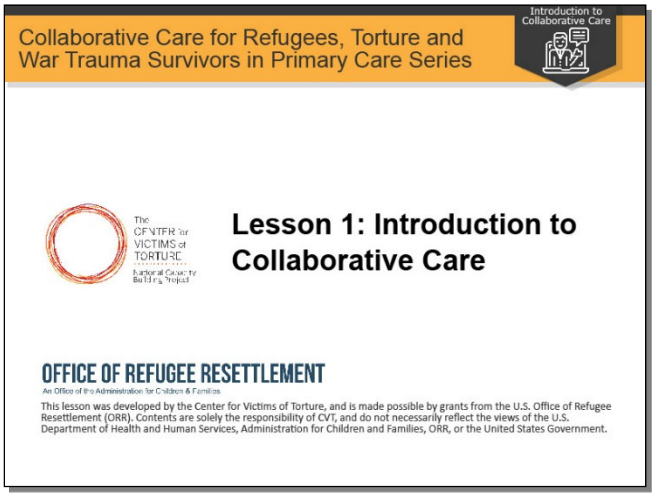
Collaborative Care Series
Introduction to Collaborative Care
Lesson Transcript

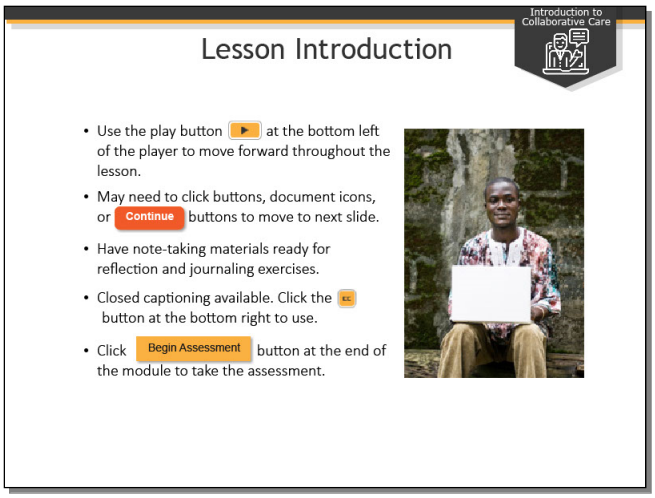
Lesson Title



Welcome to the Introduction to collaborative care lesson in the Collaborative care for refugees, torture, and war trauma survivors in primary care elearning series.

We will be talking about trauma in this lesson series. Trauma impacts us all in different ways. For some people, the following information, images, and discussion can be triggering or uncomfortable at times. Please take care of yourself and take breaks as you deem appropriate.

Lesson Instructions

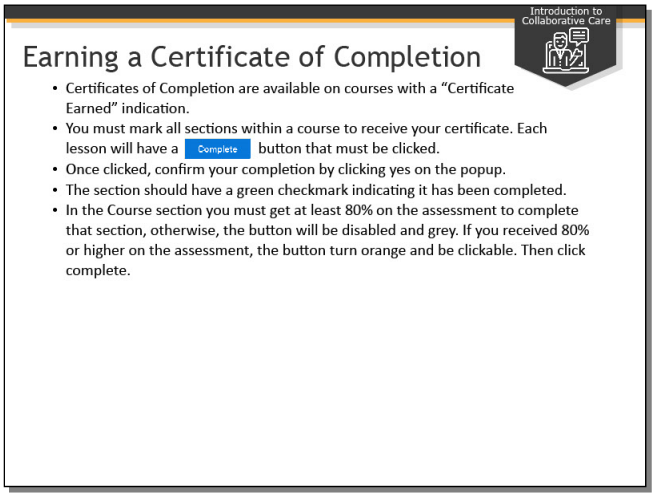


These lessons are structured for you to progress at your own speed. Throughout the lesson you will need to click the “Play” button at the bottom left of the player to move forward to the next slide. At any

point, if you need more time, you can click the pause button at the bottom of the player. As you progress through the lesson module, there may be times when you will need to click buttons to see additional content or to continue.

We recommend that you have a notepad dedicated to this course in which you can take notes, journal your reflections, or respond to questions. Have it available to you when you watch lessons or read materials in this course. To see subtitles or closed-captioning for the audio, click the “CC” button at the bottom right of the player.

Certificates of Completion



Certificates of Completion are available on courses marked with a “Certificate Earned” indication. Currently, certificates are available for all the Collaborative Care and Fundamental courses. If a course does not have this indication, a certificate is not available to be earned.

Each course in this series contains 4 sections: introduction, course, assessment, and additional materials. The upper right displays your progress through the course. In this example you see 3 of 5. This person has completed three of five total sections. You will need to complete each section to finish the course and obtain a certificate.

The introduction, includes lesson objectives, the lesson transcript, and any suggested pre-reading for the lesson. The course includes the lesson module, which needs to be viewed in its entirety. Next, is the assessment or quiz for the lesson. You will need to obtain 80% or higher on the assessment to complete that section and you can retake the assessment as many times as you need to pass. The last section is additional materials, which includes lesson references and additional resources. The left sidebar contains the full list of sections contained in the course. The main section contains the content of the lesson. If the content of the lesson is larger than the section frame, you can use the inner scrollbar to reach all of the content, as well as the complete button. You must complete all items within a course to receive your certificate. Each item will have a “Complete” button that must be clicked. Once clicked, confirm your completion by clicking yes in the popup.

Now, each section you have completed should have a green checkmark, indicating that a lesson has been completed. If you have not completed a section you will see a grey check mark.

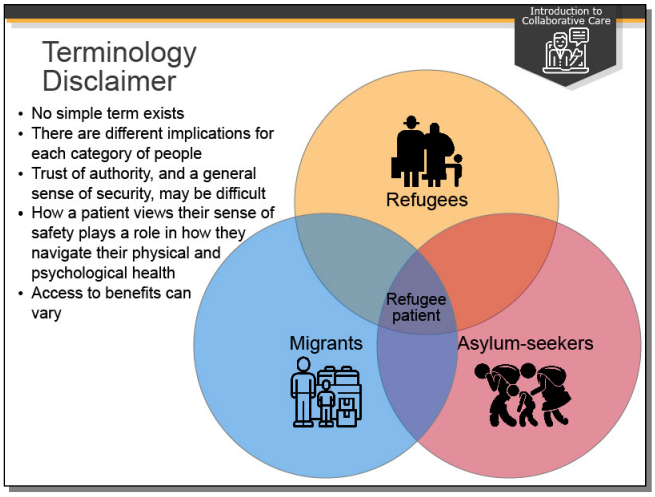
In the assessment section you must obtain 80% or higher on the assessment to complete that section, otherwise, the button will be disabled and grey. Once you receive 80% or higher on the assessment, the button should turn orange and be clickable. Make sure to click the complete button to complete that section of the course.

After all sections have been marked complete, you must then click the “Finish course” button. It will either be located in the upper right or lower right of the screen. After the button has been clicked, a popup will appear. Please confirm “Yes” that you could like to finish the course. Then the certificate may popup on your screen. Once you’ve finished a course, you can view your certificate on the course page or in the “Certificate” tab of your profile.

To download the certificate, scroll to the bottom of the certificate and locate and click on the download icon. Your certificates are available to view and download in your profile at any time.

Note: If you have completed a course and do not see your certificate, please email healtorture@cvt.org to request your certificate.

Disclaimers

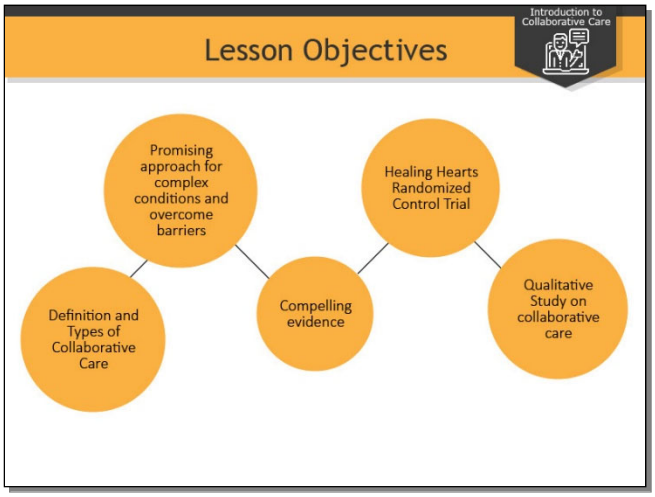


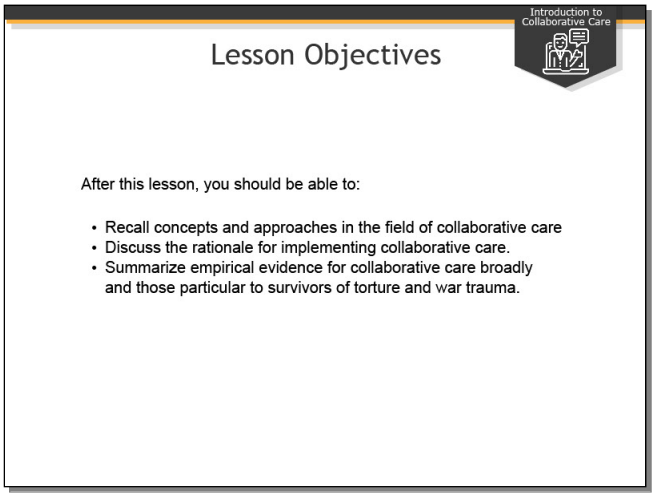
A note on terminology: No simple term exists to describe the unique set of circumstances that factor into how refugees, asylum-seekers, and migrants perceive and receive healthcare. There are different implications for each of these categories of people. Asylum-seekers, for example, who are technically seeking the official status as a “refugee,” are vulnerable to returning to their country of origin, and remain so until they are granted asylum (a process which can take years to complete). Trust of authority, and a general sense of security, therefore may be more difficult for this population due to the uncertainty of their immigration status. How a patient views their sense of safety plays a role in how they navigate their physical and psychological health. Additionally, asylum-seekers may not be able to access the social benefits that those with refugee status can.

For the sake of simplicity, in the following lessons, the term “refugee patient” is used to encompass patients who fall into all of the above-mentioned categories. We encourage providers to acknowledge how legal, psychosocial, and environmental factors may impact treatment, and to recognize that treatment may look different for political refugees, asylum-seekers, and migrants.

A note on the content provided in this lesson: The information presented in this course is accurate to the best of our knowledge at the time it was written and developed. Please note that policies change with different administrations and over time, so check for the most current policies with an attorney.

Lesson Objectives





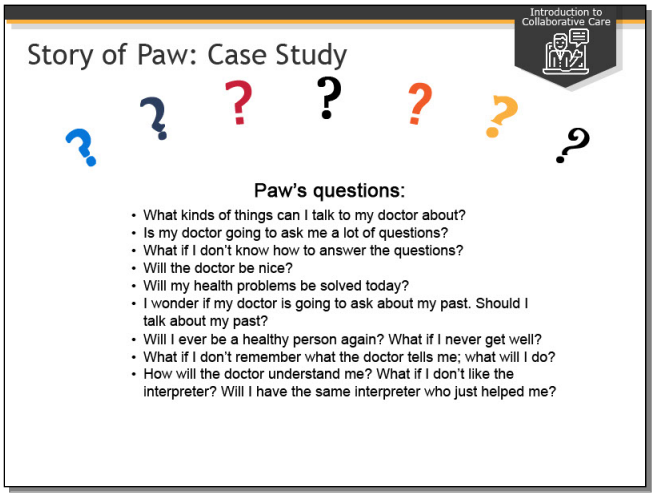
The areas we will be covering in this lesson include:

- Definition and types of collaborative care;
- Promising approach to overcome barriers and treat complex conditions;
- Compelling evidence for this approach;
- Healing Hearts Randomized Control Trial; and
- Qualitative Study on collaborative care.

