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EVIDENCE SUMMARY
April 2025

What works in providing telehealth services to newcomers?

One source of strong evidence and three suggestive studies indicate that virtual mental health services can have positive outcomes in newcomer communities despite concerns about privacy and technological access.

- Most studies included in a scoping review indicated that participants made positive progress during their time receiving virtual mental health services. Benefits of virtual mental health services were the ability to access a wider net of providers, finding new creative ways to interact, ease of attendance, and the ability to feel more comfortable sharing through text or without cameras on.
- The barriers reported remained consistent across the studies. These were generally the lack of access to technology (devices, Internet, etc.) and trouble finding a private location. Some programs addressed these challenges by providing funding or devices to participants.

One source of strong evidence and one suggestive study indicate positive outcomes for virtual perinatal mental health services with newcomers, though the literature is limited.

- Participants in virtual perinatal mental health interventions generally reported high levels of satisfaction and positive outcomes of the program. However, all the reported outcomes come from suggestive studies with varying degrees of rigor.

One source of moderate evidence indicates that a virtual diabetes and hypertension management intervention can be effective in newcomer populations.

- The intervention had very high completion rates, and members of the intervention group had better outcomes on all measures than the control group. Participants also reported more confidence in using telehealth with their providers.

Purpose of this summary

This document summarizes the state of available evidence regarding the impacts of telehealth services in newcomer communities. The original aim of this summary was to cover all virtual services for newcomers, but there was a lack of evidence for services that are not telehealth related. The information provided is ideal for service providers offering mental health services to newcomer communities and service providers interested in understanding what has worked in virtual settings with newcomers more broadly. It aims to answer the following questions:

1. What does the research say about how to successfully implement a telehealth-based program with newcomer communities?
2. What are the common barriers or obstacles to implementing telehealth with newcomers?

What is meant by "telehealth"?

Telehealth, also known as digital, remote, or virtual health, is defined as "the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration."[1]

What is meant by "perinatal"?

The perinatal period can refer to varying lengths of time related to pregnancy and the postpartum period but is commonly used to denote the entire length of a pregnancy and up to one year postpartum. This evidence summary refers to the broader length of time when discussing the perinatal period.[2]

What does the evidence show?

One source of strong evidence and three suggestive studies indicate that virtual mental health services can have positive outcomes in newcomer communities despite concerns about privacy and technological access.

- Hynie et al. (2023) conducted a scoping review between November 2020 and October 2021 on access to virtual mental health care for refugee and immigrant groups, with the goal of analyzing the appropriateness, acceptability, affordability, and availability of various programs. The review identified 44 articles covering 40 unique interventions.
    - **The extent of virtual contact** varied across the interventions, ranging from fully virtual to hybrid models that included remote therapy and in-person clinical follow-up. The most frequent method, however, was self-paced web/mobile applications followed by video calls. Audio-only and text-based interventions were also included.
    - **Populations studied:** Twelve of the included studies specifically discussed refugees or asylum seekers, and the remainder covered immigrants more broadly.
    - **The most common conditions covered** through mental health services were depression, depression/anxiety combination, PTSD, anxiety/PTSD combination, anxiety/PTSD/substance use combination, and caregiver burnout.
    - In analyzing **appropriateness and acceptability**, many interventions were rated as

[1] Chang, J. E., Lai, A. Y., Gupta, A., Nguyen, A. M., Berry, C. A., & Shelley, D. R. (2021). Rapid transition to telehealth and the digital divide: Implications for primary care access and equity in a post-COVID era. *The Milbank Quarterly, 99*(2), 340–368. https://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12509
[2] ScienceDirect. (2020). *Perinatal period.* https://www.sciencedirect.com/topics/medicine-and-dentistry/perinatal-period

