BMC Public Health

RESEARCH Open Access

Feasibility of implementation of the zero suicide model in community-based organizations serving Afghan refugees resettled in Michigan

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Abstract

Background Pioneered at HFH Behavioral Health Services in 2001, the Zero Suicide (ZS) model is comprised of several evidence-based approaches including suicide screening and assessment, caring contacts, care coordination, and suicide specific psychotherapies. The ZS model has been successfully introduced in more than twenty countries; however, to date the model has been primarily introduced in higher income countries within large health systems. It is important to understand the feasibility of this approach in a range of other settings. In the current project, a feasibility study was conducted, and a pilot program is currently underway to adapt the model for use in Community-based Organizations (CBOs) serving refugee populations.

Methods This feasibility study focused on Afghan refugees arriving in Michigan as a part of the U.S. government "Operation Allies Welcome" program. The qualitative study included interviews with social, health, and behavioral health providers and staff at CBOs serving refugee and asylum-seeking populations in Michigan and behavioral health specialists at HFH and Wayne State University. A Stakeholders' Advisory Board was established including HFH and CBO partners.

Results Afghan refugees encountered challenges on arrival and during their settlement into life in Southeastern Michigan, including linguistic, social, economic, medical, and behavioral health barriers. The data include specific recommendations made by the respondents for adaptations to the Zero Suicide model.

Conclusion While the need for behavioral health services for refugee communities is recognized, challenges remain in the implementation of accessible, acceptable, and adaptable programs. Within Michigan, CBOs have developed strong relationships with refugees and asylum seekers resettled into the state. The current project was designed to build on these existing infrastructures within CBOs and determine the feasibility of integrating an evidence-based suicide prevention program. Through the feasibility study, it was evident that CBOs were interested in including the Zero Suicide model as a part of their health services. However, it was clear that adaptations were needed to support

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the introduction of the model and that those adaptations would have to account for diverse refugee communities and varied resources and structures within each CBO.

Keywords Zero suicide, Behavioral health, Refugee, Asylee, Community based organization, Afghan, Michigan

Background

As of 2024, 120 million persons were identified as displaced including over forty million refugees and asylum-seekers [1]. It is estimated that over five million Afghan are currently displaced from their homes, of which three million have moved within their own country and approximately two million to Pakistan and Iran [2]. During the turmoil of 2021, approximately 120,000 Afghan were airlifted from Kabul, and more than 60,000 fled to neighboring countries. According to the United Nations High Commissioner for Refugees (UNHCR), up to half a million additional Afghans could flee the country in the near future. People in Afghanistan have experienced high levels of stress and trauma associated with repeated periods of mass violence, conflict, and forced displacement over several decades that have led to disruption of family and community cohesion. A recent national level survey revealed that >60% of Afghans have personally experienced at least one traumatic event, predisposing individuals to mental health conditions such as depression and suicide, with women being at a higher risk for post-traumatic stress disorder (PTSD) and suicidal behaviors [3].

In general, PTSD, major depression, generalized anxiety, panic attacks, adjustment disorder, and somatization are among the more common mental health diagnoses associated with refugee populations [4–7]. Systematic reviews estimate that 20–80% of displaced persons experience these and other mental health conditions [8, 9]. Existing research suggests that intercultural communication challenges, inaccessible healthcare, extended stays in asylum centers, and unique health profiles exacerbate these mental health conditions. Furthermore, despite experiencing improved quality of life upon resettlement, research shows that mental health issues can persist for prolonged periods after resettlement [10]. Compared with general prevalence data, there is a higher prevalence of suicidal ideation among refugees with estimates ranging from 3.4 to 34% [11]. According to the World Health Organization (WHO), risk factors associated with suicide risk for refugee populations include barriers to health services, stigma associated with health-seeking behaviors, disasters, war and conflict, trauma, displacement and stresses of acculturation and discrimination, and a sense of isolation and lack of social support [10, 12, 13]. Refugees and asylum seekers experience these risk factors as both pre- and post-migration stressors, which can increase the likelihood of suicidal behaviors [14]. Stigma related to mental health has specifically been noted as a barrier to care among Afghans, and while some research points to Afghan refugees seeking mental health support, other data suggest the use of informal sources of support [15–19]. Over the past decade, Michigan has been the fourth highest refugee recipient state in the United States. Between September 2021 and February 2022, Michigan welcomed 1,734 Afghan refugees for resettlement who were a part of the U.S. State Department 'Operation Allies Welcome' program [20, 21]. After arriving in the United States, these refugees were first housed in camps and then relocated to hotels in Michigan. Hotel stays were prolonged as housing arrangements were organized.