This lesson offers an of overview of collaborative care and existing research on the topic. After this lesson you should be able to:

- Recall concepts and approaches in the field of collaborative care;
- Discuss the rationale for implementing collaborative care; and
- Summarize empirical evidence for collaborative care broadly and evidence particular to survivor of torture and war trauma.

Case Study



Introduction to the Story of Paw

Paw's story will be used in the lesson modules to highlight problems, solutions, challenges, and strengths when refugee patients and U.S. health care providers collaborate and bridge cultural divides to offer quality health care. The lesson sections contain both a case example as well as a resolution in each section. As we go through this example, it is important to keep in mind that this is just one example from one culture. As discussed previously, cultural competence and dynamic sizing are important concepts to remember when you are sitting across a refugee patient.

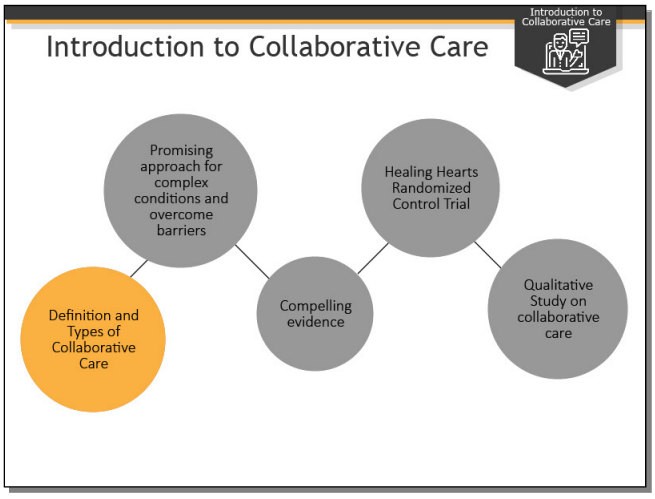
Paw, a recently arrived refugee, gets a phone call one morning. It's an interpreter telling her she has an appointment. She doesn't remember making the appointment, but the interpreter explains that it's with a doctor, and that makes her remember the outstretched hand of her resettlement worker, giving her a card with a time and date written in English. The interpreter tells her a taxi will come for her, but when an English-speaking driver arrives at her door and says her name, she hesitates. Can she really trust this person to take her to the right place? In the end, she gets in, because she's hopeful the doctor will help her stop the headaches, nightmares, and pain. Yes, she sometimes forgets things, but what she can't forget are all of the horrible things she lived through. The driver stops in front of an office building and says something, so she gets out of the car. Inside, someone behind a computer is smiling at her and motioning at her to come forward, and when it becomes clear that she doesn't speak English, the receptionist calls over an interpreter. She helps Paw check in for her appointment, and explains that her name will be called soon. Paw sits by herself in the waiting room and looks around worriedly. She sees posters on the wall in languages she doesn't recognize. She's nervous. She doesn't know what she's supposed to say or do, and her mind is filled with questions:

- What kinds of things can I talk to my doctor about?
- Is my doctor going to ask me a lot of questions?
- What if I don't know how to answer the questions?
- Will the doctor be nice?
- Will my health problems be solved today?
- I wonder if my doctor is going to ask about my past. Should I talk about my past?
- Will I ever be a healthy person again? What if I never get well?
- What if I don't remember what the doctor tells me; what will I do?
- How will the doctor understand me? What if I don't like the interpreter? Will I have the same interpreter who just helped me?

We, as health care providers in the United States, would benefit by asking our own questions about this meeting as well. Will we:

- Assess Paw in a way that comprehensively addresses her health concerns?
- Understand how Paw's experiences, health literacy and education level impact her understanding of her problems and treatment?
- Be able to offer a clear treatment plan that Paw will understand how to implement?
- Recognize if Paw's basic needs are being met and prioritize identifying ways to help her meet those needs?
- Recognize and attend to her mental health symptoms?
- Work well with an interpreter to accurately understand Paw's problems and respect her privacy and autonomy?
- Discuss any medication recommendations with details that will help Paw take the medicine safely, accurately, and effectively?
- Help her address barriers to her ongoing care so that she can experience health improvements?
- Be able to work with refugees like Paw in a professionally sustainable way? Or will we get burnt out form doing this work?

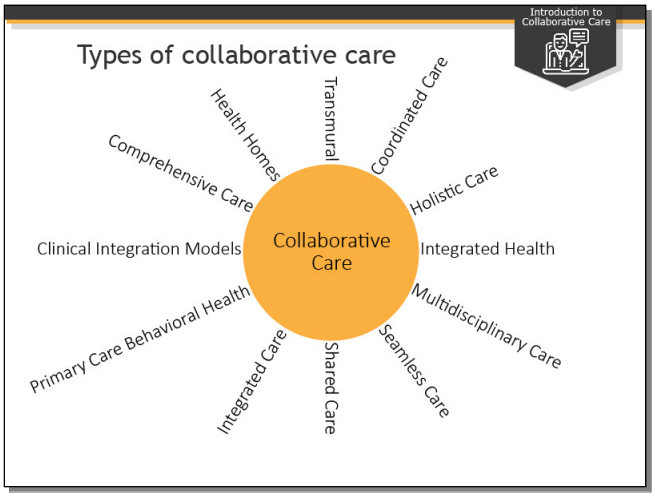
Next: Definition and Types



While collaborative care has many variations, there are shared definitions and frameworks for classifying approaches, which helps individuals and organizations consider what is most appropriate and realistic for their own organizational circumstances.

But, before coming to a shared definition, let's explore the full range of terms for and types of collaborative care.

Types of Collaborative Care

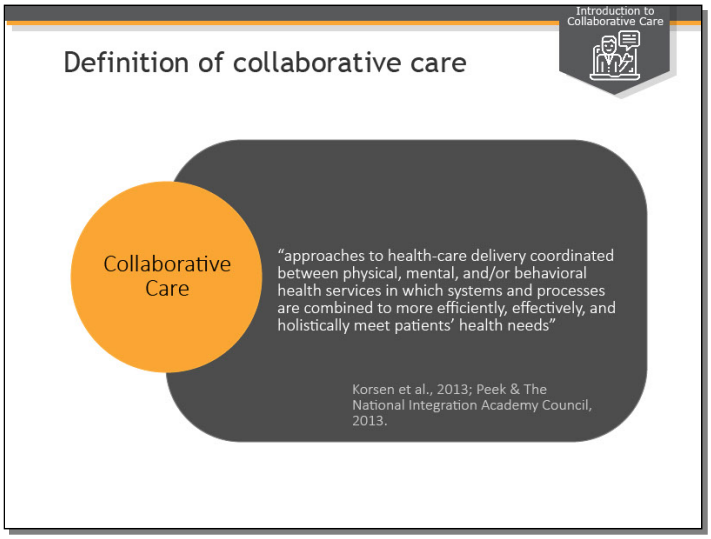


This eLearning series is about “collaborative care.” There is a wide range of terminology for practices that are the same, encompass, or are related to collaborative care. You might hear terms like:

- Clinical Integration Models
- Comprehensive Care
- Coordinated Care
- Health Homes
- Holistic Care
- Integrated Care
- Integrated Health
- Multidisciplinary Care
- Primary Care Behavioral Health
- Seamless Care
- Shared Care
- Transmural

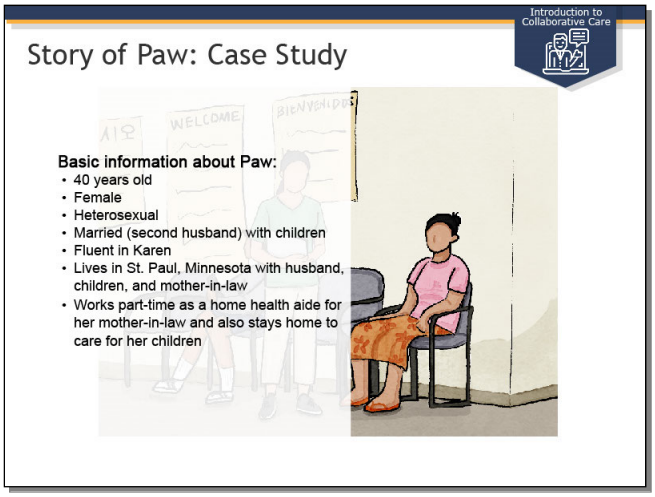
While each of these has specific connotations and features, they all indicate ways that we different disciplines within the full range of client care professions are brought together to care for clients – through physical proximity, system integration, and the coordination or integration of services. They all have the objective of provide better and more complete care for clients.

Definition of Collaborative Care



For the purposes of this elearning series we use one of the most commonly used and inclusive term, collaborative care. And in this lesson, we offer a definition based on the field and in research. Collaborative care includes "approaches to health-care delivery coordinated between physical, mental, and/or behavioral health services in which systems and processes are combined to more efficiently, effectively, and holistically meet patients' health needs" (Korsen et al., 2013; Peek & The National Integration Academy Council, 2013).

Case Study (continued)



Remember, Paw? We left her waiting in reception area of a primary care clinic. Paw, as you'll remember, is a recently arrived refugee. While Paw is waiting, an interpreter comes over and helps her fill out some paperwork. Here's some basic information about Paw, some of which ends up on the paperwork and some of which doesn't:

- 40 years old.
- Female.
- Heterosexual.
- Married (second husband) with children.
- Fluent in Sgaw Karen.
- Lives in St. Paul, Minnesota with husband, children and mother-in-law.

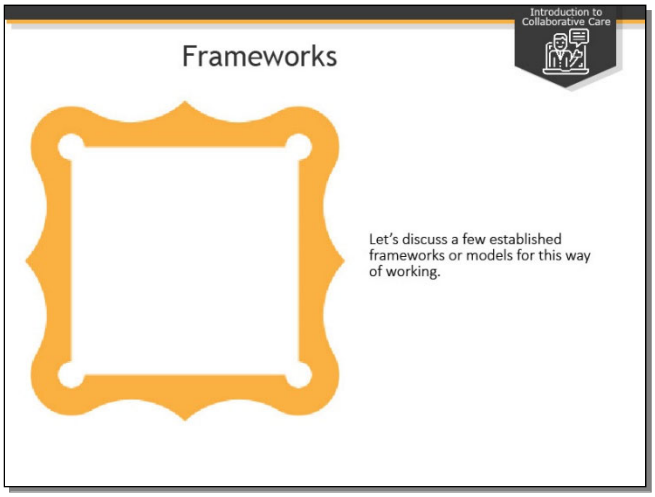
- Works part-time as a home health aide for her mother-in-law and also stays home to care for her children.

Today, the clinic is running a pilot project. If the doctor who meets with Paw thinks she might have experienced torture or war trauma, Paw will be referred for further mental health screening to identify past war and torture experiences and current mental health symptoms. The role of the screener (who is a licensed mental health professional) is to identify war trauma survivors with mental health symptoms and then complete a brief assessment to determine if an internal referral to behavioral health services is indicated. When the doctor meets with Paw, it's clear that she may have experienced trauma and Paw is immediately referred to this mental health screener. After working through the questions on the assessment tool, the screener asks some follow-up questions:

MH Screener: You said you experienced war and other difficulties back in Burma. I'd like to understand some of your experiences.
Paw: Life there was good in Burma.
MH Screener: Before you fled?
Paw: Until we were forced to flee.
MH Screener: Who did you live with?
Paw: I lived with my husband. [Paw is visibly agitated]
MH Screener: I'm sorry. I don't mean to upset you. I'd like to know more to help you heal, but it's important that you feel safe.
Paw: Many bad things happened.
MH Screener: I'll try to make sure you don't feel overwhelmed.
Paw: My first husband was killed when a bomb blew up on our path. I was pregnant at the time when we ran and lost my baby too. I wanted to die. I did not get to bury her.
MH Screener: You suffered incredible losses.
Paw: Yes.
MH Screener: You made it to a refugee camp and stayed there prior to coming to the United States?
Paw: I made it to Mae Sot and stayed there with help of family. My oldest child was sick there and no help and no medicine. He died; I don't know why. I could not move for a month.
MH Screener: You wanted to die as well?
Paw: Yes.
MH Screener: How long did you live at the camp called Mae Sot?
Paw: I don't know. Many years.
MH Screener: Have you spoken about these experiences with your doctor?
Paw: No. I don't talk about these things. They create heavy heart and headache. I don't want to talk about it. My family tells me not to talk about it because I get upset. I am still very scared for my family in Burma.
MH Screener: I know it's difficult, but we can talk about these experiences in a way that helps you to heal.
Paw: Remembering makes me feel heaviness in my neck and head.
MH Screener: I'd like to recommend that you meet with the therapist in our team here at the clinic. This person will talk with you and listen and try to better understand what you lived through. She'll help you with feelings like sadness or worry or heaviness you are having now. Would you be interested in that?
Paw: I think so. I would like to think about it.