helpful and trustworthy. A highlight regarding appropriateness in virtual services was the **ability for individuals to overcome cultural and language barriers through being able to contact providers outside of their geographic location**. The most common adaptations to interventions were linguistic modifications, cultural modifications (e.g., incorporating cultural concepts or practices), combined cultural and linguistic modifications, and matching client ethnic and cultural identities to providers.
    - Participants in **self-paced stand-alone web-based programs** appreciated the anonymity of online services, which allowed them to avoid cultural stigma in their communities. However, many programs had high dropout rates (9% to about 40%). Those who did complete self-paced programs reported **high satisfaction, reduced costs and stigma, and increases in coping techniques**. Overall, video-therapy programs had high satisfaction rates, but these were lower among individuals with lower education levels.
    - **Affordability concerns** involved the ability to procure technological devices and cover costs of data and Internet. To circumvent these issues, some programs offered services in a community or clinical office, allowing patients to access their technology and remote providers. Other interventions provided devices or funding directly to participants.
    - **Availability concerns** involved **technical issues**, including "the quality of the technology itself, and the challenges users faced with operating the technology, such as dropped calls, poor-quality videos or corrupted audio files"(p. 1189). Some users also expressed concerns about the security of the platforms. To combat these challenges, several studies offered **facilitators to support technology use,** and most studies included some **in-person sessions** to **introduce the study** or **provide training on the technology**. At least one study noted hearing difficulties as a particular barrier for older participants.
    - **Over half of the studies reported improvements in the mental health conditions they were following**, covering various designs, quality, and diagnoses.

- Marcelin et al. (2021) reported data from 12 participants of a modified version of the Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA) specifically for Haitian youth in Miami-Dade County who were involved with the juvenile justice system. Five participants started the program with in-home therapy and then transitioned to teletherapy due to COVID-19, and seven initiated the program with teletherapy. To help practitioners adjust to teletherapy, the intervention team developed a guide that was heavily reviewed, discussed, and validated.
    - The **intervention included individual and family psychoeducational sessions** delivered as 12 weekly one-hour sessions but could be as long as 18 weeks with up to two one-hour sessions per week, depending on how at-risk a participant was. Additionally, participants received a one-hour booster session six months after completing the program.
    - Ethnographers with Haitian backgrounds conducted baseline and 3-, 6-, and 12-month post-intervention assessments with each participant.
    - Therapists found that **most families had access to a cell phone, but many did not have phones for all family members or phones that were consistently in service**. This meant participants often needed to rely on the availability of their parents' or older siblings' phones, causing some disruption to schedules. Particularly with participants who joined the intervention during the pandemic, **when participants were using audio-only avenues, the therapists were unable to observe the space and ensure privacy was maintained** during the session. Therapists had to rely on background noise or mediate interjections from family members. This resulted in **some participants not always feeling free to fully express themselves**.
    - Regarding **engagement**, therapists reported they had more success maintaining engagement for participants who started the intervention before the pandemic than those who initiated with teletherapy, and they felt **the virtual nature reinforced avoidant behaviors in participants already prone to them.** Although the program was able to transition to virtual services and maintain participation, the program planned to return to in-home therapy as soon as possible.

