

Elevating Refugee Perspectives about Access to Disability Services in Arizona

A Report for the Arizona Developmental Disabilities Planning Council

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Project Overview

According to the United States (U.S.) Department of Homeland Security, a refugee cannot “return to their country of nationality because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion” (Gibson 2023). Internationally, 35.5 million people are refugees who have been forcibly migrated from their country of nationality, and 41% are children (UNHCR 2023). A study done in 2018 of self-reported disability in newly arrived refugees showed that slightly over 20% of refugees had a disability, which is much higher than the national average of 13% among the general population (Kaur et al., 2023).

In 2023, Arizona is in the top 10 states for refugee resettlement in the U.S. (Ward & Batalova, 2023) and in the top 15 states for refugee arrivals per capita (Gibson, 2023). Refugees’ nations of origin vary over the years, based on disruptions that lead people to migrate, but in 2023 the most common sending nations of refugees to various locations around the U.S. were the Democratic Republic of Congo, Myanmar (Burma), Syria, Afghanistan, and Ukraine (Ward & Batalova, 2023). In Arizona, the top 5 sending nations in 2023 included Cuba, Democratic Republic of Congo, Ukraine, Syria, and Myanmar (Burma). In addition, Arizona’s diverse population of refugees includes members of preceding years’ waves of migration, such as people from Vietnam in the 1980s and 90s, migrants from Bosnia and Bhutan in the late 1990s through early 2000s, and people from Iraq and Somalia in the early and mid-2010s (Arizona Refugee Resettlement Program, 2023).

As a testament to the upheaval and trauma experienced by refugees and their recognition of opportunities in the U.S., one of our participants noted what he is grateful for after relocating to the U.S.: “One of the things I'm very thankful [for] is the education we're getting, especially for the kids. even though I struggled at the beginning, one thing I can say is that there are some resources and some things for children with disabilities. Another thing I am very grateful [for] is the safety. Like, you're not going to sleep and worry about being killed. You're getting enough food... The children get very ... excited when they go to the school and they see food at their school and then they come home and there's food.”

In Arizona, the Developmental Disabilities Planning Council’s (ADDPC) 2018 report on Refugees with Disabilities found a lack of collaboration between Refugee Resettlement Agencies and disability services/agencies (e.g. Vocational Rehabilitation [VR]). Many barriers identified in other sectors (e.g., health care) were also identified in the report, including lack of language interpretation and various understandings of disability. The report highlighted

the intersectoral barriers that result in fragmented systems that are difficult to navigate. The current report aims to highlight areas where Arizona could improve access to disability services for the diverse populations of refugees in the state, drawing from data that were collected primarily from refugees with lived experience of disability and professionals who work with them.

The central goal of this project was to understand how policies and practices within and around the disability service system affect accessibility of these services for refugees with disabilities. This project centers the experiences of refugees themselves. The project's findings highlight the broad and diverse population of refugees with disabilities in the state of Arizona, with a focus on Tucson and Phoenix, the primary resettlement areas. This report builds on ADDPC's 2018 report, which focused on the perspectives of service providers, to include input from refugees with lived experience. The study team used a number of complementary data collection methods to better understand and illuminate the experiences of refugees with disabilities in Arizona.



Amal is a 12-foot puppet of a 10-year-old Syrian refugee, who visited Tucson, Arizona in October 2023. For more information about her journey, visit <https://www.walkwithamal.org/>

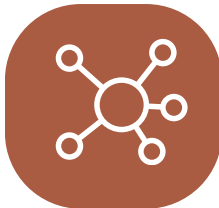
Summary of Methods



Community engagement with refugee resettlement agencies and ethnic-based community organizations in Tucson and Phoenix helped the team gain information about the lived experience of refugees in Arizona. Guidance from a community advisory board helped frame the work.



Policy scans focused on Arizona agencies and United States-wide policies and practices related to service accessibility for refugees with disabilities.



Group concept mapping with refugees with disabilities, their support people, and professionals helped the team understand the areas of greatest need and potential for addressing gaps.



In-depth in-person interviews with dyads (a refugee with a disability and their supporter) were used to understand how their intersectional experiences as a refugee with a disability affects their interactions with the service system.

Refugees with disabilities need better disability services, including education and health care services, and improved coordination among agencies. Findings from this study can inform how to make services better for refugees with disabilities.



