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Preparing Clinicians to Conduct Forensic Medical and Mental Health Evaluations for People Seeking Asylum

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Abstract

Introduction: Teaching graduate medical trainees to conduct forensic medical and mental health evaluations (FMEs) of people seeking asylum fosters knowledge and skills needed to care for displaced and trauma-exposed populations. The national Asylum Medicine Training Initiative (AMTI) is the new standard for training clinicians to conduct FMEs but has not yet been evaluated in graduate medical education.

Methods: We designed a novel, year-long, interdisciplinary, graduate medical elective in asylum medicine that combines AMTI's asynchronous didactics with experiential learning in the form of small group skills practice and mentored FMEs. We used a formative, mixed-methods approach to evaluate participants' acquisition of knowledge essential for conducting FMEs, self-reported comfort with relevant skills, and self-reported preparedness for conducting independent FMEs.

Results: Eight trainees participated in the elective from September 2022 to June 2023. The evaluation (response rate 100%, 8/8) showed a significant increase in knowledge essential for conducting FMEs, and most participants felt prepared to conduct FMEs independently. Qualitative analysis showed participants felt they benefited from the experiential learning and that, despite barriers to conducting FMEs, they intend to apply these skills in future work with displaced populations.

Conclusions: Though limited by small sample size and reliance on self-assessment, our results indicate that this novel curriculum helped prepare interdisciplinary trainees to conduct FMEs and improved their comfort with skills applicable to working with displaced populations. This elective could be replicated at other institutions because of the accessibility of the AMTI curriculum and use of virtual space for small groups and mentored FMEs.

Introduction

As the unprecedented number of displaced persons globally grows, leaders in graduate medical education must prepare trainees to care for these populations.[1] Training clinicians to conduct forensic medical and mental health evaluations (FMEs) for people seeking asylum develops competencies essential for working with

displaced populations, such as trauma-informed interviewing and examination, cultural competence, and helping them to defend the fundamental human right to asylum.[2–10]

In an FME, a clinician evaluates an applicant for evidence of alleged persecution and documents their findings in a medico-legal affidavit.[2] Traditionally, training involved day-long sessions with expert speakers, though few participants conducted FMEs afterward.[11] In 2022, the Asylum Medicine Training Initiative (AMTI)[12] sought to improve the existing training paradigm by bringing together 80 stakeholders across more than 40 institutions to create an interdisciplinary, consensus-driven, virtual curriculum that can be paired with experiential learning in a flipped classroom format to better prepare learners.[13–15] AMTI has been adopted as the training standard by Physicians for Human Rights, an organization that hosts the largest referral network for pro bono FMEs nationally. However, the AMTI has not been evaluated as a tool in graduate medical education. A few curricula designed to train residents in FMEs have been described,[16–18] but they predate the development of the AMTI.

We piloted a year-long, interdisciplinary, graduate medical elective in asylum medicine by pairing AMTI's curriculum with experiential learning in the form of skills practice and mentored FMEs. Our objectives were to determine if (1) participants acquired knowledge essential for conducting FMEs, (2) participants felt more comfortable with key skills in asylum medicine, and (3) the curriculum helped learners feel prepared to conduct independent FMEs.

Methods

Setting and Participants

We piloted the elective at an academic safety-net hospital from September 2022 to June 2023. Our cohort included three internal medicine residents, two family medicine residents, two psychiatry residents, and one clinical psychology postdoctoral fellow. We selected amongst interested trainees by lottery.

Intervention

The elective featured a flipped classroom design informed by experiential learning theory and supported by evidence demonstrating the success of this approach in health professions education.[14,19] In semester one, participants independently completed AMTI's five core modules, then met virtually for four 90-minute small groups (blocks A-D) for skills practice and discussion with faculty experts. In semester two, participants performed three mentored FMEs with increasing independence.

Outcomes Measured

We designed a formative, mixed-methods evaluation to assess knowledge acquisition, skills comfort, and perceived effectiveness in preparing participants to conduct FMEs. The evaluation included surveys at the end of semesters one and two (40-items and 38-items; respectively), a 20-minute semistructured exit interview, and AMTI's pre-post assessment (68-items).

Surveys and interview questions were developed iteratively with faculty. Questions assessed demographics, prior FME experience, FME skills comfort, elective experience, perceived elective effectiveness, future intentions, and burnout using Likert scales and free-text.