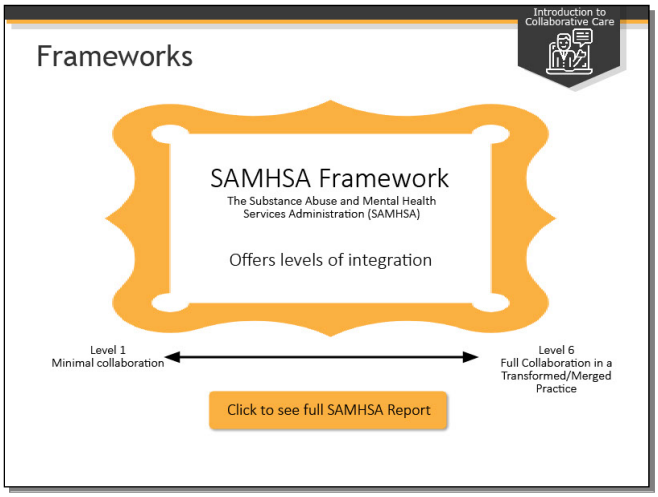
In the end, Paw meets clinical cut-offs for symptomatic depression, anxiety, and PTSD according to reported levels of distress from the refugee screening assessment.

Frameworks of Collaborative Care



To help clarify the features of collaborative care, let's discuss a few established frameworks or models for this way of working.

SAMHSA Framework



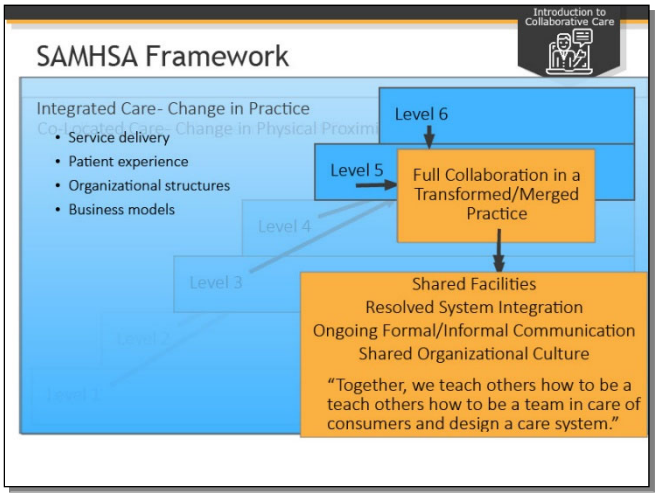
To begin, The Substance Abuse and Mental Health Services Administration (SAMHSA) offers a framework for levels of integration with six levels of collaboration that fall within an overarching framework with three larger categories — coordinated, co-located, and integrated care. This framework ranges from

Level 1 "minimal collaboration" through to Level 6 "Full Collaboration in a Transformed/Merged Practice." At Level 1, there are separate locations, systems, and limited communication, whereas at Level 6, there are shared spaces, systems, and goals that fundamentally transform services and patient care.

Let's hear more about this framework.

You can also click here to see a report by SAMHSA on this framework.

SAMHSA Framework Explained



Let's get into more specifics about each of those levels.

Coordinated Care

For the first two levels within the grouping of "coordinated care", this framework emphasized a change in the level of communication.

- Level 1 is Minimal Collaboration where providers are at separate locations, have separate systems, and have almost no communication.
- Level 2 is Basic Collaboration at a Distance where providers are at separate locations, have separate systems, but have some communication about specific issues or concerns.

Co-located Care

For levels 3 & 4 within the grouping of "Co-located Care", this framework emphasized a change in physical proximity.

- Level 3 is Basic Collaboration Onsite where providers have separate facilities but meet regularly to communicate about patients.
- Level 4 is Close Collaboration with Some System Integration where providers have shared facilities, share some systems, and communicate regularly about patients.

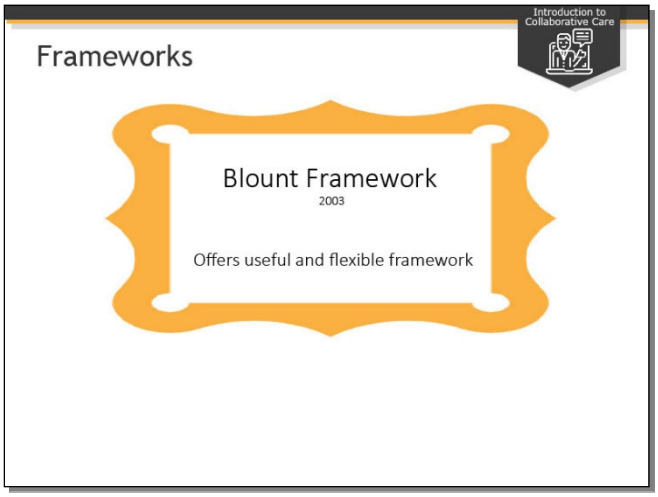
Integrated Care

For levels 5 & 6 within the grouping of "Integrated Care", this framework emphasized a change in practice.

- Level 5 is Close Collaboration Approaching an Integrated Practice where providers collaborate on system-level integration as a team, communicate frequently about patients, and have developed a good sense of shared organizational culture.
- Level 6 is Full Collaboration in a Transformed or Merged Practice where providers have resolves issues of system-level integration, have ongoing formal and informal communication about patient care, and have a shared organizational culture.

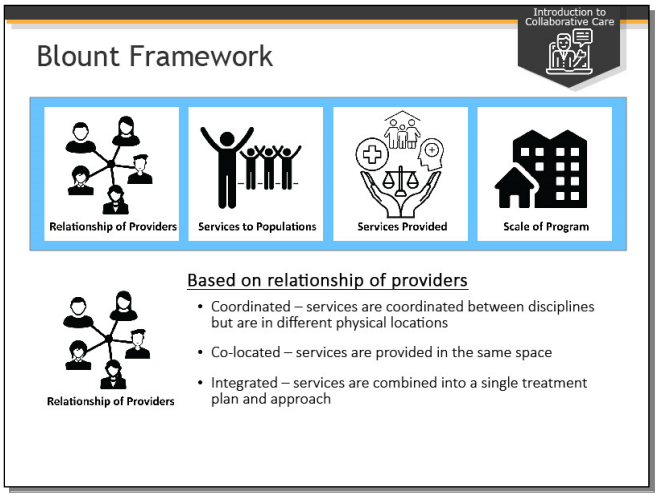
Additionally, this framework emphasizes changes in service delivery, patient experience, organizational structures, and business models at each of these six levels.

Blount Framework



The Blount framework is often cited in published research on collaborative care and provides a flexible approach to thinking about and conceptualizing collaborative care.

Blount Framework Explained



Blount's framework (2003) helps to of conceptualize a program within an Integrated Behavioral Health Care (IBHC) (or collaborative care) models; this framework offers four criteria to consider:

- The first is the relationship of providers or disciplines. These concepts should be familiar from the previous section on the SAMHSA framework. Within this category of "relationship of providers or disciplines" this framework offers three options:
    - Coordinated – in which services are coordinated between disciplines but are in different physical locations
    - Co-located – in which services are provided in the same space
    - Integrated – in which services are combined into a single treatment plan and approach
- The second it the Relationship of services to populations. this framework offers two options:
    - Targeted: in which services are aimed at a specific client population (for instance, Survivors of Torture)

    - Non-targeted: services are for any individual expressing need
- Specificity of behavioral health services provided this framework offers two options:
    - Specified – which is a unified and systematic treatment approach is provided to all clients / patients; this tends to be a more manualized or standardized approach to client care.
    - Unspecified – in which treatment is dependent on the skills and approaches of the specific provider
- Scale of program implementation which ranges from small to extensive.

These criteria are particularly helpful to practitioners and researchers who are assessing the relevance of findings or learnings from other collaborative care programs; this framework allows us to more systematically consider how those learnings from another program might be different from those in our own program or intervention.

For instance, imagine you work at a SOT program that is Integrated within a primary care setting, and that you provide a specified or manualized 10-week CBT intervention with patients at the clinic who are identified as survivors of torture, the majority of whom are from Cameroon.

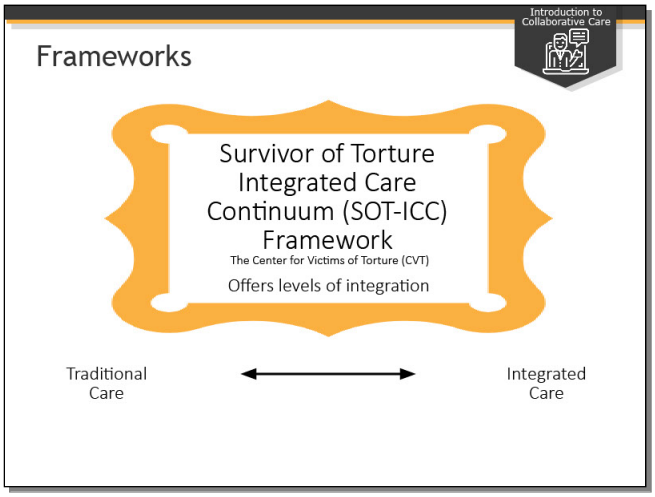
Now imagine that you find a research article based on a study at another SOT program that is co-located within an emergency room with an unspecified intervention for a Survivor of Torture population from many different global regions. This article shows excellent improvements with physical health outcomes, above and beyond what they see in the general patient population.

Certainly, this is good empirical information for you to have and it is also a great moment to reflect on Blount's framework. Critical differences between your program and the one under study are:

- the relationship of providers or disciplines – *integrated* in primary care versus *co-located* in an emergency room
- the relationship of services to populations – *Targeted* (Cameroonian SOT) versus *Less Targeted* (any SOT)
- specificity of behavioral health services – *Manualized* versus *unspecified*

Despite the differences between the programs, the findings of this study can be helpful to you! It is promising to see the physical health outcome improvement in a SOT program operating in a healthcare context. It might prompt you to consider physical health outcomes in your own programmatic design and evaluation. At the same time, it is important to think through how other program factors might be critically different. Does your manualized approach make explicit therapeutic connections to physical health care and wellbeing? Does your targeted population present with significant health issues that can be supported through your existing intervention? And so on. Blount's framework doesn't give answers to these questions, but it points us to these critical factors and questions.