Findings



Community Engagement

The team's visits with refugee resettlement agencies and ethnic-based community organizations (EBCOs) in Tucson and Phoenix enabled an understanding of the importance of identifying critical "gatekeepers" for refugee communities. Interactions with various gatekeepers helped us contextualize findings from the group concept mapping and in-depth interviews. Gatekeepers may be language interpreters, health care providers, or other community leaders, but they may have very little knowledge about or misunderstandings of disability services.

The community advisory board met 5 times over the course of the project to provide input on our approach and offer guidance for recruitment and analysis. The 9-person board was composed of professionals in the fields of education and refugee or disability services, several of whom have lived experience as a refugee. Appendix A contains a list of organizations represented on the advisory board.



Policy Scans

Sonoran Center Disability Fellows and Interns scanned all U.S. refugee websites for mention of disability and accessibility of materials, and interns reviewed disability websites for policies related to language access. Of the 40 states with statewide refugee resettlement websites, less than half (n=17, 42.5%) referenced disability and/or provided disability resources, while others had no mention of disability (n=33). Further, in a scan of Developmental Disabilities State Services websites (N=50), only 16 (32.0%) mentioned language access and only 20 (40%) provided home page content in languages other than English and/or offered website translation (e.g., Google translation). As of October 2023, Arizona's refugee resettlement

website did not refer to disability. Arizona's Division of Developmental Disabilities home page does refer visitors to their language access policies and provides translation of the website into 15 languages.

The team also conducted a survey of refugee health coordinators, distributing the survey in all 50 states. While we received only a few responses (N=3), their open-ended responses to our questions provided insight into challenges for refugees with disabilities across the U.S. Respondents could provide an open-ended response to the question, "What is the biggest gap in serving refugees in your state?" Participants described length of time to receiving services (e.g., Home & Community Based Services or school services) after arrival, with complicated ("convoluted") referral processes and students not receiving timely school assessments to facilitate enrollment. They also commented on lack of access to equipment, such as wheelchairs, and described a need for intensive case management to provide sustained advocacy for clients.

Our conversations with the community advisory board clearly echoed these concerns, with board members noting that the assessment processes for service qualification (i.e., IQ assessments) may not be culturally or linguistically appropriate. Policy fellows from the Sonoran Center completed research highlighting the need for support for refugees in the schools finding that school social workers and counselors receive little to no training on the specialized needs of this population, whose members may enter with trauma exposure and substantially different or little school experience.



Group Concept Mapping

Group concept mapping (GCM) is a mixed-method, participatory action-oriented approach that provides a way to organize ideas on a specific issue from a diverse group of stakeholders to generate a visual conceptual framework for planning and evaluation (Kane & Trochim, 2007). This technique combines qualitative input with quantitative data analysis to provide a visual representation of the important issues on which to act, making it more directly accessible to stakeholders than other methods. Figure 1 below outlines the GCM process utilized with Arizona community members and the CAB.

