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EVIDENCE SUMMARY
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What works to support newcomers with disabilities and chronic illnesses?

Strong but limited evidence indicates that cultural adaptations and connections can increase self-efficacy, health knowledge, and health care access for some newcomers with chronic illnesses.

- A systematic review of studies looking at community health navigators or cultural case workers revealed their impact on immigrants with medical conditions to be overwhelmingly positive. All of the studies found that health navigator interactions with chronically ill immigrants was associated with higher quality of life, fewer reported symptoms, and increased condition knowledge.
- A systematic review of interventions targeting chronic disease in Korean-Americans found that culturally adapted interventions, embracing elements of social inclusion, were highly successful.

There is little existing evidence on non-health-related interventions for newcomers with disabilities.

- The review found no relevant evidence on interventions related to accessing social services, housing, or employment.

Purpose of this summary

This document summarizes the state of available evidence regarding the impacts of interventions with newcomers with a disability or chronic illness.

What is meant by "disability"?

The Americans with Disabilities Act defines a person with a disability as "someone who 1) has a physical or mental impairment that substantially limits one or more major life activities, or 2) has a history or *record* of an impairment (such as cancer that is in remission), or 3) is *regarded* as having such an

impairment by others even if the individual does not actually have a disability (such as a person who has scars from a severe burn that does not limit any major life activity)."[1]

What is meant by "chronic health condition"?

Chronic health conditions are defined by the Centers for Disease Control and Prevention as "conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both." This encompasses conditions such as heart disease, cancer, and diabetes.[2] This summary includes chronic health conditions like diabetes and hypertension, while excluding mental health disabilities due to existing evidence summaries on related topics.

What does the evidence show?

Strong but limited evidence indicates that cultural adaptations and connections can increase self-efficacy, health knowledge, and health care access for some newcomers with chronic illnesses.

- Shommu et al. conducted a systematic scoping review of community health navigator programs targeting immigrant and minority populations in Canada and the U.S. They focused on outcomes related to chronic disease management and primary care access. The authors included 30 studies and identified several topics: health equity, diabetes management, cardiovascular disease management, metabolic syndrome management, asthma management, and cancer screening. Community navigators were selected based on personality traits, cultural competence, and interpersonal skills—medical professionals almost always trained them on topics related to the target condition. Their responsibilities consisted of "providing culturally tailored health education, lifestyle workshops, self-care training and guidance to overcome barriers to accessing the healthcare system" (p. 4). **All of the included studies found improvements in quality of life:** increases in self-efficacy, increased condition knowledge, reduction of ER visits, and improvements in health indicators (HbA1c, blood pressure, etc.).

- Heo and Braun conducted a systematic review of interventions targeting chronic disease in Korean-Americans (immigrant and non-immigrant), specifically evaluating their levels of cultural adaptation in relation to outcomes. The systematic review identified 21 articles describing 16 unique interventions. Target intervention conditions included hypertension, diabetes, chronic mental illness, and breast and cervical cancer screening. The intervention designs generally included group and/or individual education sessions and post-intervention follow-ups. Twelve of the interventions employed formative research as part of their design (focus groups, in-depth interviews, etc.), but only eight of these reported measurable levels of success, while three of the interventions that did not describe using formative research also found success. **All the included interventions tailored their materials to be more culturally relevant to their population, in both the *surface structure* and the *deep structure***. Surface structure refers to the components of the intervention, such as materials, communication, staff, and recruitment strategies. Deep structure reflects more on cultural practices and beliefs and how those impact behaviors. Five of the interventions did not address social support as part of their deep structure, and the same five interventions did not find meaningful differences related to their target behavioral changes. **The success rate of interventions that both adapted surface structure and incorporated cultural**

[1] *How is Disability Defined in the Americans with Disabilities Act? | ADA National Network*. (n.d.). Adata.org. https://adata.org/factsheet/ada-definitions

[2] Centers for Disease Control and Prevention. (2022, July 21). About chronic diseases. Centers for Disease Control and Prevention. https://www.cdc.gov/chronicdisease/about/index.htm

values into their deep structure ranged from 68% to 73%, but those that also integrated social support into their deep structure had a 91% success rate.

- Mortensen et al. evaluated the effectiveness of cultural case workers (CCW) in child development services for refugees resettled in New Zealand. Two CCW positions were established in the Waitemata district in 2009 with the goal of providing "child health and disability services that were accessible and culturally appropriate" for children from refugee families or otherwise culturally and linguistically diverse backgrounds. The researchers conducted interviews with families, health care workers, social service providers, and managers (at clinics as well as in government). The identified benefits for the families receiving the services included **improved access to health and other services, reduced isolation, increased knowledge, and improved living situations**. Service providers identified **improved cultural knowledge and understanding, improved relationships between health services and families, and procedural streamlining for families** as the main benefits of their work. This study did not report on any concerns either group had about the program or on any areas that still need focus.

There is little existing evidence on non-health-related interventions for newcomers with disabilities.