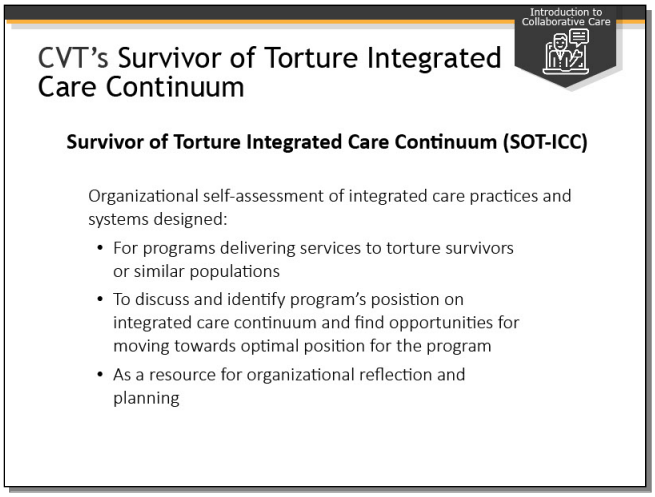
CVT Framework

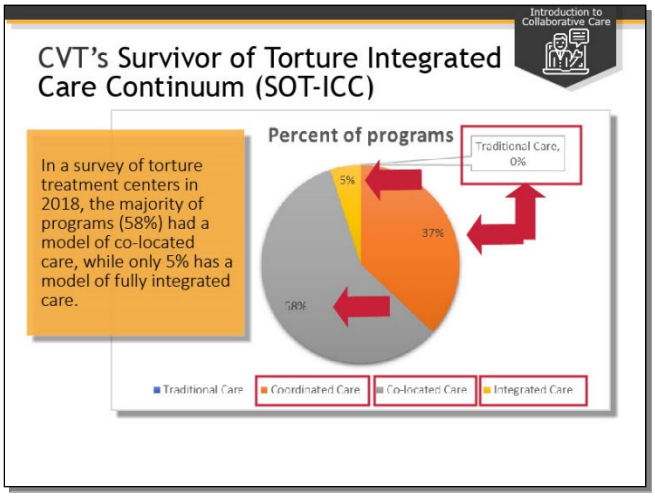


The Center for Victims of Torture (CVT) Framework

Building on the existing frameworks in the field and experience working with torture and war trauma survivors, the Center for Victims of Torture developed a framework for integrated care for these specific populations. The Survivor of Torture Integrated Care Continuum, also known as the SOT ICC, includes four levels ranging from minimal coordination of services and systems (“traditional care”) to full integration (“integrated care”).

CVT’s Framework Explained





The Survivors of Torture Integrated Care Continuum instrument, or SOT-ICC, which is an organizational self-assessment of integrated care practices and systems, is designed for programs delivering services to torture survivors. The assessment was designed specifically for SOT programs, but could be used by other programs serving similar populations. The purpose of the SOT-ICC instrument is for program staff to discuss and identify the program’s position on the integrated care continuum, and find opportunities for moving towards the program's optimal position on the continuum. In other words, this is [not only] an assessment tool but it is also a resource for organizational reflection and planning.

The Integrated Care Continuum (ICC) includes four levels ranging from minimal coordination of services (Traditional Care) and systems to full integration of services and systems (Integrated Care). The icons on the screen show the four levels of integration on the continuum.

In Traditional Care there are:

- Separate facilities
- Separate systems, and
- Rare communications about client care
- In Coordinated Care there are
- Separate facilities,
- Separate systems, and
- Occasional communications about client care

In Co-located Care there are:

- Some shared facilities
- Some shared systems, and
- Regular communications about client care
- Lastly, in Integrated Care there are
- Fully shared facilities
- Fully shared systems, and
- Frequent formal and informal communications about client care

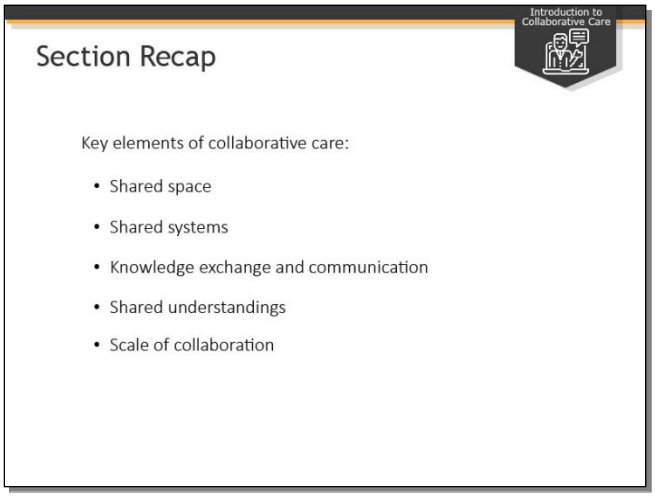
The SOT-ICC assesses these levels of integration in three specific domains of care:

- The first is program development, which includes the planning and development of services. An example of this is fundraising strategies – ranging from traditional levels of integration with each service providing organization planning and implementing fundraising individually to service providing entities sharing a fundraising strategy, process, and the resulting funds for their integrated services.
- The second is program logistics, which includes the day-to-day operations related to providing services. An example of this is scheduling appointments.
- The third is treatment delivery, which includes how treatment is actually provided. An example of this is treatment planning.

Notably, this framework emphasizes that an organization can have high levels of integration in one area and almost none in another. The intention is that this better matches the practical realities of programs and offers a more nuanced set of information for organization to consider when planning changes to their levels of integration.

In a survey of torture treatment centers in 2018 [where 19 programs responded], none of the programs had a model of traditional care, nearly 40% had a model of coordinated care, the majority of programs (at 58%) had a model of co-located care, and only one program had a model of fully integrated care.

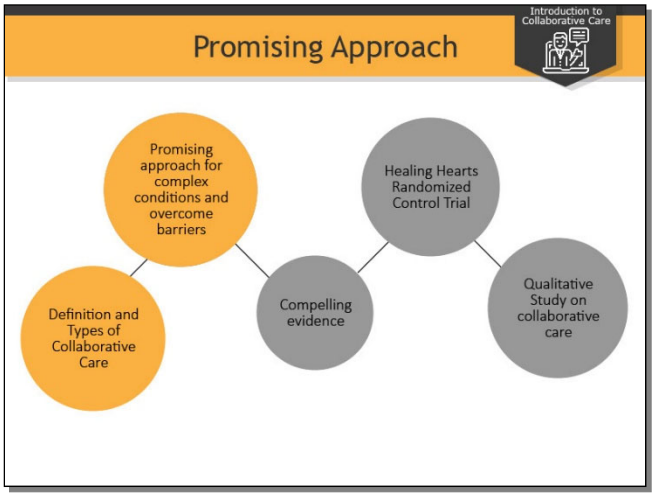
Section Recap



To summarize, the key elements of collaborative care, emphasized in our definition and in these models, include:

- Shared Space
- Shared Systems
- Knowledge Exchange / communication
- Shared understandings (examples include: roles, processes, tasks, etc.), and
- Scale of collaboration

Next: Complex Conditions



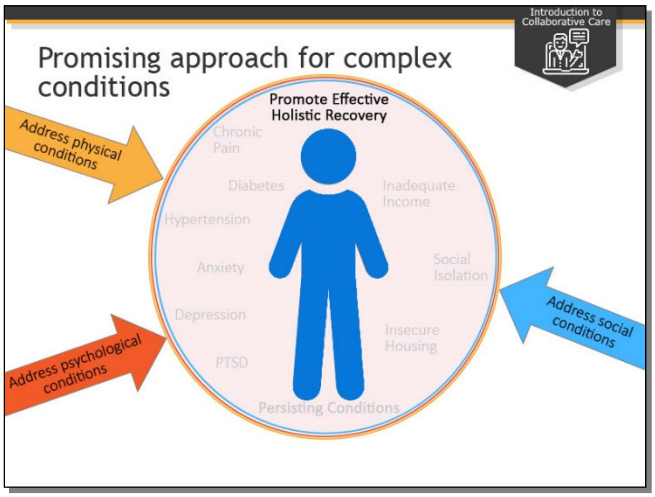
Next, we will discuss how collaborative care has been found to be a promising approach for complex conditions and overcoming barriers to behavioral health care.

Research suggests that collaborative care represents a promising [practice] to providing rehabilitation services to survivors of torture. Specifically, torture and war trauma survivors often experience complex health conditions and have a particular need for care that addresses a range of physical, psychological, and social conditions. Collaborative care offers a promising approach for these types of complex conditions.

We know that torture and war trauma survivors also experience significant barriers to accessing behavioral health services; collaborative care offers other, often highly utilized points of contact, such as primary care clinics, as potent points of entry for these populations.

In this section we will discuss both the complex conditions and barriers to care and how collaborative care helps in addressing them.

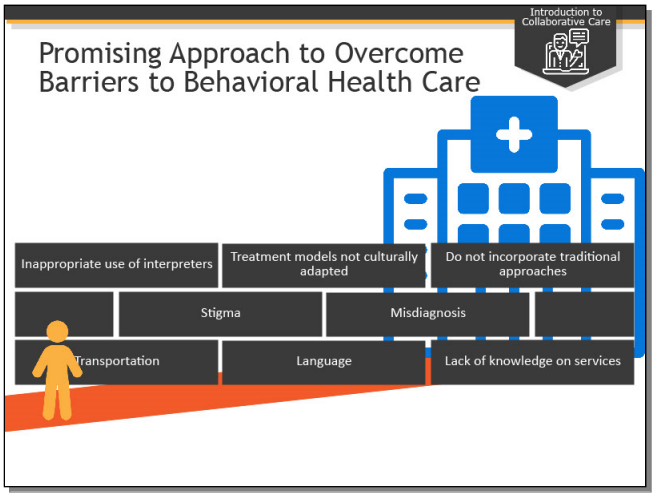
Approach for Complex Conditions



Torture and war trauma, both of which are common among refugees, are strong predictors of persisting physical and mental health conditions (CVT, 2015; Jaranson et al., 2004; Keller et al., 2006; Quiroga & Jaranson, 2005; see also Filges, Montgomery, & Kastrup, 2016). Torture and war trauma also increase the likelihood of chronic health conditions such as diabetes, hypertension, and chronic pain (Dahl, Dahl, Sandvik, & Hauff, 2006; Jaranson & Quiroga, 2011; Keatley, Ashman, Im, & Rasmussen, 2013; Olsen, Montgomery, Bøjholm, & Foldspang, 2007; Willard, Rabin, & Lawless, 2014). Moreover, refugees and torture survivors experience challenging social conditions, such as insecure housing, inadequate economic resources, and social isolation, which have implications for wellbeing and health-care needs (Casimiro, Hancock, & Northcote, 2007; Phillips, 2006; Rasmussen, Crager, Keatley, Keller, & Rosenfeld, 2011; Walsh, Hanley, Ives, & Hordyk, 2016). Accordingly, care for survivors of torture and war trauma should address a range of physical, psychological, and social conditions to promote effective and holistic recovery. A promising approach to treating complex conditions is collaborative.

For example, when a patient brings up sleep difficulties, it is very possible that this is related to psychological health concerns, such as PTSD or underlying medical health conditions. However, it is also possible that the patient lives in an unsafe or noisy neighborhood. Similarly, it is very possible that the smoke alarm battery is low in their apartment, and the alert is disrupting their sleep since they are not sure where the noise is even coming from.

Approach to Overcome Barriers



Access to appropriate mental health services is challenging in the general population and poses an even more serious challenge for refugees (Gong-Guy et al., 1991; Asgary and Segar 2011; Shannon et al., 2016). Estimates of the percent of people in the general population with severe mental illness who do not seek or receive treatment are between 50 and 70 percent (Blount et al., 2007; Satcher, 2000).

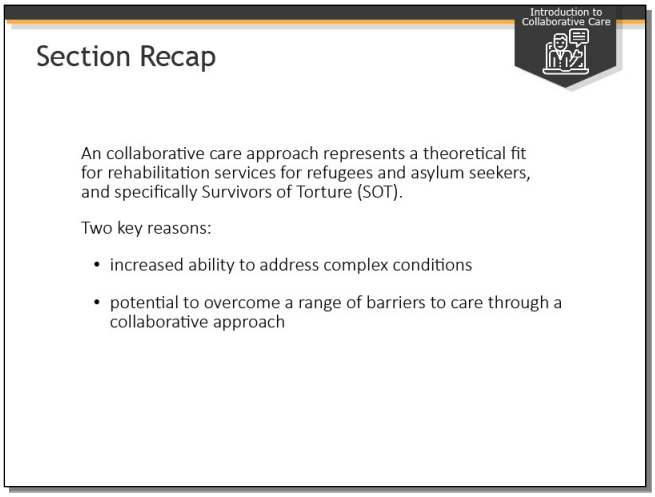
Refugee-specific literature identifies many access barriers to mental health care, including: logistical challenges, such as transportation, language barriers, lack of knowledge about available services and stigma (Pavlish et al., 2010; Wong et al., 2006).