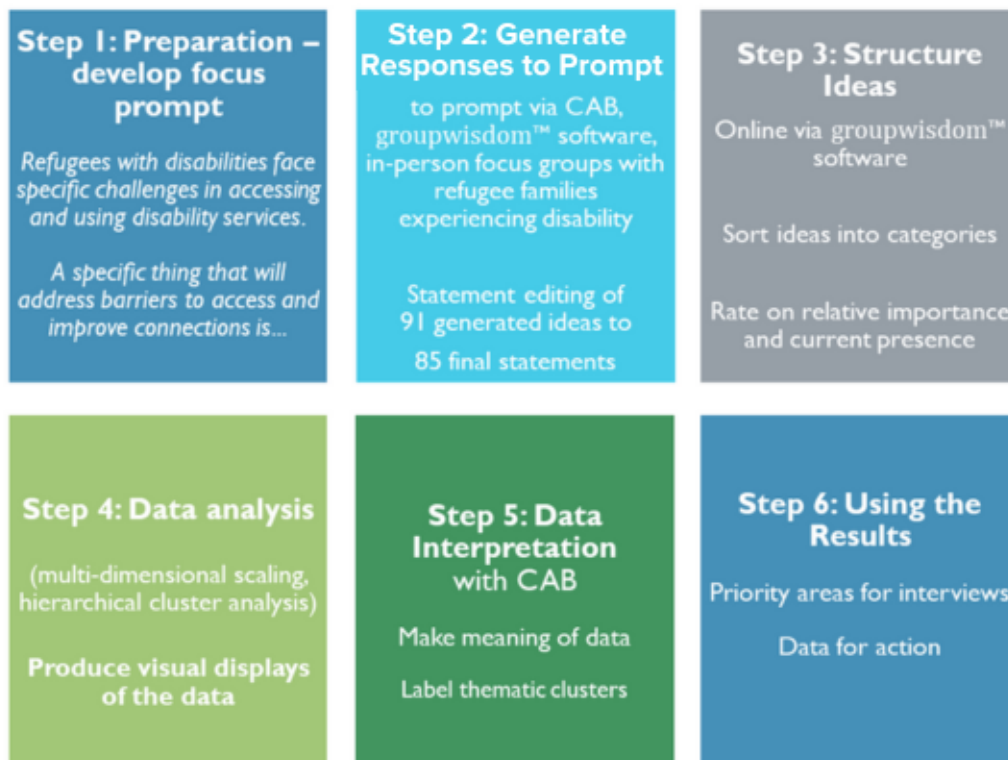


Figure 1. Elevating Refugee Perspectives Group Concept Mapping Process

The team engaged with three distinct groups in brainstorming ideas in response to the prompt (see Figure 1, Step 2) to gather ideas that will address barriers to access and improve connections for refugees with disabilities. Group 1 – CAB members (n=9) brainstormed ideas during their first meeting via zoom. Group 2 – ideas generated by the CAB were added to the online GCM software groupwisdom™ and disability and refugee professionals were invited to add ideas online (4 professionals added additional ideas). Group 3 – three focus groups were held in Phoenix (n=8) and one in Tucson (n=5) with refugee families experiencing disabilities with Somali, French, Swahili, and Kikongo interpretation.

These groups generated 91 ideas which the team edited and refined to a list of 85 final unique statements. CAB members and the broader Arizona community of disability and refugee professionals, caregivers and individuals with lived experience who communicate in English were invited to participate in online groupwisdom™ activities to organize and prioritize these final statements (Figure 1, Step 3).

Rating of statements	
Relative Importance	Current Presence
How important is this?	How much is this currently happening?
1. Not so important	1. None of the time
2. Somewhat important	2. Some of the time
3. Important	3. Most of the time
4. Very important	4. All of the time

Figure 2. Rating questions and scales used for GCM process.

Twenty-three participants completed the sorting activity and 24 completed the rating activities. The final data for the cluster map (Figure 3) and Go-Zone analyses (Table 1) were based on the responses of participants (n=16) who reported having any experience supporting refugees with disabilities. These participants represented perspectives from different regions of the state including Pima county (greater Tucson area, 38%), Maricopa county (greater Phoenix area, 25%), Apache county (19%), Cochise county (13%), and Santa Cruz county (6%).

The cluster map (Figure 3) is a visual depiction of how the statements (N=85) were grouped together by participants. The CAB assisted the research team in identifying the themes that unify the statements in a cluster. The five clusters reflect the primary relevant themes for improving access to disability services for refugees: 1) *Culturally responsive, accessible health & disability services and benefit systems* (12 statements); 2) *Agency Training & Coordination about Refugees & Disability* (18 statements); 3) *Community Support, Representation & Mentorship* (26 statements); 4) *Refugee Rights & Self-Advocacy Education* (18 statements); and 5) *Language & Resource Access* (11 statements). (Appendix B contains a list of all ideas by cluster.) The cluster map was layered with the rating data to visually depict each cluster’s relative importance and current presence (See Appendices B and C). The cluster representing *Agency Training & Coordination about Refugees & Disability* statements was ranked highest for both importance and currently happening, while statements representing *Language & Resource Access*, *Refugee Rights & Self-Advocacy Education*, and *Community Support, Representation & Mentorship* ranked among the lowest for importance and currently happening.



Figure 3. Cluster Map of primary themes for improving access to disability services for refugees

The “Go Zone” analyses allowed for comparison of importance and current presence among the statements and within each cluster. The “Go Zones” were areas where participants identified the statements as most important but not currently happening (see Appendix D for the “Go Zone” graphs). The statements in the “Go Zone” for each thematic cluster are listed in Table 1. These “Go Zone” items highlight the need for a) support professionals, providers, and navigators who understand disability and refugee systems, b) education and awareness of services and supports available to refugees with disabilities across stakeholder groups, c) opportunities to empower and connect refugee communities around disability rights and issues, and d) culturally and linguistically appropriate services and supports. The CAB utilized these “Go Zones” to assist in developing recommendations.