- Martinez et al. (2022) conducted a trial of the *Fuerte* program, a school-based program aiming to reduce mental health disparities. *Fuerte* is delivered in small groups (4–8 students) and consists of eight sessions. The target population was newcomer Latinx middle and high school students in California. This presentation of *Fuerte* was adapted to be entirely conducted through videoconferencing, and recruitment was conducted telephonically by the study team. Eligibility requirements were having arrived in the U.S. within the last five years and being from a Latin American country, a high school student, and predominately Spanish speaking. Each series had two group leaders, at least one of whom was a licensed behavioral health clinician or a trainee supervised by a licensed clinician. This study reports on data from focus groups with 12 participants from the 2020–2021 school year and semi-structured interviews with eight of the nine group leaders.
    - **Group leaders reported that the telehealth modality made several elements easier,** such as eliminating the need for travel or to find a space to fit the group. Several leaders also shared that the Zoom interface allowed them to find **creative ways to engage the participants,** such as digital whiteboards and screen sharing websites and videos.
    - **Participants shared that the virtual modality allowed them to share things in ways that they otherwise may not have**, such as sharing family pictures as the topic came up, rather than having to remember to bring something in during the next session. The chat function also allowed some participants to share thoughts they weren't comfortable voicing aloud.
    - **Participants faced several technical issues** such as lack of stable Internet and video and audio quality issues.
    - Regarding **engagement**, some participants reported they were more engaged during *Fuerte* than in either remote or in-person interactions with classmates. **The ability to turn off their camera made participants feel more comfortable engaging on deeper levels**. The virtual format allowed participants with other responsibilities to have more flexibility to join, but **there were struggles with finding private, quiet locations to join and engage**. Group leaders also felt it was harder to re-engage students when they previously would have been able to follow up with them in school.
    - Regarding **social connectedness**, both group leaders and participants felt that **virtual *Fuerte* was successful in creating and maintaining a sense of connectedness.** The participants felt that, especially with much of their lives being virtual, *Fuerte* was a great avenue to build new friendships and connect with other students; they felt happy, valued, and part of a community.

- Disney et al. (2021) investigated the ways clinicians in a refugee-serving mental health clinic were able to successfully transition to telehealth provision during COVID-19, the obstacles they faced, and resources that were helpful during the transition. Most refugees being served in this clinic presented with PTSD and/or Major Depressive Disorder. The clinic practiced an integrated treatment model allowing clinicians to provide both therapy and case management.
    - Data was collected through a survey sent to all mental health providers employed at the selected agency. After removing clinicians who did not serve refugees, the sample included 17 responses. Most respondents were female (87%), and their ages ranged from 27 to 65.
    - Regarding previous training in administering telehealth, 41% stated they had telehealth-specific training prior to COVID-19, but only 29% had used telehealth in that time**. Even with that training, 53% stated they did not feel equipped to switch to telemental health before COVID-19**, but all respondents stated they felt equipped at the time of the survey. Respondents shared that telemental health training and electronic resources (email, listserv, etc.) were the most helpful resources when adapting their services (both 94%), followed by periodic supervisor check-ins on a weekly or biweekly basis (88%).
    - Qualitative questions from the survey yielded **two themes**: (1) providers are flexible and take initiative in adapting their services, and (2) refugee mental health providers faced

multiple obstacles in adapting to telemental health with refugee clients.
    - **Providers discussed challenges in using only phone telemental health and not video** and the need to compensate for the lack of nonverbal cues.
    - Several **client barriers** were noted, including lack of access to technological devices, Internet, and/or money to pay for phone plans. **The lack of private and confidential spaces hindered clients' ability to feel comfortable opening up completely**.
    - **Obstacles in the therapeutic relationship** included trouble building rapport with clients who initiated therapy via telehealth, finding interpreters, and working with three people (including an interpreter) via telehealth modalities.
  - **Despite these obstacles, providers reported they felt they were able to make progress with their clients via telehealth**.

One source of strong evidence and one suggestive study indicate positive outcomes for virtual perinatal mental health services with newcomers, though the literature is limited.

- Salameh, Nyakeriga, and Hall (2023) conducted a scoping review of telehealth interventions focusing on perinatal depression in immigrant and refugee women. Five articles met the inclusion criteria, all of which would be considered suggestive evidence. Each study's sample comprised at least 50% refugee or immigrant women. Three of the articles covered women in the U.S., one took place in Switzerland, and one was conducted in Turkey. Three of the five studies focused on Latina mothers, one on Chinese immigrants, and one on Syrian refugees. Three studies analyzed perceptions of using apps and social media for receiving care and information. One study tested the Perinatal Mental Health Model, a short-term telemedicine intervention that asked participants to attend at least one telephone-based session**. The results of the studies were generally positive, with most participants reporting increased access and satisfaction**. The review concluded that evidence on telemedicine for perinatal depression in refugee and immigrant populations is still preliminary, although existing evidence indicates positive experiences.

