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Screening for Torture, Asylum, and Trauma among Patients Seeking Care in an Urban Student-Run Free Clinic

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Abstract

Introduction: Many immigrants have histories of violence and persecution in their countries of origin that may make them eligible for asylum in the United States. East Harlem Health Outreach Partnership (EHHOP) is a physician-supervised, student-run free clinic (SRFC) of the Icahn School of Medicine at Mount Sinai that serves exclusively uninsured persons, nearly all of whom are immigrants. This study aimed to provide a screening tool to measure the prevalence of self-reported histories of persecution which may be grounds for asylum and connect these patients to appropriate resources such as legal aid and forensic medical services.

Methods: The Screening for Torture, Asylum, and Trauma (STAT) questionnaire was developed to screen patients for potential asylum-eligible histories. The questionnaire probed if participants were ever victims of violence or abuse in their countries of origin and the contexts of such violence. Patients screening positive for trauma which may constitute grounds for an asylum claim ("STAT-positive") were assigned a case manager to oversee referrals to appropriate resources. Changes in demographics between STAT-positive and STAT-negative patients were determined using Fisher Exact Tests and binomial exact calculations to generate P-values and 95% Confidence Intervals (CI), respectively.

Results: Of the 86 patients screened, 27 (31%; 95% CI [0.22-0.42]) were STAT-positive. Nineteen (70%) were interested in applying for asylum and 15 (79%) of these patients were successfully referred to legal assistance programs. Seventeen (63%) were already receiving care at EHHOP's mental health clinic.

Conclusion: There is a high prevalence of patients (31%) within the EHHOP SRFC with histories of violence, abuse, persecution, or discrimination which may be grounds for asylum in the United States. Identifying these patients for targeted interventions may have a significant positive impact for these patients.

Introduction

East Harlem Health Outreach Partnership (EHHOP) is a student-run, physician-supervised free clinic that provides longitudinal healthcare for patients in the East Harlem neighborhood of New York, New York (NY) who do not qualify for health insurance. The EHHOP patient population is underserved, marginalized, and predominantly comprised of immigrants. Immigrants to the United States include asylum seekers who have often escaped violence and torture in their countries of origin and are unable or unwilling to return because of well-founded fears of persecution on account of their race, religion, nationality, membership of a particular social group or political opinion.[1] Additionally, asylum seekers are present in the United States or are seeking entry at a port of entry at the time they request protected status. Identifying patients who have such

histories of persecution is crucial in providing the appropriate legal assistance and trauma-informed healthcare. The latter focuses on safety and avoidance of re-traumatization in patients and a strengths-based approach to healing, utilizing patients' own resilience to develop coping skills.[2]

There are currently 3 million refugees living in the United States and as many as 44% of them are survivors of torture.[3,4] Given this significant prevalence, it is inevitable that physicians encounter such survivors in their practices, especially in urban settings. Previous studies have found the prevalence of survivors of torture in urban primary care and emergency department setting ranges between 6.2% to 11.5%.[5–7] Often, these patients and their histories of torture were not previously identified.[5,8] This has important implications for whether or not a patient receives the appropriate care for psychological and physical sequelae of trauma, as well as referrals to legal resources that can assist in the asylum application process.

While there is existing literature examining the prevalence of survivors of torture in primary care settings, there are two important gaps. First, prior studies have not explored the prevalence of patients who may be eligible for asylum in a student-run, physician-supervised free clinic like EHHOP. Second, even when patients were identified as survivors of torture in primary care settings, no prior studies examined the follow-up of these patients nor the legal and medical resources to which they may have been referred.

The goals of this study were to (1) provide a screening tool to measure the prevalence of self-reported histories of persecution which may be grounds for asylum and (2) develop a program to connect those patients who may be eligible for asylum to appropriate resources such as legal aid and medical services.

Methods

The Screening for Torture, Asylum, and Trauma (STAT) questionnaire (Online Appendix) was developed by EHHOP clinic student-leadership and the Mount Sinai Human Rights Program, a faculty–supervised, student-led organization at the Icahn School of Medicine at Mount Sinai that provides pro-bono forensic medical, psychological and gynecological evaluations and linkages to continuity medical care and social services to survivors of human rights abuses who are seeking asylum in the United States. The questionnaire was based on a modified version of the Detection of Torture Survivors Survey used in prior studies.[9,10] This survey has been validated against blinded expert clinical interviews using the Harvard Trauma Questionnaire, followed by in-depth psychological assessments, to identify people who meet the World Medical Association's Tokyo Declaration.[11] This was used in conjunction with the United Nations Convention Against Torture (UNCAT) definition of torture, upon which asylum eligibility in the United States is often based. UNCAT defines torture as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."[12]

Specifically, the STAT questionnaire probed if participants were ever subjected to violence or abuse in their countries of origin, the reasons for such violence (religion, race, political beliefs, nationality, or a particular social group), and whether the abuse was perpetrated by a public official or person acting in an official capacity. Both English and Spanish questionnaires were generated and made available during screening. The STAT questionnaire was used to screen patients who receive care at EHHOP from July 2018 to March 2019. Patients were provided with the questionnaire, the purpose of the study as well as the benefits and risks of participating were discussed with the patients, and patients could accept or decline to complete the questionnaire.