Table 1. Go-Zone Items – Important, but Not Happening

Note. Statement numbers match the list in Appendix B. The corresponding “Go Zone” graph for each cluster are available in Appendix E.

Culturally responsive, accessible health & disability services and benefit systems

2. Getting timely diagnosis

82. Accepting verified international medical records or disability diagnoses to establish disability eligibility in U.S.

34. Requirement that DDD / AHCCCS (Medicaid) health plans have Case Managers that are specialized in refugee care / LEP (limited English proficiency)

Agency Training & Coordination about Refugees & Disability

19. Training for law enforcement and border patrol on refugees, disability, and crisis

77. Cultural competency in the provision of services

12. Knowledge of the variety of services available across the service providers

33. Disability awareness training for refugee serving organizations and their staff

49. Primary care provider education on how to speak about disabilities with refugees

73. To have health care professionals provide disability information and available resources
81. Interpretation available to request transportation
59. Primary care provider education on how to increase buy-in for disability support/services with refugees
Community Support, Representation & Mentorship
24. More funding for language access
10. Pipeline of caregivers and providers from refugee communities
78. Reduce burden on refugee families to prove need for services
56. Refugee resettlement employees/case managers being connected to the disability services system
22. Improved interconnection of service providers, so that if a person is accessing one service, the service provider knows about and can provide information regarding other services available
66. Provider agencies run by and for refugee communities
50. Higher pay for caregivers
Refugee Rights & Self-Advocacy Education
6. Peer mentorship from refugees who have successfully navigated disability systems
3. One-page fact sheets for refugee parents about how you can send your child to school with a disability
72. Parental group meetings to share information and build community with other refugee parents

18. Having refugees engaged in the advocacy efforts to influence policy

9. Refugee parents being educated to know parental rights under Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act

42. Leaders in refugee communities to turn to who speak the language, know the culture, and know the disability resources

68. Reducing stigma of disability through more visibility of successful refugees and others living with a disability.

Language & Resource Access

32. Having IEP assessments and services for refugee children or children of refugees in their language

36. Cultural training for refugees on disability in the U.S. to reduce stigma



In-Depth Interviews

The team conducted in-depth interviews (N=9) with dyads (person with a disability and supporter) and one triad (two family members and a person with a disability). Interviews centered on individual and family/supporter experiences within a social ecological model (Golden & Earp, 2012) which acknowledges the interactions of individuals and environments to produce health outcomes (Figure 4). Three interviewees with disabilities were over the age of 18 and no longer in school; one interviewee with a disability was under 18 and still in high school. The interviews were conducted in Kirundi (n=3), Somali (n=6) and English. Participants' length of time in the U.S. ranged from 8 to 19 years. Most interviews took place in Tucson (n=7) and one took place in Phoenix (n=2). The interviews were recorded with permission and transcribed for review by a team of three researchers (JA, JF, and DF) to identify common themes.