Pioneered at Henry Ford Behavioral Health Services (BHS) in 2001, the premise of the Zero Suicide (ZS) model is that suicide is preventable. Comprised of several evidence-based approaches, the model includes suicide screening and assessment, caring contacts, care coordination, and suicide specific psychotherapy [22, 23]. Over the past 20 years, the ZS model has been successfully implemented in more than 20 countries [24]. The current project was funded by the Michigan State, Office of Global Michigan specifically for the 'Operation Welcome Allies' Afghan refugee population and to determine the feasibility of adapting the health facility-based ZS model within community-based organizations (CBOs).

The objectives of this paper are to present data from a qualitative feasibility study conducted in 2023 to identify the following: (1) challenges facing Afghan refugees resettled in Michigan during the 'Operation Allies Welcome' program; (2) availability and accessibility of behavioral health programs for Afghan and other refugee populations; and (3) potential barriers and facilitators to adaptation and pilot of the Zero Suicide model in CBOs serving refugees and means of addressing identified barriers. The paper expands on literature about barriers to both mental health services and suicide prevention programs with a focus on the Afghan refugees resettled in the United States. It provides the perspective and experiences of health and social service providers. In addition, these data are unique to understanding how challenges affecting Afghan and other refugee communities need to be identified and acknowledged throughout the transition of the Zero Suicide model from a health systems environment to community-based organizations.

Methods and materials

Stakeholder advisory board

A Stakeholders' Advisory Board (SAB) was established which included CBO representatives and project team

members from the HFH Global Health Initiative and Department of Behavioral Health. The SAB provided recommendations in terms of individuals and organizations to be included in the study and in a dissemination workshop conducted in September 2023. The workshop supported a review of the findings from the feasibility study and needs assessment and made recommendations for the adaptation and piloting of the ZS model, which is currently ongoing.

Research sites, population, and sampling strategy

The study included seven CBOs which provided services to the Afghan community as well as other refugee and asylum-seeking communities in Southeastern Michigan. A total of 28 individuals were interviewed. The 24 respondents from the CBOs included case workers, program managers and coordinators, healthcare providers including psychiatry, and therapists. These individuals represented staffing from refugee and immigrant behavioral health services and trauma services, family medicine, child and adolescent health, and refugee resettlement services including the Afghan Placement and Assistance program. In addition, two participants were from Henry Ford Health (HFH) Behavioral Health Services and two participants were from a university-based refugee arts-based mental health program. The HFH Behavioral Health Services participants are a part of the team that has developed and implemented the Zero Suicide model in health systems and clinics. Inclusion of a range of specialists provided a range of experiences working with the Afghan community and multiple perspectives regarding barriers and facilitators to mental health programs and adaptation of the Zero Suicide model.

Prior to the study, a sample size of 25 to 30 individuals was estimated to reach a breadth of participant experiences (e.g., type of organization, position within the organization). As is standard practice with qualitative research, a 'data saturation' approach was used to finalize the sample size. Data saturation refers to the point at which no new information or themes are observed in the data. This approach supports both variability in the data set and need for sufficient data to identify patterns. Sampling included reaching out to organizations which serve immigrants and refugees and identifying employees with experience working with the recently arrived Afghan community.

Data collection, management, and analysis

Qualitative interview guides were developed specifically for this project by the research team for CBO respondents and for behavioral health specialists (see Supplements). The CBO guide included items on: (1) services provided by the organizations for Afghan resettlement communities; (2) challenges faced by Afghan community members and how those challenges were addressed; (3) collaboration, coordination and referrals between CBOs working within the Afghan community; (4) perceived need for mental health services and specifically for suicide prevention and the ZS model; (5) how the ZS model could be adapted for CBOs providing services to Afghan and other refugee/asylum-seeking community members; and (6) potential barriers to implementing the ZS model within CBOs and sustainability for using the model. The guide for behavioral health specialists at HFH also included questions regarding their experiences with the ZS model and implementation within and outside of HFH.

The interviews were conducted virtually, and in-person based on logistics and preferences of the participants. There was no difference in terms of length of interviews or procedures followed during the interview between in-person and virtual. Interviews were conducted by the project principal investigator and the project manager both with experience in qualitative methodologies. All interviews were audio recorded and transcribed.