Even in instances where refugees are able to access mental health services, they may face other barriers to receiving high-quality care, including: misdiagnosis, inappropriate use of interpreters and professionals and treatment models that are not culturally adapted or do not incorporate traditional health approaches (Gong-Guy et al., 1991; Shannon et al., 2016; Hauff and Vaglum, 1997).

The main point of access for mental health services is through primary care providers and emergency rooms (Kessler et al., 2003; Regier et al., 1993; Wang et al., 2005). Up to 70 percent of the general population receives mental health services through their primary care providers (Regier et al., 1993; see also Wang et al., 2005). This proportion is likely higher for refugees due to the aforementioned barriers to care (Maier and Straub, 2011). This shifts responsibility for behavioral health care to primary care providers and emergency room staff, placing the burden of mental health care on medical practitioners who often lack training in this area. With primary care providers taking appointment time to address pervasive mental health issues, there may be less time to manage physical health issues, which may contribute to poorer quality medical services and care.

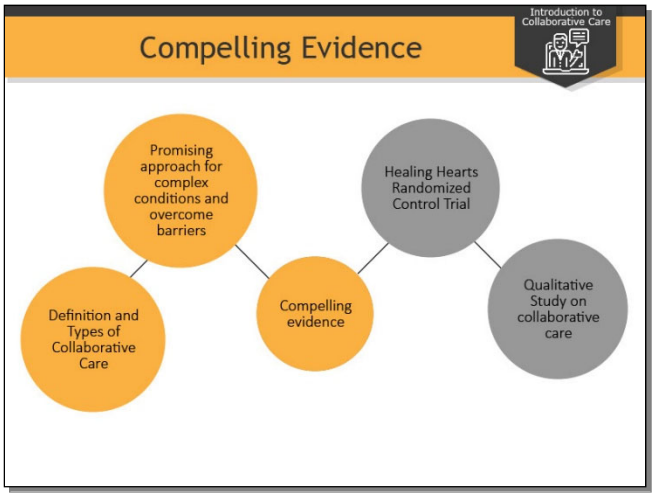
Providing mental health and social work services where patients are already accessing primary medical care is an intuitive way to meet the mental health and social needs of patients, particularly those who face barriers to care access. Integrated Behavioral Health Care (IBHC) has been suggested as a method to better meet the needs of marginalized populations, including low-income clients, by improving access to and coordination of care (Thompson et al., 2015; McMurray et al., 2014; Pollard et al., 2014).

Section Recap



To summarize, current research suggests that a collaborative care approach represents a theoretical fit for rehabilitation services for refugees and asylum seekers and specifically SOTs. The two key reasons are: the increased ability to address complex conditions and the potential to overcome a range of barriers to care through a collaborative approach.

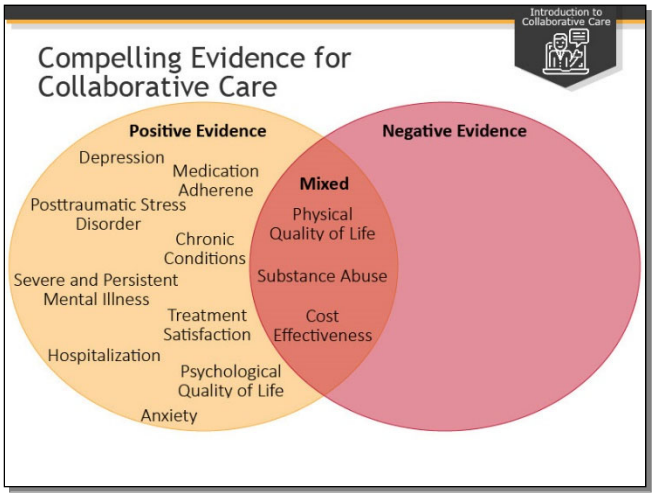
Next: Compelling Evidence



Next, we will discuss Collaborative care: There is emerging and compelling empirical evidence supportive of a collaborative approach with SOTs. With a few notable exceptions, most published research is limited to relevant outcome areas, rather than studies specifically conducted with SOTs. Despite the growing body of evidence to support the effectiveness of collaborative care (Kwan and Nease, 2013), there remains a lack of research on integrated for resettled refugee populations, who might benefit substantially from this model (Pollard et al., 2014).

For that reason, we begin with a summary of the broader literature in collaborative care that is highly relevant to torture and war trauma survivors. We then turn to research in the area conducted by the Center for Victims of Torture.

Compelling Evidence



There is robust evidence for the increased effectiveness of an integrated approach in general populations on key mental health, social, and physical conditions of with direct relevance to refugees, asylum seekers, and torture survivors specifically.

The key outcomes and populations in the literature that have direct relevance for refugees and torture survivors, include: depression, anxiety, posttraumatic stress disorder (PTSD), severe and persistent mental illness (SPMI), chronic conditions, quality of life, treatment satisfaction, medication adherence, substance abuse, older adults, and cost effectiveness. (see summary table)

There is robust empirical evidence for the effectiveness of a collaborative care approach to depression and anxiety, including multiple meta-analyses.

There are multiple randomized controlled trials (the gold standard of intervention research) suggest that collaborative care enhances the reduction of the symptoms of posttraumatic stress disorder. A particularly promising finding was that collaborative care increased the likelihood of participants seeking treatment for PTSD after screening positive (Bohnert, Sripada, Mach, & McCarthy, 2016).

Regarding severe and persistent mental illness (SPMI, there is evidence based on nine studies included in a systematic review that suggest “feasibility, acceptability, and preliminary effectiveness” of collaborative care (Whiteman, Naslund, DiNapoli, Bruce, & Bartels, 2016)

Multiple randomized controlled trials and a number of meta-analyses indicate that collaborative care approaches are superior to traditional approaches to treating chronic health conditions that are common among torture and war trauma survivors, including: cardiovascular conditions, high blood pressure, high cholesterol, diabetes, chronic pain.

Research shows that collaborative care is more effective than other usual care approaches in increasing psychological quality of life on both short-term and long-term outcomes. The impact of collaborative care on physical quality of life—which can include content such as general health, sleep quality, and specific physical symptoms limiting activities—is, on the other hand, mixed. A meta-analysis showed collaborative care was only effective on long-term physical quality-of-life measures, (Archer et al., 2012), whereas other research showed no impact at all (Baumeister & Hutter, 2012).

Research, including a meta-analysis, shows the collaborative care significantly increases patients’ satisfaction with care.

As for medication adherence, a meta-analysis composed of 79 randomized controlled trials showed that collaborative care increases rates of adherence to antidepressant and anxiety medications (Archer

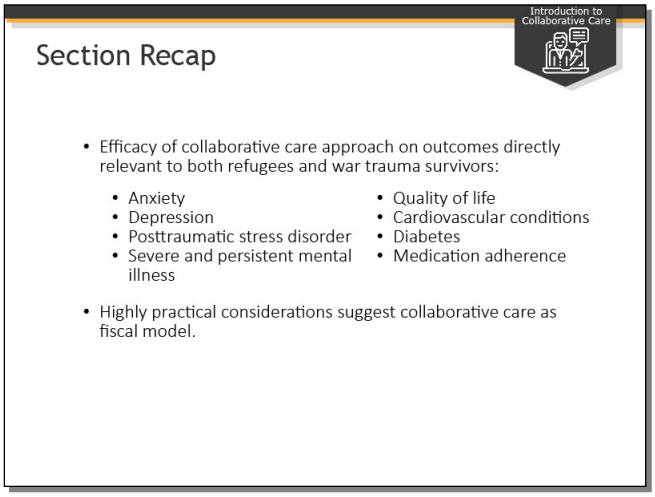
et al., 2012). There is limited to no consistent evidence that collaborative care contributes to reductions in substance abuse more than traditional approaches.

Less than half of published randomized control trials measured cost outcomes systematically, and the research that does assess cost-effectiveness is mixed (Jacob et al., 2012; see also Nolte & Pitchforth, 2014). A later systematic review, however, found moderate effectiveness for collaborative care on cost-effectiveness (Lemmens et al., 2015).

Closely related to cost-effectiveness are hospitalization rates and lengths of stay. There is evidence that collaborative care helps reduce overall cost by reducing both. A meta-analysis of 53 trials showed that collaborative care approaches reduced hospitalization rates (McKinsey, 2015). And one specific study showed that collaborative care decreased health-care costs due to a large reduction in emergency department visits, overnight admissions, and bed days; this reduced health-care costs for both the patient and the hospital (Bird, Noronha, Kurowski, Orkin, & Sinnott, 2012; see also Siouta et al., 2016).

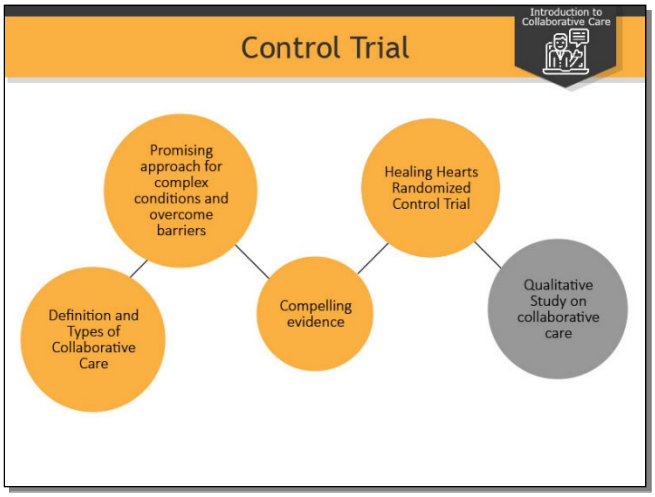
Existing research on integrated care, not specifically with but certainly relevant to refugees and war trauma survivors, is robust and highly promising for this population.

Section Recap



To summarize, current research with the broader population suggests the efficacy of a collaborative care approach on outcomes directly relevant to refugees and war trauma survivors, such as: anxiety, depression, post-traumatic stress disorder, severe and persistent mental illness, quality of life, cardiovascular conditions, diabetes, and medication adherence. Additionally, highly practical considerations, like length of hospital stays and cost outcomes, suggest both health benefits and the practicality of collaborative care as a fiscal model.

Next: Control Trial



Next let's discuss empirical research on collaborative care with refugees and war trauma survivors.

We will begin with the Healing Hearts Randomized Control Trial (evidence for CVT-like approach). CVT conducted a randomized controlled trial that showed strong evidence for collaborative care (as compared to care as usual) on mental health symptoms and social functioning among war trauma survivors We will also discuss a Qualitative Study on collaborative care with war trauma survivors. As a component of the CVT randomized controlled trial, there was a qualitative component that explored collaborative care from the perspective of the patient / client. The section provides a view into the lived experience of collaborative care.

Healing Hearts Control Trial

While there is robust research on collaborative care broadly (as discussed in the last section), there is very little on collaborative care for torture and war trauma survivors. The Center for Victims of Torture (CVT) published one of the only randomized control trial of this kind in 2019. The study was conducted at two primary care clinics with large resettled Karen refugee patient populations. Patients received either: (1) collaborative care including psychotherapy and case management (n = 112), or (2) care-as-usual (CAU) (n = 102).