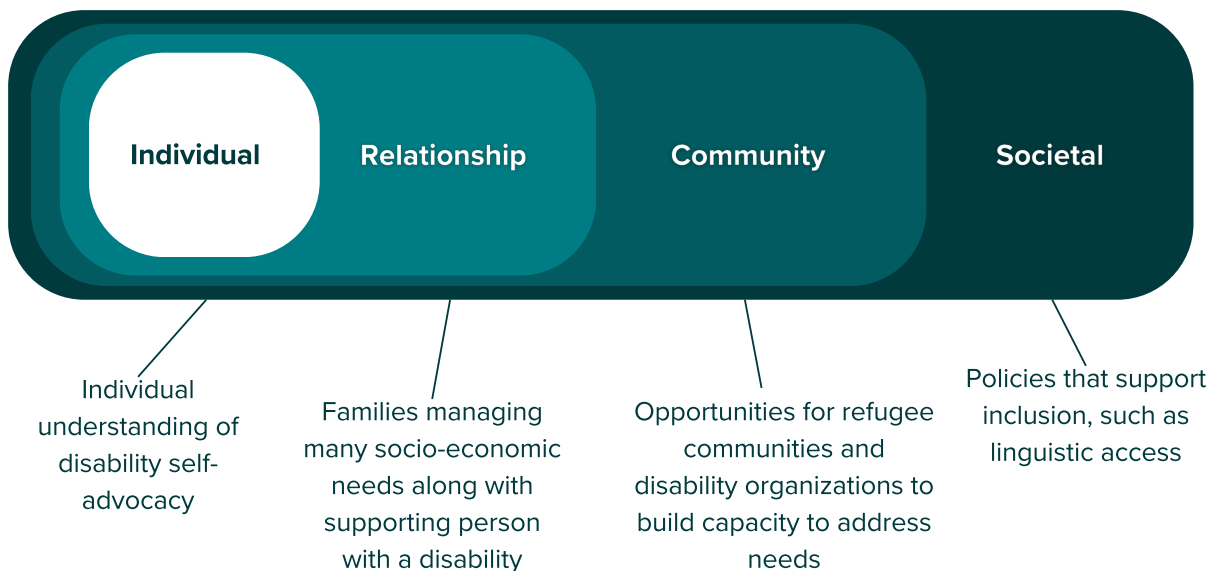


Figure 4: The social-ecological model with examples of characteristics that may be part of each level.

Major themes from these interviews highlighted the ways in which families become disengaged from the disability service systems. Themes included: Lack of knowledge about individual rights and opportunities for people with disabilities; lack of interpretation; family disengagement caused by service system issues; and the importance of the community/collective. Each of these broad themes will be addressed briefly below with case studies illustrating these points.

Lack of knowledge of individual rights/opportunities for people with disabilities

- Family members require information about individual rights and opportunities, e.g. students with disabilities may stay in school until age 22 with goals/units to complete.
- Participants described not being able to get the support needed to pursue education/employment.

Case Study #1: Support for Education & Employment

Thirty-one year old participant Astur* came to the U.S. when she was 21 from Somalia, via Pakistan. She uses a wheelchair and has limited mobility. She applied for the Arizona Long Term Care System (ALTCS) after she was referred to the program by social security. Her mother, with whom she lives, provides much of her support during the day and receives 4-hours of compensation a day for this support, but feels this is not enough, as caregiving is more than a full-time job. Astur also receives support from a personal care assistant funded by ALTCS, but neither woman feels it is enough support. Astur was told that if she wanted more support, she could move into a long-term care facility, but she prefers to stay with her mother.

Astur wants to complete a degree in computer science but has experienced barriers to her education. She completed high school in Pakistan. When she arrived in the U.S., she planned to take Community College courses in computer science, but was told that she needed to take additional high school units before registering for college. She completed these units but did not receive needed functional support to complete her college coursework.

In Astur's words (via interpreter): "Here, the problem is, after I finish the ESL [course] and I transferred to the college, I had difficulty [getting] somebody to assist me with the computer, handling books... My hands are not strong enough to do that. And that's the main reason that I don't go to school now, that I am at home, because I did not get the assistance that I need personally, for somebody who can help me with carrying books and the computer, laptop and all that stuff. And my hands are not as strong enough to do that."

* A pseudonym, as are all the names reported in the case studies. Some details were revised in these vignettes to preserve anonymity.

Lack of Interpretation

- Interpreters are not provided or they are provided in the incorrect language or dialect.
- Interpretation may not be made available to supporters of adults with disabilities.
- Without effective interpretation it is not possible for staff to meaningfully engage with the person with a disability and their supporters.

Case Study #2: Interpretation to Be Inclusive of Non-English Speaking Family/Other Supporters

Twenty-eight year old Jama* lives with mental health concerns. He describes experiencing a “mental breakdown” while at his job at a grocery store in 2016, shortly after he and his family arrived in the U.S. After his parents left Somalia due to conflict in the country, they became refugees in Kenya, where he was born. He completed high school in Egypt, where the family lived as refugees for 20 years. In 2016, he started taking coursework to complete his US high school diploma.

Jama became part of the behavioral health system in 2017 and receives treatment and job assistance there. He lives with his mother, Asha,* and younger brother. His mother expresses frustration, as his sole caregiver, because he has not been able to qualify for disability, despite three applications. Asha also feels that she is not able to advocate for him as she would like because she cannot speak English, although Jama does speak English. When asked if the behavioral health organization provides an interpreter when she joins their meetings, she notes (via an interpreter), “[No, there are] always excuses and runaround. And it's like for example, one of the many things they always tell [Jama's mom] is, 'he seems okay.' But... if you're not sitting down with the guardian and him together and you're not getting all the information, how are you assuming he's okay? So then a lot was undermined and then the crisis escalated.”