The AMTI assessment was developed iteratively with a national stakeholder working group. Questions assessed demographics, FME knowledge and skills comfort, and direct knowledge acquisition using Likert scales and multiple-choice.

Analyses

We assigned numerical values to Likert questions and compared pre-post change scores using Wilcoxon

Signed-Rank tests. Knowledge acquisition was assessed using AMTI scores with a paired samples *t* test for normally distributed data, with significance at $P<.05$. Free-text responses and interviews were analyzed using a grounded theory approach to develop a codebook. Two researchers double-coded data in Dedoose software (Los Angeles, CA: Sociocultural Research Consultants), systematically identified emerging themes, and resolved discrepancies through consensus. The Cambridge Health Alliance Institutional Review Board approved this study.

Results

The response rate was 100% (8/8). Half of the participants identified themselves or their parent/guardian(s) as refugees or immigrants, and none had previously conducted a FME (Table 1).

During semester one, AMTI's direct knowledge assessment revealed a significant increase in knowledge necessary for conducting FMEs. After the elective, participants reported high comfort levels with many key FME skills and 75% (6/8) felt "prepared" or "completely prepared" to conduct FMEs independently. Most participants reported they were likely to use the skills in their future careers and an increased likelihood of working with displaced persons in the future (mean scores: 9.6 and 9.3 on an 11-point scale; Table 2).

Qualitative analyses revealed seven themes (Table 3). Participants were motivated to participate by their lived experiences and desire to benefit displaced populations. They felt their learning was enhanced by the experiential learning components of the course but desired a stronger sense of community than the fully virtual format created. They identified two barriers to conducting FMEs in the future: lack of protected time and ongoing mentorship. Nevertheless, participants felt they would be able to use the skills acquired in work with displaced populations.

Conclusions

Our study addresses a literature and training gap by presenting a curriculum that integrates AMTI with experiential learning to equip interdisciplinary trainees with essential knowledge for conducting FMEs and enhancing comfort with skills relevant to working with displaced populations. The results of our formative evaluation, though limited by small sample size and a reliance on self-assessment,[21] suggest that incorporating experiential learning helped participants feel more comfortable with FME skills and prepared to conduct independent FMEs.[9,22]

Participants identified lack of protected time and ongoing mentorship as barriers to conducting future FMEs. However, they reported an increased likelihood of working with displaced populations and rated themselves highly likely to use skills learned in the elective, with the potential to decrease burnout.[20] Thus, this curriculum has the potential to better equip trainees to deliver general clinical care in today's era of unprecedented migration.[23–26]

Strengths of this study include the interdisciplinary cohort. Limitations include the small sample size, singular site, and reliance on self-assessment.[21] Participants also opted-in, so the results are not generalizable to nonelective contexts. Next steps include direct skills and longitudinal assessments using a larger cohort to determine if/how the skills participants acquired are applied.

To our knowledge, this is the first study evaluating FME training in graduate medical education using the AMTI curriculum.[13] This elective could be replicated at other institutions due to AMTI's accessibility and the use of virtual spaces for small groups and mentored FMEs.

Tables and Figures

Table 1. Demographics of Elective Participants

Characteristic	n=8 (%)
Age[a]	
Mean[range]	31.5 [29-39]
Gender	
Female	6 (75)
Race/ethnicity	
White	6 (75)
Asian	1 (13)
Multiracial	1 (13)
Sexual orientation	
Heterosexual	5 (63)
Bisexual	2 (25)
Lesbian	1 (13)
Self-identified refugee or immigrant or child of refugee or immigrant	4 (50)
Birth country	
United States	7 (88)
China	1 (13)
Clinical or professional degree	
MD	7 (88)
PsyD	1 (13)
Specialty	
Psychiatry	2 (25)
Internal medicine	3 (38)
Family medicine	2 (25)
Psychology	1 (13)

[a]Data derived from 2023 AMTI and midline survey.