- The search yielded no evaluations that met our inclusion criteria for topics such as case management, accessing social services, housing, employment, or social security income approval. While literature on accessing special education and involving parents in the individualized education program development process does exist, there were no retrievable intervention evaluations.

- Conditions included within the retrievable health intervention evaluations were severely limited.

What are the implications for practice and research?

> "Community navigators were created to provide appropriate support to underserved populations who have the least ability to access healthcare."
>
> (Shommu et al., 2016)

Community Health Navigator programs are an effective tool for working with newcomers with chronic illnesses.

- Community Health Navigator programs have consistently been associated with improved quality of life factors in minority communities. Community health navigators can also make a positive impact on the relationship between health care providers and their patients. Selecting the right individuals to fill these roles is crucial in shaping positive outcomes, as is training those individuals properly.

- If creating a community health navigator program is not feasible, vetting educational materials and other resources for cultural relevance can also contribute to increased success. Opening channels for cultural connection beyond community health navigators may also enhance programming.

There is limited research relevant to newcomers on this topic.

- The available evidence identified in this review is limited to a small fraction of the broader disability experience. Even within that literature, the evidence specific to refugees and other newcomer populations is further limited. Shommu et al. were only able to find three articles for their systematic review that specifically studied immigrants.

- More evidence on best practices for serving newcomer clients with disabilities, in areas beyond health care specifically, would contribute to a more well-rounded evidence base. Partnerships between research institutions and organizations serving newcomers with disabilities could encourage more knowledge production and distribution.

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 2014. 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
EBSCOHost Google Scholar	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	disabilit* OR handicap* OR disabled OR "medical condition" OR “chronic disease” OR “chronic condition”

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 search 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 430 studies. After removing duplicates, 411 studies were then screened. Of these, 395 were determined to be irrelevant to this search. Sixteen full-text articles were assessed for eligibility. Thirteen 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. Three studies were eligible for inclusion. They are listed below, with hyperlinks to the abstracts or full text (when available).

Meta-Analyses and Systematic Reviews

Heo, H. & Braun, K. L. (2014). Culturally tailored interventions of chronic disease targeting Korean Americans: A systematic review. *Ethnicity & Health, 19*(1), 64–85. Abstract.

Shommu, N. S., Ahmed, S., Rumana, N., Barron, G. R. S., McBrien, K. A., Turin, T. C. (2016). What is the scope of improving immigrant and ethnic minority healthcare using community navigators: A systematic scoping review. *International Journal for Equity in Health, 15*(6), 1–12. Full Text.

Impact Evaluations

None.

Suggestive Studies

Mortensen, A., Latimer, S., & Yusuf, I. (2014). Cultural case workers in child disability services: An evidence-based model of cultural responsiveness for refugee families. *Kotuitui: New Zealand Journal of Social Sciences Online, 9*(2), 50–59. Full Text.

Supplemental Studies

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.

Adams, N. B. & Santos, R. (2022). A call for support for refugee families and their children with disabilities. *Exceptionality, 30*(5), 351–365. Abstract.

Alsharaydeh, E. A., Alqudah, M., Lee, R. L. T., & Chan, S. W. (2019). Challenges, coping, and resilience among immigrant parents caring for a child with a disability: An integrative review. *Journal of Nursing Scholarship, 51*(6), 670–679. Abstract.

Common health needs of refugees and migrants: literature review. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO. Full Text.

Kaur, M., Kamalyan, L., Abubaker, D., Alheresh, R., & Al-Rousan, T. (2023). Self-reported disability among recently resettled refugees in the United States: Results from the national annual survey of regugees. *Journal of Immigrant Minority Health.* Full Text.

Malloy, A., Rogers, C. M. Caine, V., & Clandinin, D. J. (2023). Experiences of refugee children living with disabilities: A systematic review. *International Journal of Migration, Health and Social Care, 19*(2), 108–121. Abstract.

Rfat, M., Zeng, Y., Yang, Y., Adhikari, K., & Zhu, Y. (2023). A scoping review of needs and barriers to achieving a livable life among refugees with disabilities: Implications for future research, practice, and policy. *Journal of Evidence-Based Social Work, 20*(3), 373–403. Abstract.

Rossetti, Z., Redash, A., Sauer, J. S., Bui, O., Wen, Y., & Regensburger, D. (2020). Access, accountability, and advocacy: Culturally and linguistically diverse families' participation in IEP meetings. *Exceptionality, 28*(4), 243–258. Abstract.

Ventevogel, P., Ryan, G. K., Kahi, V., & Kane, J. C. (2019). Capturing the essential: Revising the mental health categories in UNHCR's refugee health information system. *Intervention, 17*(1), 13–22. Full Text.

Xu, Y., Zeng, W., Wang, Y., & Magaña, S. (2022). Barriers to service access for immigrant families of children with developmental disabilities: A scoping review. *Intellectual and Developmental Disabilities, 60*(5), 382–404. Abstract.