She would like to have support to take English classes so that she can help advocate for her son, as well as for other refugee families that need a bilingual advocate. Jama's mother acknowledges, “Many times it's hard to find an advocate, somebody who can understand [a refugee who does not speak English]. It's hard to find sufficient translation. And even after you go through all of that struggle [to find an interpreter], when you get to the site you are not seen as an equal. You don't get your rights.”

Family Disengagement Caused by Service System Issues

- Person with a disability is not included in the meeting.
- Family is presented with a list and told the goals for their child, although they do not feel they are realistic.
- Length of time to get services creates additional barriers.
 - One family took 10 years to get services, even with a support coordinator.
 - The process starts over with one mistake, e.g. the family or service system representative missing the meeting.

Case Study #3: Inability to Secure Services Despite Qualifying

Aaden* is 22 years old and lives with his mother and sister. During the interview, he was not present and his perspective was represented by his mother and sister—his primary caregivers—as he does not speak much and he does not have a working communication device. His sister also provides support to their mother who has had multiple brain surgeries after an illness during her adulthood. Aaden and his family arrived in the U.S. from Somalia in 2004 after a brief stay in a Tanzanian refugee camp. Aaden receives services from the Division of Developmental Disabilities, which deemed him eligible after 7 years of the family’s efforts to qualify him. They described needing to start over with the application when appointments were missed.

Aaden finished high school in the U.S., but his family notes he still has skills to learn and it is unclear to them what he learned in high school. When he was part of IEP meetings, he emphasized a desire to work. Once he qualified for DDD, the family received visits from staff to discuss services, but services were not approved until 2022, despite years of visits. The family notes that an in-person interpreter came for the visit only once, but that phone interpretation was used on occasion. They report that most visits did not involve a Somali interpreter. For this family, however, transportation has been a longstanding issue in enabling Aaden to meet his goals. After his mother’s surgeries, she was not able to drive him to work. Currently, he’s too discouraged to work due to unreliable transportation. His mother reported (via an interpreter), “Because the transportation would not show up [or the] guy would come late and [Aaden would] miss work. ... And [Aaden] is very anxious, he goes there way before they even come, waiting [for transportation]. And then sometimes he’ll get stuck at work ...because of transportation.”

Importance of the Community/Collective

- For children under 18, families reported a significant burden because they were told parents are unable to serve as caregivers for reimbursement under AHCCCS. It may be important to the family to provide care, instead of a Direct Support Professional, as the family knows the person best.
- Clients may prioritize the well being of their families and/or communities, rather than the individual.

Case Study #4: Respecting the Knowledge of Caregivers/Supporters

16-year-old Salomon's* father is originally from Burundi, but fled to a refugee camp in Kenya. Salomon and his sister were born in Kenyan camp and came to the US. in 2015.

Salomon's father described struggling to get his son disability services after arrival, due to limited English language skills and lack of knowledge about the disability systems. He describes the great luck of being connected to an advocate who could help him navigate these systems, which enabled him to enroll his son in services through the Division of Developmental Disabilities (DDD).

Salomon attends high school and goes to a day program after school, where he likes to build towers with legos. His sister serves as his support professional, after becoming certified while taking high school classes herself. His sister became certified because the family understood that Salomon's parent could not be his paid supporter, since he is a minor.

The family appreciates the services Salomon receives at school. They have regular IEP meetings with school staff, but do not feel that the planning reflects reality for Salomon nor the family's experiences. Salomon does not attend the IEP meetings, but would like to. His father describes being disengaged during these meetings, commenting, "So sometimes when I go to these meetings and I give them suggestions they already have a proposal and a plan and they tell me, these are the things he's going to do. Because he spends seven, eight hours with them every day. But I stay with him more than 10 hours every [day]....So compared to them, I'm the one that knows more about him--not the teachers. The average he spends with each teacher is like one hour, two hours. I am the one who knows his concerns and needs and struggles."

Recommendations

Recommendations arising from data collected in this project align with findings from U.S. and International research. This research emphasizes the need for resettlement services to adequately address the social determinants of health, provide linguistically accessible services, and foster collaboration among refugee resettlement, disability, and health programs to address the needs of the broad population of refugees (Dew et al., 2022). The recommendations outlined here, developed in consultation with the project's CAB, should be implemented with multisector collaboration and should maximize service availability, accessibility, acceptability, quality, and utilization to ensure equity (Goode, 2019).