STAT questionnaires completed by patients were reviewed by a specialized team who identified patients who screened positive for having

Table 1. Patient demographics

Patient Demographics (N=86)	STAT-Positive, N (%)	STAT-Negative, N (%)	P-value
New versus Established Patients			
New	2 (7)	4 (7)	1.000
Established	25 (93)	55 (93)	1.000
No record of potential asylum-eligible history*	16 (64)	0 (0)	-
Country of Origin			
Mexico	19 (70)	43 (73)	0.801
Ecuador	3 (11)	9 (15)	0.746
Bolivia	1 (4)	0 (0)	0.314
Honduras	1 (4)	0 (0)	0.314
Panama	1 (4)	0 (0)	0.314
Ukraine	1 (4)	0 (0)	0.314
Yemen	1 (4)	0 (0)	0.314
Dominican Republic	0 (0)	2 (3)	1.000
French Guiana	0 (0)	1 (2)	1.000
Nicaragua	0 (0)	1 (2)	1.000
Total (%, 95% CI)	27 (31, 0.22-0.42)	59 (69, 0.58-0.78)	-

**Includes any history of violence, abuse, persecution, or discrimination in patient's countries of origin*
STAT: Screening for Torture, Asylum, and Trauma; CI: Confidence interval

histories of violence or persecution in their countries of origin which may be grounds for asylum (STAT-positive). If patients screened positive, they were also assigned a medical-student caseworker, who followed up to offer referrals to (1) legal assistance programs to help the patients apply for asylum if they desired this path and/or (2) EHHOP's mental health clinic to address any sequelae of psychological trauma. Legal assistance programs included organizations in New York City that specialized in immigration law as well as EHHOP's own legal clinic.

Data on patients who screened positive with the STAT questionnaire were also collected from the electronic medical record including demographics, the type of appointment visits the patients had scheduled, and any previously documented histories of violence, abuse, or persecution patients faced in their countries of origin. 95% Confidence Intervals (95% CI) were calculated using binomial exact calculation and p-values were determined using Fisher Exact Test (SPSS Statistics Version 27, 2019, IBM Corp Armonk, NY). The study was reviewed and approved by Mount Sinai's Institutional Review Board.

Results

Screening Results

All patients were screened using the STAT questionnaire at EHHOP's primary care clinic, between July 2018 and March 2019. Screening results are summarized in Table 1. Of 86 patients who were screened, 27 (31%; 95% CI [0.22-0.42]) screened positive for having histories of violence or persecution in their countries of origin which may be grounds for asylum based on at least one affirmative answer ("STAT-positive") while 59 (69%; 95% CI [0.58-0.78]) screened negative. Of the 27 STAT-positive patients, 25 (93%) were already established patients at EHHOP and 2 (7%) were new patients. Of the 59 negative screens, 55 (93%) were established patients, 4 (7%) were new patients, and there was no statistical difference between the proportion of established versus new patients when comparing positive and negative screens (p=1.000). Of the 25 established, STAT-positive patients, 16 (64%) had no documented record in the electronic medical record of histories which may be grounds for asylum, including violence, abuse, persecution, or discrimination in their countries of origin. STAT-positive patients hailed originally from Mexico, (n=19; 70%), Ecuador, (n=3; 11%), and

Table 2. Reason for leaving country of origin

Reason	N (%)	95% CI
Domestic Violence	7 (26)	0.11-0.46
Violence	5 (19)	0.06-0.38
Economic	4 (15)	0.04-0.34
LGBT Discrimination	3 (11)	0.02-0.29
Political	2 (7)	0.00-0.17
Education	1 (4)	0.00-0.19
Other	5 (19)	0.06-0.38

CI: Confidence interval; LGBT: Lesbian, Gay, Bisexual, and Transgender

Bolivia, Honduras, Panama, Ukraine, and Yemen (n=1; 4%). STAT-negative patients came from Mexico (n=43; 73%), Ecuador (n=9; 15%), Dominican Republic (n=2; 3%), French Guiana (n=1; 2%), and Nicaragua (n=1; 2%). There were no statistical differences between STAT-positive versus STAT-negative screens in terms of country of origin.