Table 2. Evaluation of Asylum Medicine Elective

Knowledge Acquisition				
Semester 1. Acquired knowledge (AMTI pre & postsurvey)	**Premodules**	**Postmodules**	***t* score (df) [a]**	***P* value [b]**
Summation score	10.08 (0.74)	10.90 (0.65)	-2.71 (7)	**.03** [d]
Comfort with FME knowledge and skills				
Semester 1. Comfort with FME Knowledge (AMTI pre & postsurvey)	**Pre-Modules**	**Post-Modules**	**Absolute Difference on 0-4 scale**	***P* value [b]**
Please indicate how comfortable you are with each of the following:	**Mean (SD)**			
Describing the legal process individuals undergo when applying for asylum in the U.S.	2.38 (1.19)	3.88(0.83)	1.50	**.02**[d]
Explaining the role of the clinician in conducting forensic medical evaluations of asylum seekers	2.38 (1.06)	4.50(0.53)	2.12	.65
Applying key trauma-informed techniques during a forensic medical history and examination	3.13 (0.64)	4.75(0.46)	1.62	.08
Recognizing and describing commonly encountered physical and psychological sequelae of trauma among survivors of torture and ill-treatment	2.63 (0.74)	4.13(0.64)	1.50	.21
Correlating the degree of consistency between the history provided by a survivor of trauma and their forensic medical evaluation findings using the Istanbul Protocol terminology	1.75 (1.16)	4.13 (0.64)	2.38	.43
Diagnosing common mental health conditions among survivors of trauma within your scope of practice	3.00 (1.07)	4.75 (0.46)	1.75	**.02** [d]
Drafting a medico-legal affidavit based on the findings of a forensic medical evaluation with supervision from a mentor, if needed	1.75 (1.16)	3.88 (0.35)	2.13	.61
Locating additional resources that may be required to address the needs of special populations- such as LGBTQIA+ individuals, asylum seekers in detention, or survivors of sexual and gender-based violence- including additional training, mentorship, and referral for specialty care/evaluation	2.13 (0.83)	3.63 (1.19)	1.50	.25
Collaborating and communicating with attorneys in preparation for a forensic medical evaluation, while drafting a medico-legal affidavit, and when preparing for testimony, if needed	1.50 (0.93)	4.00 (0.53)	2.50	**.03** [d]
Implementing best practices while conducting remote/virtual forensic medical evaluations of asylum seekers	1.88 (0.83)	4.25 (0.71)	2.37	.47
Prioritizing strategies to mitigate secondary trauma and sustain your work with highly traumatized populations	2.75 (0.89)	4.13 (0.64)	1.38	.34

Table 2, Continued

Knowledge Acquisition					
Semester 2. Comfort with FME Skills (Semester 2 Survey)	**No Comfort**	**Discomfort**	**Comfort**	**Absolute Comfort**	**Mean (SD) on 0-3 scale**
On a scale of 0-3, where 0 = no comfort/confidence and 3 = complete comfort/ confident during the FME process, how comfortable/confident do you feel…					
Describing the role of a clinician in the asylum process	0	0	6 (75.0)	2 (25.0)	2.25 (0.46)
Describing limits of confidentiality	0	0	5 (62.5)	3 (37.5)	2.38 (0.52)
Conducting a trauma-informed interview	0	1 (12.5)	5 (62.5)	2 (25.0)	2.13 (0.64)
Working with an interpreter	0	0	5 (62.5)	3 (37.5)	2.38 (0.52)
Communicating with a lawyer	0	1 (12.5)	5 (62.5)	0	1.63 (0.52)
Maintaining boundaries as an evaluator, not a physician/ psychologist/healthcare worker	0	3 (37.5)	4 (50.0)	1 (12.5)	1.75 (0.71)
Differentiating mental health diagnoses for the affidavit	0	2 (25.0)	3 (37.5)	3 (37.5)	2.13 (0.83)
Documenting findings from an evaluation in a medico-legal affidavit	0	1 (12.5)	7 (87.5)	0	1.88 (0.35)
Being called to court for oral testimony	3 (37.5)	4 (50.0)	1 (12.5)	0	0.75 (0.71)
Mentoring new FME evaluators	1 (12.5)	4 (50.0)	3 (37.5)	0	1.25 (0.71)
Saying no when an urgent evaluation request comes and I'm feeling numb	1 (12.5)	1 (12.5)	6 (75.0)	0	1.63 (0.74)
Finding a community of evaluators support	0	1 (12.5)	6 (75.0)	1 (12.5)	2.00 (0.53)
Self-Reported Preparedness to Conduct FMEs					
Semester 1. Effectiveness (Semester 1 Survey)	**Ineffective**	**Somewhat Ineffective**	**Somewhat Effective**	**Effective**	**Mean (SD) on 0-3 scale**
How effective was [Block A, B, C1, C2, D] in preparing you to conduct FMEs?					
Block A: Introduction to Forensic Medical Evaluations	0	0	3	5	2.63 (0.52)
Block B: Trauma-Informed Interview & the Forensic Mental Health Evaluation	0	0	0	8	3.00 (0.00)
Block C1c: Forensic Physical Evaluation (n=7)	0	0	1	6	2.50 (1.07)
Block C2c: Forensic Physical Evaluation & the Advanced Mental Health Evaluation	0	0	1	7	2.88 (0.35)
Block D: Writing the Medico-Legal Affidavit	0	0	2	6	2.75 (0.46)
Semester 2. Perceived Readiness (Semester 2 Survey)	**Not at all Prepared**	**Somewhat Prepared**	**Prepared**	**Completely Prepared**	**Mean (SD) on 0-3 scale**
How well did Semester 1 (didactics) prepare you for Semester 2 (conducting FMEs)?	0	0	6 (75.0)	2 (25.0)	2.25 (0.43)
How prepared do you feel to conduct independent FMEs after completing the elective?	0	2 (25.0)	5 (62.5)	1 (12.5)	1.88 (0.60)