- Platt et al. (2023) evaluated a virtual adaptation of the Mothers and Babies (MB) programs for Latina immigrant mothers in the United States. MB is highly regarded as one of the most effective interventions for preventing postpartum depression. It combines elements of cognitive behavioral therapy and attachment theory and is available in several formats. The COVID-19 pandemic inspired these researchers to adapt the group format into an enhanced virtual group, MB-Virtual Group (MBVG). This run of MBVG included 49 Spanish-speaking mothers, 80% of whom were originally from El Salvador, Guatemala, Honduras, or Mexico. Fifty-nine percent of participants were in the perinatal period. The original MB group format consists of six 90-minute in-person sessions. MBVG modified these into eleven 60- to 75-minute Zoom group sessions and added a 15-minute Q&A session with a pediatrician at the end of each session. The researchers also "offered assistance with accessing food-related resources" and communicated via WhatsApp with reminders about meetings and assignments (p. 467). Almost 80% of participants attended more than half of the offered sessions, an increase compared to studies on in-person MB with Latinas.
  - The evaluation results showed **a reduction in average depressive symptoms and parenting distress scores** and an **increase in reported self-efficacy in emotional management.**
  - Reported benefits of the virtual format included **ease of attendance, reduction of participation barriers, and comfort in sharing** through the ability to turn off cameras.
  - Drawbacks to the virtual platform included **lack of digital literacy, social cues, and ability to be removed from at-home stressors**.
  - Participants highly valued the ability to ask questions of a pediatrician and appreciated the group messaging aspect for its ability to build community and provide reminders.

One source of moderate evidence indicated that a virtual diabetes and hypertension management intervention can be effective in newcomer populations.

- Shah et al. (2023) reported on results from the Diabetes Research, Education, and Action for Minorities (DREAM) Atlanta intervention, a randomized-controlled trial aiming to improve blood pressure in immigrant South Asian adults diagnosed with type II diabetes and hypertension. DREAM is led by community health workers (CHWs) and is administered via telehealth modalities. The intervention consisted of five monthly one-hour sessions delivered by CHWs in either Bengali or English. Topics covered in the sessions included an overview of type II diabetes and hypertension, nutrition, physical activity, stress management, and type II diabetes and hypertension management. The CHWs also created and followed up on action plans and made progress notes with the intervention participants through one-on-one phone calls each month. Members of the control group only received the overview of type II diabetes and hypertension session. All participants received a blood pressure monitor and digital scale and education on how to use them at the beginning of the intervention to help standardize reported measurements. There were 97 participants in the intervention and 93 in the control group. A large majority of the intervention group (>90%) completed all the sessions, the action plan, three or more progress notes, and the follow-up survey. A majority of the control group also completed the follow-up survey (98%).
    - **The intervention group saw better outcomes on all measures as compared to the control group.** The main outcome measure, blood pressure control, increased 33.7% in the intervention group, compared to 16.5% in the control group. Managing diabetes through diet or exercise increased by 25% and 34.8%, respectively, in the intervention group while only increasing by 5.4% and 5.5% in the control group. Managing diabetes with medication or insulin decreased by 3.3% in the intervention group but increased by 5.4% in the control group.
    - **Members of the intervention group also reported increased knowledge and comfort with using technology such as Zoom or patient portals.**

What are the implications for practice and research?

> "Offering mental health services in multiple modalities helped address some barriers to access, especially those related to challenges with literacy."
>
> (Hynie et al., 2023)

Telehealth programs can be an effective means of providing services and connecting newcomers with a wider network of providers.

- Providers should consider offering technological support to participants in telehealth programs to help overcome barriers with digital literacy or accessing technology. Connecting participants

with nearby locations, such as libraries, where they can access privacy to participate could also help mitigate concerns of intrusion from other household members.