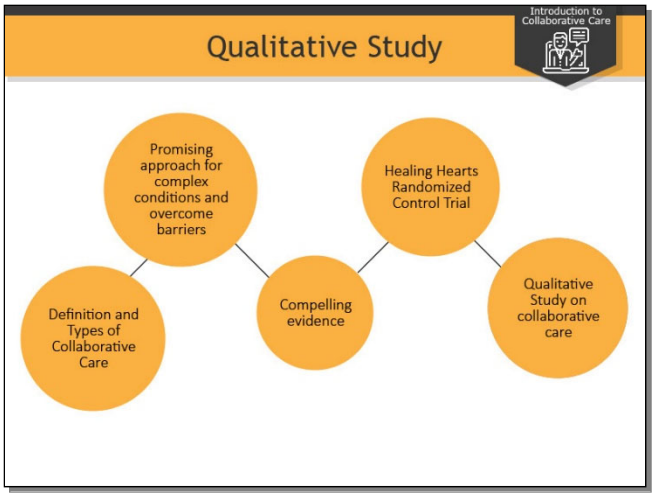
Eligibility criteria included:

- Major Depression diagnosis determined by structured diagnostic clinical interview,
- Karen refugee,
- Ages 18–65.

Results showed significant improvements in depression, PTSD, anxiety, and pain symptoms and in social functioning among those receiving integrated care. Care-as-usual (CAU) patients did not show significant improvements.

In line with previous research in the broader field of collaborative care, this study suggests that a collaborative care approach for refugees is more that promising, it has an emerging evidence base.

Next: Qualitative Study



Next, we will discuss Qualitative Study on collaborative care with war trauma survivors.

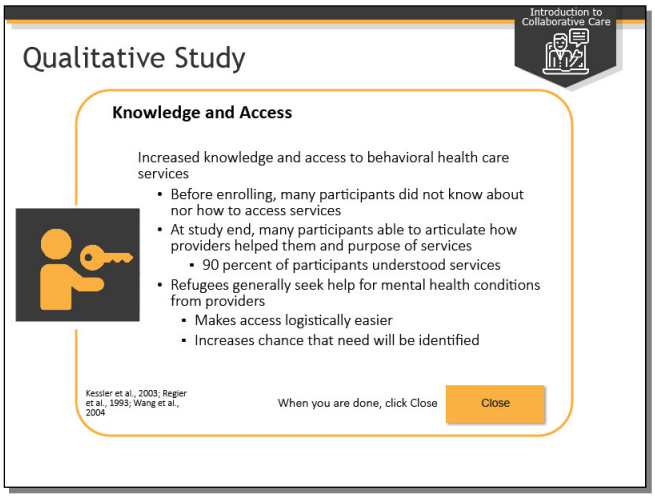
As a component of the CVT randomized controlled trial, there was a qualitative component that explored collaborative care from the perspective of the patient / client. The section provides a view into the lived experience of collaborative care.

Qualitative Study

Findings from the qualitative component of the study are organized around three key benefits identified by study participants:

- Participants showed and expressed increased knowledge about and ability to access to behavioral health care services;
- They described greater support in the treatment of complex conditions;
- And, they expressed that they had more time with care providers overall.

Knowledge and Access



First, collaborative care increased knowledge about and access to behavioral health care services.

Before being referred to the study, many participants did not know that mental health services existed or how to access them.

For instance, Htee Shwe, a woman in her late 30s who has lived in the U.S. for about ten years, describes this initial confusion, *“The first few times that I met the psychotherapist, I thought that they were going to prescribe me medications.”*

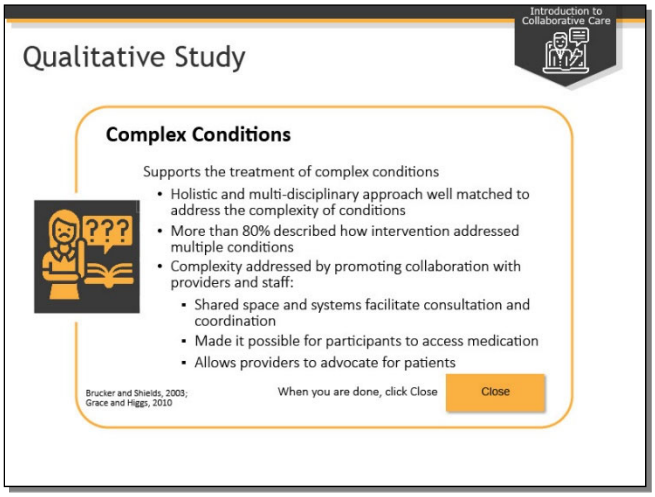
By the end of their participation in the study, however, many participants were able to articulate how their providers had helped them and the purpose of behavioral and mental health services. In fact, 90 percent of participants (n = 36) evidenced a core understanding of what behavioral health services entail.

For instance, by the end of the intervention, Saw Dah Bu, a man in his 40s, was able to explain the role of the psychotherapist well: *"What [my psychotherapist's] job is, is that […] she is helping me through the process where I am feeling very beat down in my heart, beat down in my soul, depressed at the moment when she would advise me, give me self-support, show me a way how to deal with myself, my sadness, and all these uncomfortable feelings in my body and she would tell me to think about how to stay healthy and strong, not to think about how bad things can happen but think about things that's going to happen in good ways."*

Refugees generally seek professional help for (or more often present with symptom of) mental health conditions with primary care providers (Kessler et al., 2003; Regier et al., 1993; Wang et al., 2004). Locating behavioral health care services at a primary care clinic has the benefit of increasing access to these services. Not only does this make access logistically easier; it increases the chance that the mental health need will be identified by the physician (and, in turn) the patient through the day-to-day awareness raising of being collocated or simple regular collaboration. The study participants recognized the value of locating at the primary point of contact. Nearly one-third of participants (n=12) described the location of services at the primary care clinic as convenient or easy to access.

Htee Shwe[1, 2] a woman in her late 30s who has lived in the U.S. for about ten years, explains, *"So [now] whenever I need help, I will always come here to [the primary care clinic], even if I need help with my letter or food stamps or Medicaid […]. When I had difficulties or problems, I don't go to [other community places], I don't go to other office […]. I just come here to [the clinic] and get help. Some people, when they need help with their paperwork or anything, they go to another office but for me, I don't know where those places are; I just come here and it is beneficial to me."*

Complex Conditions



Second, collaborative care supported the treatment of complex medical, mental health, and social conditions.

Our data suggested that the holistic and multi-disciplinary approach of Integrated Behavioral Health Care (IBHC) is well matched to address the complexity of refugees' health conditions. More than 80

percent of participants (n=33) described how the intervention addressed multiple mental health, physical or social conditions.

Soe Nyo, a man in his late 40s who reported multiple past traumatic events, explained how the mental health services and targeted case management worked together, while acknowledging the physical components of pain as well: *"[The study targeted case manager] worked with me about [accessing] medication, and she also arranged the medication with the nurses here. For [the Healing Hearts psychotherapist], it is about the therapy: the heart. And he told me that the pain or the sickness that I have is correlated with everything. He told me that you take medication, but it's not going to cure everything because those pains you have, it's correlated with many things, the stress and also the thought that comes up within you, it's correlated with everything."*

Participants also describe support addressing medical needs. April Eh, a woman in her mid-50s, expressed that she was grateful to her care providers for helping her access an inhaler. "*I used to be very sick, and I used to be very unhealthy. And now, because of them [the study providers], I get a lot of help getting my inhaler, and I am not depressed anymore and I am feeling better."*

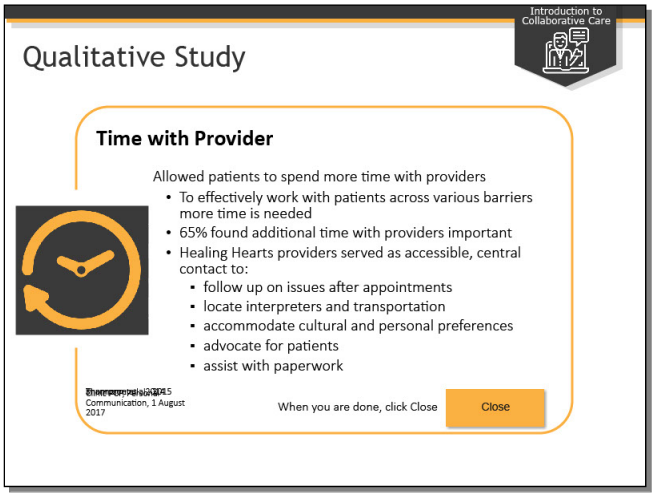
In a collaborative care approach, complexity is addressed by promoting collaboration among behavioral health providers, primary care providers, and clinic staff. Collaborative care literature has further suggested that shared space and systems facilitate in-person consultation and more frequent discussions and coordination on treatment plans between providers (Brucker and Shields, 2003; Grace and Higgs, 2010). These elements of collaborative care represent behind-the-scenes mechanisms that support a holistic approach to care, which was also reflected in interviews with participants. One-third of the participants, without prompting, described collaboration between Healing Hearts providers and primary care providers in their care.

Another study participant explained, *"I remember when I was supposed to come in to my [primary care provider] appointment but I don't have transportation. When I don't have transportation, I couldn't come to my appointment. I end up coming [to the clinic] when I come in for my appointment with [the Healing Hearts case manager]. She talked to the doctor, and the doctor was able to squeeze in my schedule so that I could meet with him, and I was able to meet with my doctor and talk to him about my medication. They were able to send me medication and then I was able to take that medication and feel better."*

The close contact between the case manager and the primary care provider made it possible for this participant to access much-needed medication.

Equally important, an integrated location and the professional relationships within this setting allowed providers to effectively advocate for a patient.

Time with Provider



Third, in a collaborative care system, patients were allowed to spend more time with care providers.

Patients with multiple or complex chronic diseases typically spend approximately 20–40 min with their primary care provider, including interpretation, once every two months (Clinic PCP, Personal Communication, 1 August 2017). This is insufficient for primary care providers to effectively work with patients across languages, educational differences, and cultural barriers (Shannon et al., 2014). In the study, the Healing Hearts intervention offered participants additional face-to-face time with care providers. In total, 65 percent of participants described the importance of this additional time with health care providers. Healing Hearts providers did not replace the primary care providers. Instead, they served as an accessible, central contact in an integrated or collaborative system of care.

For instance, Bway Hser, a 48-year-old woman, told to the psychotherapist that she was experiencing such intense leg pain that she had to stop working at her job. Bway Hser then explained that: *"[The psychotherapist] helped me […] with the medication and to get the medication. He called to make an appointment with my doctor. He called the doctor to prescribe me the medication and he called the chiropractor."* In this case, the psychotherapist was able to identify a medical issue, immediately bring it to the attention of the physician at the same clinic, and mobilize resources to help the participant access medication and a referral to a chiropractor.

Healing Hearts providers also have more time than primary care providers to follow up on miscellaneous issues after appointments. With this time, Healing Hearts providers do the critical and often invisible work of making phone calls, locating language support, securing transportation, finding services that accommodate cultural and personal preferences, advocating on behalf of patients and assisting with paperwork. In their 2015 study, Thompson identified this "non-traditional" work, most frequently "paperwork" as a way for mental health practitioners to help meet the needs of patients affected by health disparities. This was among the most prominent themes in the interviews: the participants found help with paperwork to be incredibly important.

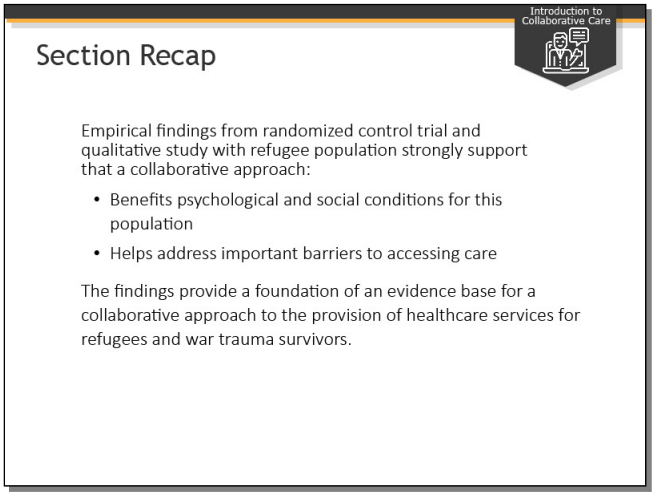
"Every time I brought a letter or any important mail, they helped me explain and they help me to solve the problem that I have to do," Bwet Kyi, 29.