A coding dictionary was developed by the research team based on the research aims and emerging themes. Transcribed data were uploaded into a qualitative data management program (Dedoose) for coding and analysis. Coding was conducted by the principal investigator and an investigator on the project. The coded data were reviewed to identify cogent themes and patterns within the coded text. These themes were documented in a table format with illustrative texts from the transcripts. Summaries of the analyzed data were developed into a report distributed among participants and SAB members. These data are presented in this paper.

Ethics

The study was reviewed and approved by the HFH Institutional Review Board (Protocol# 16168, November 20, 2022). All participants provided written informed consent prior to data collection.

Results

Challenges during resettlement

Afghan refugees encountered challenges on arrival and during their settlement into life in Southeastern Michigan, including linguistic, social, economic, medical, and behavioral health barriers.

The primary languages spoken within these Afghan communities were Pashto and Dari. Although Southeastern Michigan has a large Middle Eastern population from a broad range of countries (Syria, Iraq, Iran, Saudi Arabia), there were few existing Afghan communities in the region and only a limited number of individuals who spoke Afghan languages. In terms of behavioral health services, communication in clients' first language can be essential to optimize therapy outcomes and ensure confidential conversations on sensitive issues.

So, we really had issues with translating. We didn't have people who can help us translate to…Pashto, Dari. We had one interpreter, and that one person would help all the people from different organizations. It was inconvenient, very inconvenient. We were like four case workers.

Interpretation is another significant challenge. If the interpreter doesn't have the right skillset and that human connection is not developed…or the time is short, it's very difficult for the Afghan client to open up and share more and be engaged in the program….

Some of these linguistic issues were addressed as Afghan community members were employed within the CBOs, which opened opportunities to provide needed behavioral and social services to the new arrivals.

A lot of the Afghan speak Pashto, Dari, Farsi…and with a phone translator it's hit or miss on what you get, the quality in general. But…[CBOs] ended up employing a lot of the arrivals…which is great, now, their employees speak Pashto and Dari. And so if we can link them with the proper services with someone who can understand, that's always our end goal….

The two staff that I actually hired came over as refugees themselves from Afghanistan… and I've hired them to be our interventionalists. And so, they will be working with at least 40 Afghan families in the southeast community…There's three main goals. One is to provide information and resources about any community resources, mainly health, but any community resources…Number two, we want to increase their parenting skills. And number three, we want to increase their stress management….

In addition to language barriers, the new arrivals had to adapt to a vastly different social context. While initially housed in hotels, families faced many challenges in terms of the opportunity to settle within their new environment and begin the processes of adapting to life in southeastern Michigan. In addition, many individuals arrived at the hotels with complex medical issues which were in some instances difficult to identify, monitor, and address. For some individuals, the stress and anxiety precipitated a desire to return to Afghanistan.

…the hotel life is tight. You cannot cook, you cannot do the things…that you can do it in your own house…. You don't have that freedom in the hotel. And they stayed there, all the refugees for more than two months.

[There were] very unmanaged conditions, very significant high blood pressure, significant high blood sugars. We had one patient who was actively having a miscarriage in the hotel. Oh, yes. It was tragic situations….

…they want to go back to…Afghanistan, or to meet with their family members. And it took me a lot of time just to tell them, look, if you now leave, you'll never be able to come back…".

On arrival to Michigan, many individuals were experiencing traumatic stressors, including experiences that occurred immediately prior to leaving Afghanistan and concerns about family left behind.

When he or she talks to clients, especially the Afghan, they…went through a lot of things. [During] the evacuation…there was suicide bomb attack in the gate of Kabul, and it left a lot of people injured and died. It's still in the minds of Afghans….

…some of the women…(had) a lot of fear because they fled. Fear that they could be found, some of them had death threats after them because they left abusive families and homes, and they were able to talk to the soldiers and sneak out to escape the life that they were living….

Just some of the kids are still back home. I think somebody had like eight (children) and two of them [are] still there [in Afghanistan)]… He still has some kids back home because they couldn't escape or something.

Families were split up, and then when they came here, they wanted really to support their family that was left…in Afghanistan or surrounding countries. So, it was difficult for them to understand that you need first to take care of yourself…you cannot just send every penny to Afghanistan….

After leaving the hotel, refugees were provided with housing with a one-year lease. The refugees were spread across the southeastern region which limited opportunities to connect with one another. Ongoing economic and social stressors meant that many individuals/families prioritized meeting their basic needs over addressing mental health issues. In most instances, men were the only wage earners, families often included many children, housing costs increased after the one-year lease, and children were adjusting to the local education system. Within some families, domestic abuse was an ongoing traumatic stressor.