- Maintaining engagement and participation has also been a challenge in some programs. Following-up consistently and supporting non-traditional engagement (such as chat features) may help participants feel comfortable sharing and continuing to engage.
- If providers can build a relationship with participants before shifting to virtual services, that may help overcome concerns with client engagement and lack of non-verbal communication.

Research should focus on comparing outcomes of telehealth services with in-person services, as well as examining outcomes of non-health-related virtual services.

- While most of the studies indicate positive outcomes of telehealth services, there is a lack of comparison with outcomes from in-person services. Many of the interventions were adapted to include telehealth during the COVID-19 pandemic, but the analyses did not compare outcomes from that time with outcomes before transitioning to telehealth.
- This evidence summary initially aimed to include evidence for virtual case management or other non-health-related virtual services, but there was a lack of evidence for newcomer populations. Even the topic of non-mental-health-related telehealth is lacking robust, high-quality research.

How did we identify evidence for this summary?

Included Studies

The Switchboard evidence database includes the following types of studies, categorized by the strength of their evidence:

Strong Evidence

Meta-analyses: systematic analyses of sets of existing evaluations of similar programs

Systematic reviews: syntheses of the best available evidence on specific research questions that use narrative synthesis focused on evaluations of the impacts of at least one specific policy, program, or intervention

Moderate Evidence

Published individual **impact evaluations** using randomized controlled trials (RCTs/C-RCTs), natural experiments, quasi-experimental techniques such as difference-in-difference (DID), instrumental variables (IV), regression discontinuity design (RDD), and propensity score matching (PSM) or other forms of synthetic matching, as well as fixed effects techniques with interaction terms

Suggestive Evidence

Published studies using methods including non-systematic literature review, uncontrolled before and after tests, post-test only, interrupted time series (ITS), cross-sectional regressions, longitudinal panels, cohort and case-controls, and purely qualitative techniques

Excluded Studies

The Switchboard evidence database excludes case studies, unpublished suggestive research, opinion papers, descriptive studies, and unpublished literature reviews.

Search Protocol

Studies included in the database focused on high-income or upper middle-income countries, including but not limited to the United States. Studies included must have been published since 2012. To identify evidence, we searched the following websites and databases using the following population, methodology, and target outcome terms:

Websites and Databases	Population Terms	Methodology Terms	Target Outcome Terms
Campbell Collaboration Cochrane Collaboration Mathematica Policy Research Urban Institute Migration Policy Institute CINAHL ASSIA Social Services Abstracts Social Work Abstracts PsycInfo ERIC	refugee OR immigrant OR “unaccompanied minor” OR asylee OR “temporary protected status” OR “victims of traffick*” OR “traffick* victims” OR T-Visa OR U-Visa OR Cuban OR Haitian OR Amerasian	evaluation OR impact OR program OR intervention OR policy OR project OR train* OR therapy OR treatment OR counseling OR workshop OR review OR meta-analysis OR synthesis	"virtual case management" OR "virtual resettlement" OR "distance case management" OR "distance resettlement" OR "virtual refugee resettlement" OR "distance refugee resettlement" OR "virtual refugee services" OR "distance refugee services" OR "telehealth" OR "virtual services"

For databases or websites that permitted only basic searches, free-text terms and limited term combinations were selected out of the lists above, and all resultant studies were reviewed for relevance. Conversely, for databases or websites with advanced search capability, we made use of relevant available filters. All terms were searched in the title and abstract fields only in order to exclude studies that made only passing mention of the topic under consideration.

After initial screening, Switchboard evidence mapping is prioritized as follows: First priority is given to meta-analyses and systematic reviews, followed by individual impact evaluations when no meta-analyses or systematic reviews are available. Evaluations that are rated as impact evidence are considered before those rated as suggestive, with the latter only being included for outcomes where no evidence is available from the former.