Reasons for Leaving Country of Origin

All patients were also asked to indicate in free text their reasons for emigrating from their countries of origin to the United States. (Table 2). Of the 27 STAT-positive patients, 7 (26%; 95% CI [0.11-0.46]) left due to domestic violence, 5 (19%; 95% CI [0.06-0.38]) left due to violence (non-specified), 4 (15%; 95% CI [0.04-0.34]) left for economic reasons, 3 (11%; 95% CI [0.02-0.29]) left due to Lesbian, Gay, Bisexual, and Transgender (LGBT) discrimination, 2 (7%; 95% CI [0.01-0.24]) left for political reasons, 1 (4%; 95% CI [0.00-0.19]) left for a better education, and 5 (19%; 95% CI [0.06-0.38]) left for other reasons. This further assisted in classifying whether a patient might or might not be eligible to apply for asylum.

Case-worker Follow-up

Individual medical student case-workers were assigned to follow up with each STAT-positive patient in order to determine and complete appropriate referrals. Results of this follow-up are summarized in Tables 3 and 4. Of the 27 STAT-positive patients, 19 (70%; 95% CI [0.50-0.86]) were interested in applying for asylum. Of the 19 interested patients, 15 (79%; 95% CI [0.54-0.93]) of these patients were referred to legal assistance programs while 4 (21%; 95% CI [0.06-0.46]) were already applying for asylum with their own lawyers. Of the

Table 3. Legal resource referral

Reason for legal referral	N (%, 95% CI)
Interested in asylum	19 (70, 0.50-0.86)
Referred to legal assistance program	15 (79, 0.54-0.93)
Already applying with a different lawyer	4 (21, 0.06-0.46)
Not interested in asylum	5 (19, 0.09-0.51)
Declined to apply	3 (60, 0.15-0.94)
Applying for immigration with a different method	1 (20, 0.00-0.72)
Applied previously but did not qualify	1 (20, 0.00-0.72)
Lost to follow-up	3 (11, 0.03-0.40)

CI: Confidence interval

27 STAT-positive patients, 5 (19%; 95% CI [0.09-0.51]) patients were not interested in applying for asylum. Of these five patients, 3 (60%; 95% CI [0.15-0.94] declined to apply for asylum for unknown reasons, 1 (20%; 95% CI [0.00-0.72]) was applying for another form of immigration relief, and 1 (20%; 95% CI [0.00-0.72]) had previously applied for asylum but it was not granted. Of the 27 STAT-positive patients, the 3 (11%; 95% CI [0.03-0.40]) remaining patients were lost to follow-up.

Of the 27 patients who screened positive, 17 (63%) were already receiving care at EHHOP's mental health clinic (MHC) and of the patients who screened negative, 17 (29%) utilized MHC. The proportion of patients seeing MHC was significantly greater in the STAT-positive group compared to the STAT-negative group (p=0.004). Of the 10 patients who were STAT-positive and not being followed by MHC, 2 (20%; 95% CI [0.03-0.56]) patients were interested in referrals to MHC and 8 (80%; 95% CI [0.44-0.97]) declined referrals. By the end of the study, 19 out of the 27 patients (70%; 95% CI [0.50-0.86]) who screened positive were being seen by MHC.

Discussion

Significant Prevalence of Potential Asylum-Eligible Patients

A high number of patients (31%) screened in this study at our SRFC reported a history of violence, abuse, persecution, or discrimination

Table 4. Mental health clinic utilization

Characteristics	N (%)	P-value
Previous Mental Health Clinic Patient		
Yes		0.004
STAT-Positive	17 (63)	-
STAT-Negative	17 (29)	-
No		0.004
STAT-Positive	10 (37)	-
STAT-Negative	42 (71)	-
Interested in mental health clinic referral* (%, 95% CI)		
Yes	2 (20, 0.03-0.56)	-
No	8 (80, 0.44-0.97)	-
Total mental health clinic patients at study end	19 (70, 0.50-0.86)	-

**Denominator is the 10 STAT-positive patients with no previous mental health clinic history.*
CI: Confidence interval; STAT: Screening for Torture, Asylum, and Trauma

which may be grounds for asylum. The prevalence of such histories was much higher in this study than previous studies which estimated the prevalence for survivors of torture in an urban primary care setting to be 6.2% to 11.5%.[5–7] However, a key distinction is that EHHOP's patient population is comprised of the uninsured, with a preponderance of immigrants. The high prevalence of patients with such histories in an SRFC requires attention and effective intervention.