All state agencies should conduct ongoing evaluation of programming to ensure cultural and linguistic responsiveness. For instance, Division of Developmental Disabilities (DDD) data may be assessed quarterly for consumers' length of time to service delivery, by refugee status or language use. Many disability service systems' quality improvement initiatives could currently provide an opportunity to assess interpreter access, length of time to eligibility, and service utilization for refugees with disabilities. We recommend the ADDPC serve as a hub for broad service system data collection related to refugees with disabilities, enabling the Council to work with agencies on improving particular aspects of their services for the population. Appendix F contains the Georgetown University National Center for Cultural Competence's Disparities Framework, which influenced our recommendations' focus on service availability, accessibility, acceptability, quality, and utilization.

Accountability Methods to Improve the Quality of Existing Policy and Practices

1. **Ensure language access**, which includes adequate funding and oversight to ensure adherence to language policies.
 - All agencies that administer disability services to refugees are responsible for ensuring language access, but the refugee resettlement programs (RRPs), Department of Economic Security (DES), and specifically, the Division of Developmental Disabilities (DDD) should provide oversight of contractors and implement accountability measures. DDD has a Language Access Plan that could provide guidance for data collection and oversight.
 - The state might consider innovative approaches to ensuring on-time, accurate language interpretation, such as a stand-alone language line that provides anytime interpretation that consumers can access themselves and is at no cost to them.

2. **Establish reliable transportation** that is timely, universally accessible, and linguistically responsive.
 - State agencies that provide transportation services should oversee their contractors to ensure consumers have access to reliable, linguistically responsive transportation to a job, health care, or other activities. DDD, Vocational Rehabilitation (VR), Arizona Long Term Care System (ALTCS), and Medicaid Managed Care Organizations (MMCOs) may periodically review data to ensure adherence.
3. Bolster primary and secondary educational institutions' ability to **engage with refugee families, address their basic needs and facilitate appropriate assessment and support** for learners (McNeely et al., 2020).
 - There is an opportunity for the Arizona Department of Education (ADE) and RRP to enhance partnerships to better support refugee families, including addressing the social determinants of health in local communities and ensuring families understand the U.S. public education system's support for students with disabilities.
 - The ADE must ensure that processes are available for schools to connect to professionals who can complete culturally and linguistically appropriate assessments.
4. Make available **timely and linguistically appropriate assessment and diagnosis** for refugees with disabilities.
 - While DDD and ADE should be resources to families seeking diagnostic and assessment services, the health care systems in Arizona, and particularly, Federally Qualified Healthcare Centers (FQHCs), may also serve an important role in addressing the need for timely and linguistically appropriate services.

Program Development to Increase Family/Consumer Involvement and Community Capacity

5. **Implement peer support programs** for refugees with disabilities and their families.
 - Self-advocate organizations may partner with RRP to establish opportunities for peer-support.
6. Train **disability-focused refugee case managers**, who have knowledge of the specialized disability systems, or consider **implementing a "DD Navigator"** to provide sustained advocacy (e.g., Stewart et al., 2023).
 - A navigator may be affiliated with RRP or with DDD. A successful model of this program in New York resulted from a partnership between the Developmental Disabilities Planning Council (DDPC) and the Office for New Americans (ONA). The New York DD Navigator increased outreach to "New American" communities, in addition to creating new resources and trainings for these groups (Stewart et al, 2023).

7. **Identify and educate “gatekeepers” for refugee communities** about disability services.

These gatekeepers might be language interpreters or primary care providers.

- Training about disability services might be conducted by DDD and VR for RRP, clinical interpreting companies (e.g. Cyacom), and health care/FQHC staff. Trainings should be inclusive of other institutions with which refugees may interact as well, such as law enforcement and border patrol.

8. Provide education to refugee families about the **expectations for self-advocacy in the U.S.**, including the focus on individual rights within the disability service systems.

- There is an opportunity for self-advocacy organizations to partner with RRP to develop and implement trainings focused on the culture of disability advocacy in the U.S., the supports available (e.g. communication tools/technology), and how to access the various disability service systems in the state. Refugees may have arrived from countries without formalized disability services and support, so they require knowledge about the systems, but also about the supports available (Armstrong, & Ager, 2005; Mirza & Heinemann, 2011).

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