Studies Included

Database and website searching identified 175 studies. After removing duplicates, 164 studies were then screened. Of these, 142 were determined to be irrelevant to this search. Twenty-two full-text articles were assessed for eligibility. Fifteen full-text articles were excluded due to not meeting one or more of the inclusion criteria pertaining to resettlement country, year of publication, population, methodology, or target problem. Seven studies were eligible for inclusion. They are listed below, with hyperlinks to the abstracts or full text (when available).

Meta-Analyses and Systematic Reviews

Hynie, M., Oda, A., Calaresu, M., Kuo, B. C. H., Ives, N., Jaimes, A., Bokore, N., Beukeboom, C., Ahmad, F., Arya, N., Samuel, R., Farooqui, S., Palmer-Dyer, J., & McKenzie, K. (2023). Access to virtual mental healthcare and support for refugee and immigrant groups: A scoping review. *Journal of Immigrant and Minority Health, 25*, 1171–1195. Full Text.

Salameh, T. N., Nyakeriga, D. B., & Hall, L. A. (2023). Telehealth care for perinatal depression in immigrant and refugee women: A scoping review. *Issues in Mental Health Nursing, 44*(12), 1216–1225. Abstract.

Impact Evaluations

Shah, M. K., Wyatt, L. C., Gibbs-Tewary, C., Zanowiak, J. M., Mammen, S., & Islam, N. (2023). A culturally adapted, telehealth, community health worker intervention on blood pressure control among South Asian immigrants with Type II diabetes: Results from the DREAM Atlanta intervention. *Journal of General Internal Medicine, 39*, 529–539. Abstract.

Suggestive Studies

Disney, L., Mowbray, O., & Evans, D. (2021). Telemental health use and refugee mental health providers following COVID-19 pandemic. *Clinical Social Work Journal, 49*, 463–470. Full Text.

Marcelin, L. H., Cela, T., Dembo, R., Jean-Gilles, M., Page, B., Demezier, D., Clement, R., & Waldman, R. (2021). Remote delivery of a therapeutic intervention to court-mandated youths of Haitian descent during COVID-19. *Journal of Community Psychology, 49,* 2938–2958. Abstract.

Martinez, W., Patel, S. G., Contreras, S., Baquero-Devis, T., Bouche, V., & Birman, D. (2022). "We could see our real selves:" The COVID-19 syndemic and the transition to telehealth for a school-based prevention program for newcomer Latinx immigrant youth. *Journal of Community Psychology,* 1–18. Abstract.

Platt, R., Martin, C. P., Perry, O., Cooper, L., Tandon, D., Richman, R., Bettencourt, A. F., & Polk, S. (2023). A mixed-methods evaluation of virtually delivered group-based Mothers and Babies for Latina immigrant mothers. *Women's Health Issues, 33*(5), 465–473. Full Text.

Supplemental Resources

The following studies did not meet the criteria to be included in the evidence summary but may provide additional context, guidance, or understanding of the topic.

Andrade, E. A., Betancourt, G., Morales, G., Zapata, O., Marrero, L., Rivera, S., Nieves, E., Miranda, C., Diaz, C., Beil, R., Patel, V. V., & Ross, J. (2023). A community-based pre-exposure prophylaxis telehealth program focused on Latinx sexual minority men. *AIDS Patient Care and STDs, 37*(11), 517–524. Full Text.

Augusterfer, E. F., Mollica, R. F., & Lavelle, J. (2015). A review of telemental health in international and post-disaster settings. *International Review of Psychiatry, 27*(6), 540–546. Abstract.

Chang, J. E., Lai, A. Y., Gupta, A., Nguyen, A. M., Berry, C. A., & Shelley, D. R. (2021). Rapid transition to telehealth and the digital divide: Implications for primary care access and equity in a post-COVID era. *The Milbank Quarterly, 99*(2), 340–368. Abstract.

Endale, T., St. Jean, N., & Birman, D. (2020). COVID-19 and refugee and immigrant youth: A community-based mental health perspective. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(S1), S225–S227. Abstract.

