations by telephone. Most judges also speculated that the professional experiences of their colleagues would affect how those colleagues weigh telephonic evaluations and how fairly they consider barriers asylum seekers face in accessing in-person evaluations. A few participants noted that this was particularly true of judges who were biased against applicants. As one participant noted, "those [judges] that are looking for reasons to deny claims would give [a telephonic affidavit] enough weight as they thought would be helpful to reach the conclusion that they are predisposed to find anyway."

Recommendations for Telephonic Evaluations

Disclose Modality and Explain Rationale

All participants indicated that evaluators should state clearly that the evaluation was conducted by telephone. One participant recommended disclosure to avoid discovery of this information on cross-examination, which could potentially damage the case: "if it's not spelled out and then somebody finds it later they go, 'oh, okay, somebody tried to pull a fast one. . . ' [inclusion of this information] immunizes the evaluator against it being brought up on cross-examination." Most participants suggested that the evaluator should also explain the specific conditions that necessitated the use of a telephonic modality over an in-person or video interview.

Describe Strategies to Overcome Limitations

Nearly all participants recommended that evaluators describe the ways in which they overcame the potential limitations of telephonic technology in the affidavit. Most participants emphasized the importance of evaluators explaining how they maintained privacy during the interview, especially in evaluations of individuals in detention, to ensure that the client was comfortable disclosing sensitive information. A few participants suggested explaining why telephonic evaluations are a "professionally acceptable alternative," including a handful of participants who recommended citing literature on the efficacy of telehealth. A few participants also suggested that evaluators describe how they addressed the lack of visual cues by asking follow-up questions about pauses or hesitations to bring the level of detail closer to an in-person evaluation. A few also recommended that evaluators describe their approach to ensuring that the interpreter and the asylum seeker understood each other throughout the interview.

Discussion

The purpose of this study was to assess former immigration judges' perceptions of forensic mental health affidavits and to explore their attitudes toward telehealth as a modality for evaluating individuals seeking immigration relief. We identified three broad practice recommendations emerging from the domains and categories we defined through the CQR process. These recommendations for forensic evaluators reflect our participants' most salient beliefs about telephonic and in-person evaluations and the context in which adjudicators use the resulting evidence. The recommendations are: evaluators, regardless of modality, should detail their process; evaluators should use techniques that display their objectivity to judges; and telehealth is a reasonable modality for conducting forensic evaluations.

The first practice recommendation derived from participants' preferences for both in-person and telephonic affidavits is that evaluators need to "show [their] work." Participants encouraged clinicians to provide detailed information related to each step of their evaluations, including the circumstances of the interview and the analytic processes and clinical tools that allowed them to arrive at their conclusions. The participants' two central suggestions for telephonic evaluations (encapsulated in the categories "disclose modality and explain rationale" and "describe strategies for overcoming limitations") highlight the importance of clearly delineating the thought processes and reasoning behind evaluators' clinical determinations and acknowledging the obstacles involved. Participants explained that seeing evaluators' clinical reasoning helps them give credence and weight to an affidavit's conclusions. Our findings are consistent with previous research in which immigration attorneys explained that effective evaluations thoroughly document and describe the interview and diagnostic process.[6]

The second practice recommendation is to employ strategies that may bolster the evaluators' credibility and objectivity in the eyes of adjudicators. Many of the participants' recommendations (including attaching the evaluator's curriculum vitae, providing therapeutic recommendations, assessing for malingering, and avoiding legal terminology) were unified by the idea that evaluators need to maintain the appearance

of clinical objectivity. Participants felt that evaluators' objectivity, and therefore their credibility as expert witnesses, was paramount to the effectiveness of their affidavits because it increases the weight judges can give to the evaluations' findings and preempts accusations of bias from the opposing counsel or an immigration judge. For telephonic interviews specifically, participants suggested that evaluators could improve the perception of their credibility by clearly demonstrating why a remote modality was a professionally acceptable alternative to an in-person interview. Participants' emphasis on structuring affidavits and interviews to bolster their objectivity accords with existing best practices in the literature on conducting forensic evaluations. These guidelines, including the Istanbul Protocol,[23] suggest that clinicians maintain objectivity and avoid seeming to engage in advocacy, including assessing malingering to the extent possible.[24] Similarly, others have proposed that clinicians can use their experience as forensic evaluators to advocate broadly for asylum seekers to have access to medical and social services but serve as independent clinical witnesses in individual cases by adhering to professional practice guidelines.[1]

The third recommendation is that evaluators can pursue telephonic evaluations as an acceptable alternative to in-person evaluations especially if they explicitly implement suggested strategies to mitigate some of the modality's limitations. The attitudes of participants in our study were generally consistent with the medical literature suggesting that telehealth is an acceptable modality for psychiatric and psychological practice and diagnosis.[25–27] Telehealth technology may allow clinicians in some settings to diagnose conditions that are relatively prevalent among asylum seekers, such as PTSD or MDD,[28–31] with a high degree of accuracy.[32–25] Although literature suggests that mental health clinicians are comfortable using telehealth for forensic assessments broadly, research assessing clinicians' perceptions of telehealth forensic evaluations for immigration cases specifically is less robust.[16,17] In one small qualitative study that assessed clinicians' attitudes toward telephonic evaluations of asylum seekers, clinicians expressed concern about difficulty with rapport building, lack of visual cues limiting the comprehensiveness of the mental status exam, and interpreter challenges, but ultimately felt there was no difference in their ability to accurately make diagnoses by phone or through in-person evaluations.[15] A survey of clinicians' attitudes about video-conferencing for forensic mental health evaluations, while not specific to an immigration context, revealed similar concerns, but suggested that prior experience conducting video evaluations could mitigate them.[36]