"Everything is perfect when I'm working with [my case manager], you know she [was] helping me with the mail, the letters, everything," Mi Lay, 37.

"I get to bring my letter that I received in the mail that I don't understand, I brought it here so it got taken care of and the other thing is I got help for [was] my citizenship," Ta Net, 45.

“For [the case manager], what I like was it helped me with my social life, like simple things, like some of the forms, reading letters for me,” Nant Shee, 56.

Section Recap

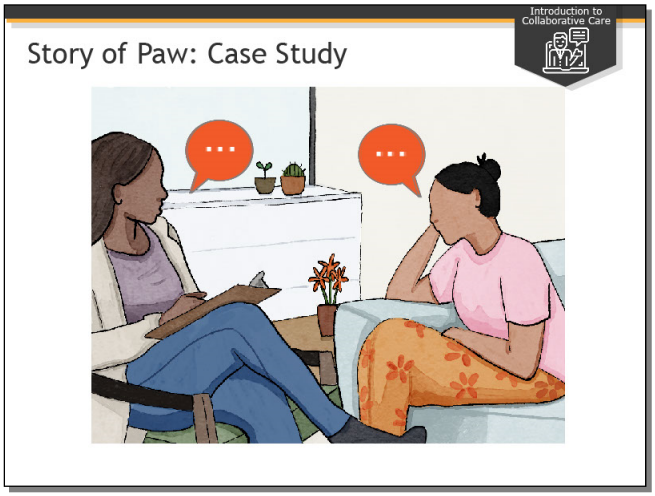


To summarize, empirical findings from a random control trial and a qualitative study conducted with a refugee client population strongly support:

- That a collaborative approach shows benefits to psychological and social conditions for this population and
- The collaborative approach, as experience by the participants, indeed helped address important barriers to accessing care.

Overall, the combination of existing research and our own empirical research provides the foundation of an evidence base for a collaborative approach to the provision of healthcare services for refugees and war trauma survivors.

Case Study: Resolution



After the screener recommended therapy, Paw met with her doctor and agreed to try meeting with a psychotherapist at the clinic named Lisa. We meet them towards the end of one of their early sessions.

Psychotherapist: Thank you for sharing these difficult experiences. I see the bravery and strength it takes. I believe we can help you find a path toward healing, especially now that we understand more about your terrible losses and how that would contribute to feelings of heaviness.

Paw: I have to be strong and steady my heart so that my family has health now.

Psychotherapist: I can tell you're very strong. How did you get through these difficult times?

Paw: It was a blessing from God; I don't know how I made it here.

Psychotherapist: You also find strength in your religious faith.

Paw: Yes, I used to be very active in my church in Burma and Thailand but cannot go now because of my headaches and fear of the drumming.

Psychotherapist: If you'd like, we could include these concerns as part of our healing plan together. You could attend church when you are feeling better.

Paw: I do not think I will feel better.

Psychotherapist: I understand; you've been feeling this way for so long time that it's hard to imagine improving. But I'm committed to helping you improve your health.

Paw: Okay.

Psychotherapist: How did you access doctors in Burma or Thailand?

Paw: In Burma, we went to the hospital, but it was far away. In Thailand, we received the medications we needed each day from the doctor in the camp.

Psychotherapist: I imagine our health system seems very different.

Paw: Yes, there are so many appointments.

Psychotherapist: I understand!

Paw: I don't know what they are all for. Sometimes I go but sometimes I don't because I don't what it means. Who are all of these people? It's confusing.

Psychotherapist: I'll talk to your providers. We'll work with you to better understand who you're seeing and why. And we'll help you manage these appointments.

Paw: Thank you.

Psychotherapist: Aside from going to church, are there other things you would like to do if you were feeling better?

Paw: I would love to go to school. When I think about school I always smile.

Psychotherapist: I can see you smiling now.

Paw: I never went to school because my family needed me to work. My children go to school now.

Psychotherapist: How does that make you feel?

Paw: I feel happy. I never went to school but that's not why we came here. We came here so that our children could go to school.

Psychotherapist: You gave them a wonderful opportunity.

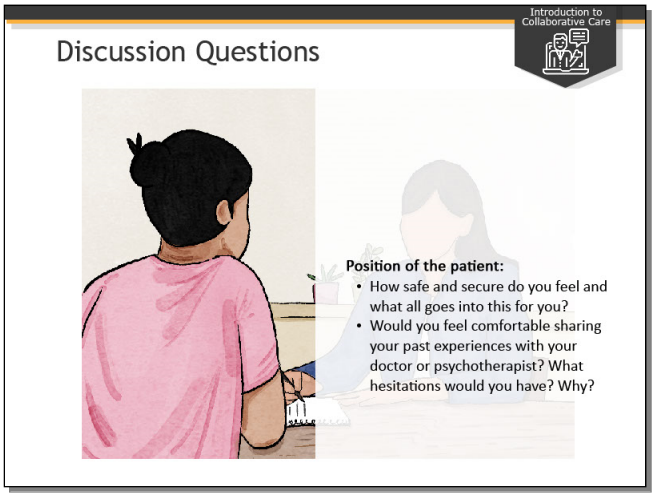
Paw: I had to. But now I have so much stress. Letters I don't understand, bills, and my children's health and education.

Psychotherapist: That sounds overwhelming. I can see that would be very hard to manage. Why don't I make a list now to make sure we continue to discuss these concerns and make a plan to help?

Paw: Okay.

Psychotherapist: I truly admire your strength. To come to the United States and start a new chapter for yourself and your family. It sounds like you are doing what you can to be successful and healthy. I also appreciate your courage in meeting with me. I look forward to building on these strengths and working with your doctor to help you feel healthier and lighter.

Discussion Questions



Following the best practices and recommendations shared during this lesson and case interactions, consider the following questions to help challenge and deepen your learning and integrate these practices into your work.

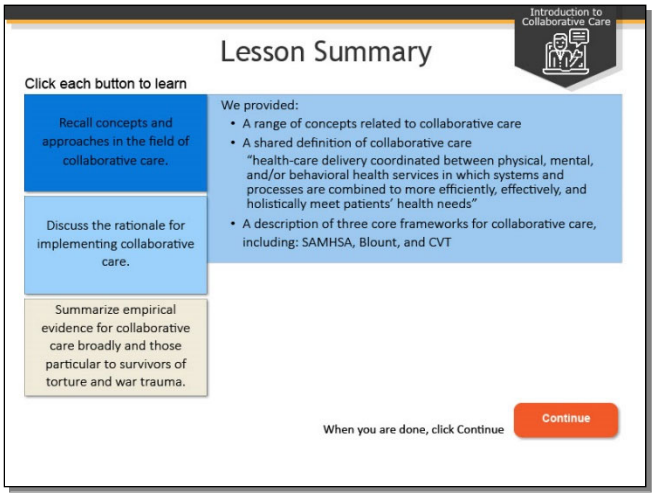
Imagine you are in the position of the patient in this case example.

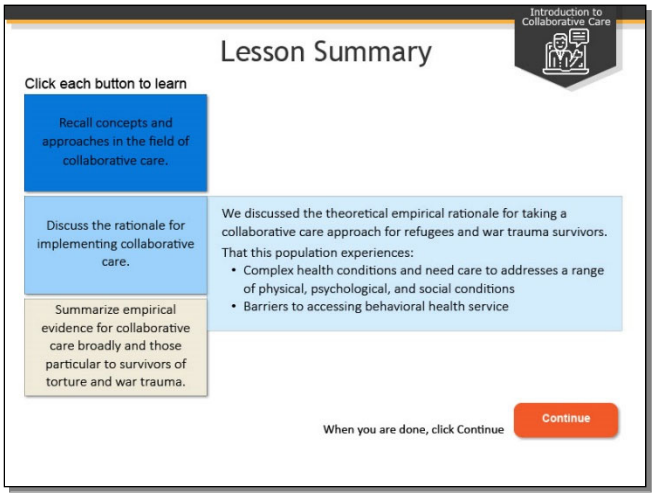
- How safe and secure do you feel and what all goes into this for you?
- Would you feel comfortable sharing your past experiences with your doctor or psychotherapist? What hesitations would you have? Why?

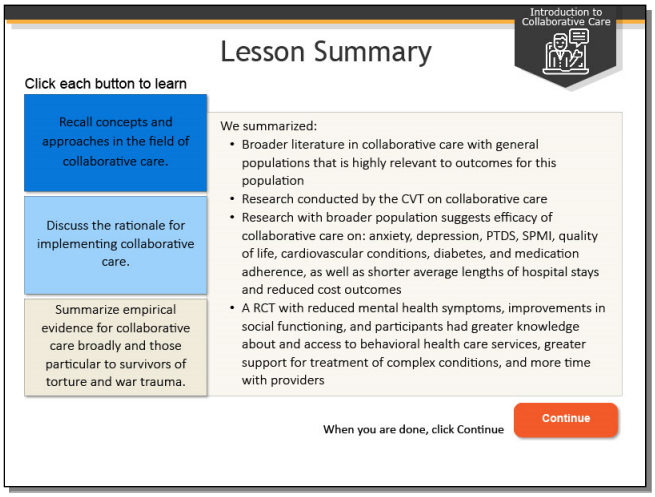
Imagine you are in the position of the provider in this case example.

- Consider when a patient has shared their trauma history. What helped make that patient feel comfortable? How did you respond?
- When do you ask about a patient's trauma history? When have you found it appropriate or inappropriate to ask?
- How do you promote patient resilience?

Lesson Summary







We will review this lesson by each objective: recall concepts and approaches in the field of collaborative care, discuss the rationale for implementing collaborative care, and summarize empirical evidence for collaborative care broadly and those particular to survivor of torture and war trauma.

In this section, we provided a range of concepts related to collaborative care and offered a shared definition of collaborative care, which is: “health-care delivery coordinated between physical, mental, and/or behavioral health services in which systems and processes are combined to more efficiently, effectively, and holistically meet patients’ health needs”. We also offered a description of three core frameworks for collaborative care, including: the Substance Abuse and Mental Health Services Administration (SAMHSA), the Blount framework, and the Center for Victims of Torture (CVT) Framework.

In this section, we discussed the theoretical empirical rationale for taking a collaborative care approach to rehabilitative services for refugees and war trauma survivors. First, torture and war trauma survivors often experience complex health conditions and have a particular need for care that addresses a range of physical, psychological, and social conditions. Collaborative care offers a promising approach for these types of complex conditions. Second, torture and war trauma survivors experience significant barriers to accessing behavioral health services; collaborative care offers other, often highly utilized points of contact (such a primary care clinics), as potent points of entry for these populations.

In this section, we summarized the empirical evidence for collaborative care broadly and those particular to survivor of torture and war trauma. We began with a summary of the broader literature in collaborative care with general populations that is highly relevant to outcomes for torture and war trauma survivors. Then, we turned to research conducted by the Center for Victims of Torture on collaborative care with torture and war trauma survivor populations.

Current research with the broader population suggests the efficacy of a collaborative care approach on: anxiety, depression, PTDS, SPMI, quality of life, cardiovascular conditions, diabetes, and medication adherence. Additionally, average lengths of hospital stays were shortened and cost outcomes were reduced.