Feen-Calligan, H., Grasser, L. R., Smigels, J., McCabe, N., Kremer, B., Al-Zuwayyin, A., Yusuf, I., Alesawy, N., Al-Nouri, J., & Javanbakht, A. (2023). Creating through COVID-19: Virtual art therapy for youth resettled as refugees. *Art Therapy, 40*(1), 22–30. Abstract.

Hart, S., Campbell, C., Divine, H., Dicks, M., Kebodeaux, C., Schadler, A., McIntosh, T. (2022). Telehealth diabetes services for non-English speaking patients. *Journal of the American Pharmacists Association, 62*(4), 1394–1399. Abstract.

Havewala, M., Wang, C., Bali, D., Chronis-Tuscano, A. (2023). Evaluation of the virtual youth mental health first aid training for Asian Americans during COVID-19. *Evidence-Based Practice in Child and Adolescent Mental Health, 8*(3), 321–334. Abstract.

Hodges, J., & Calvo, R. (2023). Telehealth for all? Assessing remote service delivery for Latinx immigrants. *Health & Social Work, 48*(3), 170–178. Abstract.

McGuire, K., & Hynie, M. (2023). Virtual care and social support for refugee mothers during COVID-19: A qualitative analysis. *INYI Journal, 13*, 5–17. Full Text.

Mishori, R., Hampton, K., Habbach, H., Raker, E., Niyogi, A., & Murphey, D. (2021). "Better than having no evaluation done": A pilot project to conduct remote asylum evaluations for clients in a migrant encampment in Mexico. *BMC Health Services Research, 21*(1), 1–8. Full Text.

Negi, N. J., & Siegel, J. L. (2022). Social service providers navigating the rapid transition to telehealth with Latinx immigrants during COVID-19 pandemic. *American Journal of Orthopsychiatry, 92*(4), 463–473. Abstract.

Nicasio, A. V., Rodriguez, J. H., Villalobos, B. T., Duewekw, A. R., de Arellano, M. A., & Stewart, R. W. (2022). Cultural and telehealth considerations for trauma-focused treatment among Latinx youth: Case reports and clinical recommendations to enhance treatment engagement. *Cognitive and Behavioral Practice, 29*(4), 816–830. Abstract.

Nieto-Martínez, R., De Oliveria-Gomes, D., Gonzalez-Rivas, J. P., Al-Rousan, T., Mechanick, J. I., & Danaei, G. (2023). Telehealth and cardiometabolic-based chronic disease: Optimizing preventive care in forcibly displaced migrant populations. *Journal of Health, Population and Nutrition, 42*(1), 1–10. Full Text.

Olavarrieta, G. A., & Benuto, L. (2022). Narrative exposure therapy: A case for use with refugees via telehealth with the use of an interpreter. *Clinical Case Studies, 21*(5), 419–437. Abstract.

Spencer, M. R. T., Yoon, S., Lee, Y., Bustamante, A. V., & Chen, J. (2024). Healthcare and telehealth use.

Frontiers in Public Health, 12, 1–10. Full Text.

Taknint, J. T., Rojas Perez, O. F., Mattar, S., & Piwowarczyk, L. (2023). Teletherapy trauma treatment in context: Caring for refugee patients during and beyond the COVID-19 pandemic. *Practice Innovations, 8*(2), 89–101. Abstract.

Weith, J., Fondacaro, K., & Khin, P. P. (2023). Practitioners' perspectives on barriers and benefits of telemental health services: The unique impact of COVID-19 on resettled U.S. refugees and asylees. *Community Mental Health Journal, 59*, 609–621. Full Text.

Zhang, D., Shi, L., Han, X., Li, Y., Jalajel, N. A., Patel, S., Chen, Z., Chen, L., Wen, M., Li, H., Chen, B., Li, J., & Su, D. (2024). Disparities in telehealth utilization during the COIVD-19 pandemic: Findings from a nationally representative survey in the Unites States. *Journal of Telemedicine and Telecare, 30*(1), 90–97. Abstract.