A recent survey of legal professionals documented attorneys' skepticism about the validity and usefulness of forensic mental health evaluations for civil, criminal, and family court proceedings conducted via video-teleconference.[36] The authors also noted that the two participant judges in that survey appeared more willing to accept evidence based on a video-conference forensic mental health evaluation than were attorneys.[36] Our study findings similarly suggest that immigration judges may hold attitudes that are more consistent with clinicians' perspectives than attorneys' perceptions reported in the literature, and that both clinicians and judges generally embrace the telephonic evaluation as a modality to make accurate diagnoses. Additional research is warranted to explore the attitudes of attorneys, clinicians, and immigration judges in studies with larger and more diverse samples.

In addition, these practice recommendations must be understood in the context of participants' beliefs that the current immigration legal system is unjust in ways that affect how judges employ psychological evidence. Broadly, participants described that asylum seekers face adjudicators who are actively seeking to deny asylum claims, are skeptical of psychiatry as a field, or are simply under too much time pressure to digest mental health evidence sufficiently. As a result, some immigration judges might discredit or ignore affidavits, regardless of the affidavits' strengths or whether affidavits contain elements that judges in this study considered significant. These perspectives are consistent with literature that shows high rates of burnout among U.S. immigration judges.[37] Our findings also accord with studies from other countries suggesting that judges across legal specialties find medical evidence too time-consuming to assess appropriately and that immigration judges frequently neglect psychological evidence in their decision-making.[38,39] Participants suggested that telephonic evaluations could be particularly vulnerable to the whims of immigration judges looking to either discredit or exploit the remote modality to help confirm a presumptive denial of the asylum claim. The findings of our study highlight that although forensic clinicians

may adhere to evidence-based best practices for both in-person and telephonic evaluations, their documentation may be effective only if adjudicators of asylum claims are fair and the system that oversees them is just. Given these limitations, forensic evaluators should actively communicate with the referring attorney to ensure that their affidavits are structured and presented in a way that maximizes their usefulness in the context of the specific case and jurisdiction.

Moreover, although the practice recommendations described above were common among study participants, there were a few areas in which participants' perspectives were contradictory. Most notably, participants had divergent opinions about whether evaluators with preexisting therapeutic relationships should conduct forensic interviews, the level of detail appropriate to a trauma narrative, and the utility of citing medical literature in affidavits. These apparent contradictions in suggestions for expert witnesses reflect a broader pattern of inconsistencies in the U.S. asylum system, in which different judges within the same court have dramatically different asylum grant rates, even for asylum seekers from the same countries.[40] Future research should explore the areas of contradiction identified in our study, as well as confirm the widely agreed upon findings among a larger sample.

Participants in this study largely found telephonic evaluations to be ethically acceptable if they met professional standards, an observation that is consistent with the attitudes previously expressed by some forensic mental health clinicians.[15] Evaluators must also weigh the ethics considerations for each case. For example, evaluators should consider the risk of re-traumatization versus benefit for the individual, their comfort providing a onetime telehealth evaluation in the absence of other forms of contact, and the potential risk to an individual's safety in a setting (like an immigration detention center) in which immediate access to follow-up mental health care is not guaranteed.

Limitations

We acknowledge limitations in the study. The snowballing approach to recruitment may have affected the diversity of our sample, skewing it toward former judges with similar professional backgrounds or legal ideologies. We tried to mitigate this limitation by deliberately soliciting peer referrals from diverse geographic areas and requesting that participants nominate peers whom they know hold a broad range of legal perspectives. We explained how participants speculated about the relationship between affidavit quality and evaluation modality. Without fully controlling the content of the affidavit, however, we cannot entirely disentangle whether the differences between the affidavits, upon which participants reportedly based their grades, were attributable to modality or inherent variability. Further research is necessary to determine whether the weight immigration judges give telephonic affidavits changes with knowledge of the evaluation's modality. Finally, developing a checklist for high-quality affidavits using a consensus methodology was beyond the scope of this study, but is an ideal next step to build on the initial findings we present in this manuscript.

Conclusions

This study sheds light on immigration judges' perceptions of forensic evaluations of asylum seekers, and provides key considerations for mental health practitioners conducting telephonic evaluations. Evaluators should consider taking into account the practice recommendations of immigration judges, both for telephonic and in-person evaluations, that can bolster the usefulness of their evaluations in the adjudication process. As telehealth continues to grow as a modality both for clinical and forensic services, additional research is needed to explore the efficacy of telephonic evaluations.

Finally, as best practices are established, it is important that they are communicated clearly among clinicians, attorneys, and immigration judges. This study highlights the fact that best practices are relevant only in a just legal system. While participants cautioned against clinician advocacy at the level of individual asylum seekers, medical professionals can play an important role in championing policy-level changes that ensure a fairer immigration system.

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