A randomized controlled trial with Karen refugees reflected these findings from the broader literature – with reductions in mental health symptoms and improvements in social functioning. Additionally, study participants described greater knowledge about and ability to access to behavioral health care services, greater support in the treatment of complex conditions, and that they had more time with care providers overall.

Lesson Resources

The Center for Victims of Torture. (2005). Healing the Hurt. Retrieved from https://healtorture.org/resources/healing-the-hurt/.

The Center for Victims of Torture (2019). Improving Well-Being for Refugees in Primary Care: A Toolkit for Providers. Retrieved from https://healtorture.org/resources/improving-well-being-for-refugees-in-primary-care-a-toolkit-for-providers/.

References

Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Coventry, P. (2012). Collaborative care for depression and anxiety problems. Cochrane Database of Systematic Reviews, (10).

Asgary, R., & Segar, N. (2011). Barriers to health care access among refugee asylum seekers. Journal of health care for the poor and underserved, 22(2), 506-522.

Baumeister, H., & Hutter, N. (2012). Collaborative care for depression in medically ill patients. Current Opinion in Psychiatry, 25(5), 405-414.

Bird, S. R., Noronha, M., Kurowski, W., Orkin, C., & Sinnott, H. (2012). Integrated care facilitation model reduces use of hospital resources by patients with pediatric asthma. The Journal for Healthcare Quality (JHQ), 34(3), 25-33.

Blount, A., Schoenbaum, M., Kathol, R., Rollman, B. L., Thomas, M., O'Donohue, W., & Peek, C. J. (2007). The economics of behavioral health services in medical settings: A summary of the evidence. Professional Psychology: Research and Practice, 38(3), 290.

Blount Framework 2003. Blount, A. (2003). Integrated primary care: Organizing the evidence. Families, Systems, & Health, 21(2), 121–133. https://doi.org/10.1037/1091-7527.21.2.121

Bohnert, K. M., Sripada, R. K., Mach, J., & McCarthy, J. F. (2016). Same-day integrated mental health care and PTSD diagnosis and treatment among VHA primary care patients with positive PTSD screens. Psychiatric Services, 67(1), 94-100.

Brucker, P. S., & Shields, C. G. (2003). Collaboration Between Mental and Medical Healthcare Providers in an Integrated Primary Care Medical Setting. Families, Systems, & Health, 21(2), 181.

Casimiro, S., Hancock, P., & Northcote, J. (2007). Isolation and insecurity: Resettlement issues among Muslim refugee women in Perth, Western Australia. Australian journal of social issues, 42(1), 55-69.

Dahl, S., Dahl, C. I., Sandvik, L., & Hauff, E. (2006). Chronic pain in traumatized refugees. Tidsskrift for den Norske laegeforening: tidsskrift for praktisk medicin, ny raekke, 126(5), 608-610.

Esala, J., Hudak L., Eaton A., Vukovich M., (2018) "Integrated behavioral health care for Karen refugees: a qualitative exploration of active ingredients", International Journal of Migration, Health and Social Care, 14(2), 133-145.https://doi.org/10.1108/IJMHSC-10-2017-0043

Filges, T., Montgomery, E., & Kastrup, M. (2016). The impact of detention on the health of asylum seekers: a systematic review. Research on Social Work Practice, 28(4), 399-414.

Gong-Guy, E., Cravens, R. B., & Patterson, T. E. (1991). Clinical issues in mental health service delivery to refugees. American Psychologist, 46(6), 642.

Grace, S., & Higgs, J. (2010). Integrative medicine: enhancing quality in primary health care. The Journal of Alternative and Complementary Medicine, 16(9), 945-950.

Grail D., Tim F., Sorcha M., Brindan S. (2015). The Evidence for Integrated Care. McKinsey & Co.

Hauff, E., & Vaglum, P. (1997). Physician Utilization among Refugees with Psychiatric Disorders: A Need for 'Outreach' Interventions?. Journal of Refugee Studies, 10(2), 154-164.

Heath, B. W. R. P., Wise Romero, P., & Reynolds, K. (2013). A standard framework for levels of integrated healthcare. *Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions*. https://www.pcpcc.org/sites/default/files/resources/SAMHSA-HRSA%202013%20Framework%20for%20Levels%20of%20Integrated%20Healthcare.pdf.

Higson-Smith, C. (2015). Updating the estimate of refugees resettled in the United States who have suffered torture. Center for Victims of Torture.

Jacob, V., Chattopadhyay, S. K., Sipe, T. A., Thota, A. B., Byard, G. J., Chapman, D. P., & Community Preventive Services Task Force. (2012). Economics of collaborative care for management of depressive disorders: a community guide systematic review. American journal of preventive medicine, 42(5), 539-549.

Jaranson, J. M., Butcher, J., Halcon, L., Johnson, D. R., Robertson, C., Savik, K., Spring, M & Westermeyer, J. (2004). Somali and Oromo refugees: Correlates of torture and trauma history. American Journal of Public Health, 94(4), 591-598.

Jaranson, J. M., & Quiroga, J. (2011). Evaluating the services of torture rehabilitation programmes. Torture, 21(2), 98-140.

Keatley, E., Ashman, T., Im, B., & Rasmussen, A. (2013). Self-reported head injury among refugee survivors of torture. The Journal of Head Trauma Rehabilitation, 28(6), E8-E13.

Keller, A., Lhewa, D., Rosenfeld, B., Sachs, E., Aladjem, A., Cohen, I., Smith, H., & Porterfield, K. (2006). Traumatic experiences and psychological distress in an urban refugee population seeking treatment services. The Journal of Nervous and Mental Disease, 194(3), 188-194.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., … & Wang, P. S. (2003). The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). jama, 289(23), 3095-3105.

Korsen, N., Narayanan, V., Mercincavage, L., Noda, J., Peek, C. J., Miller, B. F., & Christensen, K. (2013). Atlas of integrated behavioral health care quality measures. Rockville, MD: Agency for Healthcare Research and Quality.

Kwan, B. M., & Nease Jr, D. E. (2013). The state of the evidence for integrated behavioral health in primary care. Integrated behavioral health in primary care: Evaluating the evidence, identifying the essentials, 65-98.

Lemmens, L. C., Molema, C. C., Versnel, N., Baan, C. A., & de Bruin, S. R. (2015). Integrated care programs for patients with psychological comorbidity: a systematic review and meta-analysis. Journal of psychosomatic research, 79(6), 580-594.

Maier, T., & Straub, M. (2011). “My head is like a bag full of rubbish”: Concepts of illness and treatment expectations in traumatized migrants. Qualitative health research, 21(2), 233-248.

McMurray, J., Breward, K., Breward, M., Alder, R., & Arya, N. (2014). Integrated primary care improves access to healthcare for newly arrived refugees in Canada. Journal of immigrant and minority health, 16, 576-585.

Nolte, E., Pitchforth, E. (2014). What is the evidence on the economic impacts of integrated care?. World Health Organization. Regional Office for Europe, European Observatory on Health Systems and Policies. https://iris.who.int/handle/10665/332002

Northwood, A. K., Vukovich, M. M., Beckman, A., Walter, J. P., Josiah, N., Hudak, L., O’Donnell Burrows, K., Letts, J. P., & Danner, C. C. (2020). Intensive psychotherapy and case management for Karen refugees with major depression in primary care: a pragmatic randomized control trial. BMC family practice, 21(1), 17.

Olsen, D. R., Montgomery, E., Bøjholm, S., & Foldspang, A. (2007). Prevalence of pain in the head, back and feet in refugees previously exposed to torture: a ten-year follow-up study. Disability and Rehabilitation, 29(2), 163-171.

Pavlish, C. L., Noor, S., & Brandt, J. (2010). Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries. Social science & medicine, 71(2), 353-361.

Peek & The National Integration Academy Council, 2013. Peek, C. J. (2013). The National Integration Academy Council. Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus. Rockville, MD: Agency for Healthcare Research and Quality; 2013. Contract No.: AHRQ Publication No.

Phillips, D. (2006). Moving towards integration: The housing of asylum seekers and refugees in Britain. Housing Studies, 21(4), 539-553.

Pollard Jr, R. Q., Betts, W. R., Carroll, J. K., Waxmonsky, J. A., Barnett, S., de Gruy III, F. V., … & Kellar-Guenther, Y. (2014). Integrating primary care and behavioral health with four special populations: Children with special needs, people with serious mental illness, refugees, and deaf people. American Psychologist, 69(4), 377.

Quiroga, Jose, and James M. Jaranson. (2005). Politically-motivated torture and its survivors. Torture, 15 (2-3), 1-111.

Rasmussen, A., Crager, M., Keatley, E., Keller, A. S., & Rosenfeld, B. (2011). Screening for torture: A narrative checklist comparing legal definitions in a torture treatment clinic. Zeitschrift für Psychologie/Journal of Psychology, 219(3), 143–149. https://doi.org/10.1027/2151-2604/a000061

Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. Archives of general psychiatry, 50(2), 85-94.

Satcher, D. (2000). Mental health: A report of the Surgeon General–Executive summary. Professional Psychology: Research and Practice, 31(1), 5–13. https://doi.org/10.1037/0735-7028.31.1.5

Shannon, P. J., Vinson, G. A., Cook, T. L., & Lennon, E. (2016). Characteristics of successful and unsuccessful mental health referrals of refugees. Administration and Policy in Mental Health and Mental Health Services Research, 43, 555-568.

Siouta, N., Van Beek, K., Van der Eerden, M. E., Preston, N., Hasselaar, J. G., Hughes, S., … & Menten, J. (2016). Integrated palliative care in Europe: a qualitative systematic literature review of empirically-tested models in cancer and chronic disease. BMC palliative care, 15, 1-16.

Survivor of Torture Integrated Care Continuum from the Center for Victims of Torture Integrated Care Continuum for Survivors of Torture Instruction (SOT-ICC). The Center for Victims of Torture, 1 May 2017, https://healtorture.org/wp-content/uploads/2023/05/NCB_SOT-ICC_Guide_and_Instrument_2020_0.pdf.

The Center for Victims of Torture (2019). Improving Well-Being for Refugees in Primary Care: A Toolkit for Providers. Retrieved from https://healtorture.org/resources/improving-well-being-for-refugees-in-primary-care-a-toolkit-for-providers/

Thompson, M. N., Nitzarim, R. S., Cole, O. D., Frost, N. D., Ramirez Stege, A., & Vue, P. T. (2015). Clinical experiences with clients who are low-income: Mental health practitioners' perspectives. Qualitative Health Research, 25(12), 1675-1688.

Walsh, C. A., Hanley, J., Ives, N., & Hordyk, S. R. (2016). Exploring the experiences of newcomer women with insecure housing in Montréal Canada. Journal of International Migration and Integration, 17, 887-904.

Wang P.S., Lane, M., Olfson, M., Pincus, H.A., Schwenk,T.L., Wells, K., Kessler, R.C.(2004), "The primary care of mental disorders in the United States", in Manderschied, R.W. and Berry, J.T.(Eds), Mental Health, Department of Health and Human Services, Rockville, MD, pp.117-33.

Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., Kessler, R.C. (2005), "Twelve-month use of mental health services in the United States: results from the national comorbidity survey replication", Archives of General Psychiatry, 62 (6), 629-40.

Willard, C. L., Rabin, M., & Lawless, M. (2014). The prevalence of torture and associated symptoms in United States Iraqi refugees. Journal of Immigrant and Minority Health, 16, 1069-1076.

Whiteman, K. L., Naslund, J. A., DiNapoli, E. A., Bruce, M. L., & Bartels, S. J. (2016). Systematic review of integrated general medical and psychiatric self-management interventions for adults with serious mental illness. Psychiatric Services, 67(11), 1213-1225.

Wong, E. C., Marshall, G. N., Schell, T. L., Elliott, M. N., Hambarsoomians, K., Chun, C. A., & Berthold, S. M. (2006). Barriers to mental health care utilization for US Cambodian refugees. Journal of consulting and clinical psychology, 74(6), 1116.

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