Other Findings				
Changes from Semester 1 to Semester 2 Survey	**Mean (SD) Midline Score**	**Mean (SD) Endl ine Score**	**Absolute Difference on 0-10 scale**	***P* value[b]**
How likely are you to conduct free (pro-bono) FMEs in your career?	7.3(2.80)	7.60 (2.70)	0.30	.80
How likely are you to work with displaced persons in your career?	7.5(1.90)	9.3(1.20)	1.80	**.02** [d]
On a scale of 0-10, please type your current burnout percentage.	5.9(2.30)	3.8(2.60)	2.10	**.04** [d]
On a scale of 0-10, how likely are you to use the skills you developed during this elective in the future?[e]	N/A	9.3(0.97)	-	-

Abbreviation: FME, forensic medical and mental health evaluations.
[a] Paired-samples *t* test calculated mean differences change scores; df = degrees of freedom, number of participants minus 1.
[b] *P* value calculated using Wilcoxon Signed-Rank test
[c] Block C was split into C1 for the internal medicine and family medicine residents and C2 for the psychiatry residents and clinical psychology postdoctoral fellow.
[d] Statistically significant responses are bolded.e Only asked on Semester 2 Survey.

Table 3. Themes From Resident Free-Response Questions and Exit Interviews

Themes	Sample Quotes
Enrollment was driven by participants' lived experiences and desire to use skill sets for the benefit of displaced populations	"I have been interested in asylum medicine in part inspired by my family's own immigration experiences."
Small groups led by experts solidified AMTI content through rich discussions	"I loved each virtual session, found it very helpful to discuss and learned so much from the experts." "The small groups allowed the didactics to come alive. It's so helpful to have an interactive first-hand account from someone."
Mentorship model was a valuable teaching tool	"I think [mentorship is] the most valuable part of the experience." "I worked with three separate mentors, and I think that was actually helpful to see how different people did [evaluations]."
The fully virtual format of the elective created a sense of disconnection/isolation for some participants	"It would have been much more rewarding to have more group cohesion."
Lack of protected time was a common barrier to scheduling mentored FMEs and when considering conducting independent FMEs in the future	"It's hard to schedule FMEs with our busy schedules." "I was nervous for most of the semester [two] the scheduling wouldn't work out." "I think that supporting a program and protecting time for clinicians to actually do this work, especially people who work as PCPs. Being able to do this work and gain exposure is a huge part of their population that…we don't really talk about in our regular visits. I think [protected time for FMEs] would impact care and … increase the financial aspect."
Performing more mentored FMEs during/after the elective would increase participant comfort with conducting independent FMEs	"…I might want to do 1-2 more supervised evaluations before I did them like, completely independently."
Participants expressed intent to use skills gained from the elective in their future career, both with FMEs and beyond	"I would love to do [FMEs] independently and train people." "I want to do a grand rounds later this year." "I'd love to continue like a relationship with you know the asylum training program." "[I'm] interested in knowing where your networks are…in the country and where I could get involved locally."

Abbreviations: FME, forensic medical and mental health evaluations; AMTI, Asylum Medicine Training Initiative; PCP, primary care physician.

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