Established Patients with Unknown Histories

This study also found that a majority of established SRFC patients (64%) who screened STAT-positive did not have any documentation of histories of violence or persecution in their countries of origin which may be grounds for asylum. This likely meant that the healthcare team was unaware of these patients' histories and thus potentially delaying appropriate care and referrals. This finding is consistent with previous studies in which physicians were often unaware of patients' histories of torture.[5,6] There may be several contributing factors that could explain these findings such as limited training in asking screening questions, finite time in the primary care setting to address these issues, and difficulty disclosing traumatic histories in a clinical setting. Nevertheless, this study highlights the importance of asking patients about their histories of trauma in their countries of origin and doing so in a trauma-informed way. Techniques include asking for permission to discuss sensitive topics to allow the patient to be in control of the conversation and recognizing the emotions of the patient and adjusting the conversation to avoid re-traumatizing the patients.[3]

Referral to Legal Assistance Programs

A majority of patients (70%) who screened STAT-positive were interested in legal assistance to apply for asylum. While some patients had already begun the process of applying for asylum, most patients had not. Legal assistance is crucial for individuals successfully obtaining asylum. In 2018, 38,687 people were granted asylum in the United States.[14] Asylum seekers were much more likely to be granted asylum if they had legal representation and also received forensic medical evaluations to document past trauma, which is often requested by an attorney, (89%) as opposed to merely having an attorney alone (50%) or having neither forensic medical evaluations or attorneys assigned to their cases (37.5%).[15] The granting of asylum prevents deportation to a potentially life-threatening situation in one's country of origin, permits long-term employment in the United States, and is the first step to gaining lawful permanent resident status. Therefore, the roles that both healthcare professionals and lawyers assume in the life of an asylum seeker is potentially significant.

High Rates of Mental Health Clinic Utilization

Another key finding from this study is that patients who screened STAT-positive were more likely to utilize EHHOP's MHC than the rest of EHHOP's patient population. While only 29% of patients who screened negative utilized MHC, significantly more of patients who screened positive for histories of violence, persecution, or abuse utilized mental health services (63%; p=0.004). The high prevalence of mental health utilization underscores the importance of addressing the psychological sequelae of trauma these patients experience. In fact, previous studies have estimated that 9% of adult refugees may suffer from post-traumatic stress disorder (PTSD), approximately 10 times the national average in

age-matched individuals.[16] In addition, previous studies have also observed that among asylum-seeking women fleeing from the Northern Triangle countries of El Salvador, Honduras, and Guatemala, 80% had symptoms of anxiety and 91% had symptoms of depression.[17] Therefore, patients seeking asylum in an SRFC setting may require additional screening and intervention for mental health care.

In addition to connecting asylum seekers with medical and mental health care, clinicians should also tailor their treatment plans in a trauma-informed way, harnessing patients' resilience to promote healing. There are also a number of best practices that clinicians can implement in survivors of torture.[18,19] One is ensuring longitudinal care for those with symptoms of PTSD, as a large percentage of survivors face chronic mental health sequelae and are susceptible to exacerbations of their symptoms by triggering events.[19,20] A second is addressing cross-cultural barriers patients may face in accepting psychiatric care, as many have had minimal exposure to such care in their countries-of-origin where mental illness may have been stigmatized.[18,19] A third is rehabilitating patients with traumatic head injuries with specialized psychosocial and cognitive training.[18,19] A number of additional best practices relating to this have been described in the literature as well.

Limitations and Future Studies

One limitation of the study is its self-reporting nature. While we were able to screen patients for histories of violence which may be grounds for asylum, because the survey was self-administered, there was no further definition of torture or probing about patients' experiences of torture outside of what the patient reported. In the setting of trauma and abuse, further attempts at verification could have, in fact, negatively affected patient care, but as discussed before, if discussions are conducted in a trauma-informed way, the benefits outweigh the risks when addressing past trauma. A second limitation was that it was not feasible to follow outcomes to confirm if patients eventually received asylum in the legal system. The time from an initial asylum application to the adjudication of a case often takes several years, with an average wait time of 696 days for an immigration hearing in 2019.[20] It should also be noted that many of the patients who screened positive on our STAT questionnaire had missed the one-year filing deadline for asylum and, therefore, filed defensive asylum applications. Such cases are more challenging and asylum is generally granted less frequently in these instances.

Future research could include a longitudinal study of patients screened with the STAT questionnaire to investigate the effect, if any, of linking patients to legal resources and forensic medical evaluations with the legal outcomes of their asylum cases. Scaling this screening model to other clinics in high-density immigrant areas as well as exploring the relationship between patient histories and the long-term trauma they might experience, including PTSD, are other areas of future study.

Conclusion

There is a high prevalence of patients within EHHOP's SRFC with histories of violence, abuse, persecution, or discrimination which may be grounds for asylum in the United States. These histories had not been previously elicited from a majority of the patients, who also showed a higher rate of mental health utilization than the general EHHOP patient population. Interventions to treat these patients in a trauma-informed and culturally sensitive fashion must be utilized, and particular attention should be paid to refer these patients to legal assistance programs and mental health care when needed.

Disclosures

The authors have no conflicts of interest to disclose.

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