When they first get here, they're so focused on surviving, getting a job, getting food, getting the kids in school. Their mental health is in the back of their concern, unless it's something extremely blatant where people aren't functioning properly, which we've had that before, but a lot of times the mental health needs aren't coming up until two or three years later.

I have a family (I work with), and the son is fifteen. He's failing algebra. He's stressed about it. People think that they're not going to be stressed by failing grades. They are. The parents are worried about it.
I have clients that their partners or perpetrators are not substance use users, but they have mental health issues. And they're not compliant with treatment, or they don't think that they need treatment. And that's where the abuse comes in the home… It goes hand in hand, unfortunately.

Medical and behavioral health services

Afghan refugees faced challenges navigating the US healthcare system, e.g., long wait times to see a provider, issues with insurance and difficulty maintaining health records. Additionally, some refugees had complications related to health program enrollment, as few refugees had come to the United States with any personal documentation.

They had no ID, no vaccination records, no medical history, nothing. And then, the issue came that, okay, the first thing we've got to do is get them on Medicaid. So, they need a name and birthday and an address…They don't know their birthday, right? And it's posed a lot of challenges when it came to navigating the healthcare system.

Many Afghan refugees faced mental health challenges including depression, anxiety, stress, and trauma. CBOs had teams of behavioral health specialists located at the hotels when refugees first arrived. However, there was a barrier in relation to stigma and mental health and the willingness of individuals/families to utilize services. The presentation of mental health conditions was often described as physical maladies, such as headaches or chest pain.

We know that Afghan refugees and any refugees have experienced a significant amount of trauma, and that we know with trauma comes a great need for mental health services….But, one of our largest barriers is just getting the refugees to acknowledge that this is an issue, and being able or willing to get treatment for it….

The CBOs either had in-house behavioral health services and/or referral mechanisms to ensure that those in need of programs could be assessed and treated. Multiple approaches were used to 'normalize' mental health services and to establish relationships of trust between the providers and their clients.

She's (Therapist) has been taking more of an approach of just saying…"I'm here to hopefully make you feel better. I'm here to support you and your stressors that you're having." So, making it very generic and immediate. " So, what are the immediate things in your life that are bothering you?" So not even bringing up mental health, not even bringing up depression, not even bringing up trauma, not even bringing up anxiety until later on in the process when they may understand her role as a therapist. So that's been kind of an interesting journey with her and how best for her to do her job and also connect and build a relationship with the clients.

Mental health services were also integrated into other programs, such as maternal and child health and education. In some instances, a case management approach was important in terms of integrating mental health services with services that meet other more basic needs of families and individuals. This approach was also one which helped to establish trust between the provider and client and to destigmatize behavioral health.

Now, if the client said they didn't want mental health therapy or psychiatry services, as a case manager, I would just keep them on for case management. And I would say the bulk of my clients were just case management, and they didn't want the mental health service part….

…just this past year [we] started an Afghan mothers' program, which is through our behavioral health

division…We just saw a really big need for young/ new mothers, and even just mothers in general, who are now mothers in a new country and it's just a whole different system… it's like a support group. They provide education, training in support services, referrals. They bring in WIC, infant mental health… support mothers and encourage a healthy start for them and their children.…

And then I think they started to slowly see me as a friend that they can trust and they can talk to and they can say anything to, and I'm not going to judge them…this is a safe space for you.….

Another approach to mental health services came out of the Wayne State University Stress, Trauma and Anxiety Research Clinic (STARC). Art and movement therapies were introduced to help address behavioral health issues for refugees. This approach provided a comfortable setting in which participants could discuss issues and problems but also have diverse ways to communicate.

…it's a big language component of being able to say, "We will do this art class." Or "We're going to do arts today." Instead of saying, "We're going to go to therapy." And that has been a really big component for some, we've been working most recently with some youth who are unaccompanied minors…(including) some boys from Afghanistan…and they had experienced forced therapy in that process. And so, this was something that they had reported that they were not okay with.… talk therapy that they had experienced in a forced environment…but that this [art therapy] was something that was okay for them and that was acceptable.

Community outreach was also described as a vital component in terms of providing information to Afghan and other refugee communities about CBO services. This included outreach through schools and faith-based organizations, and through fundraising events.

… we have health educators that go to all the schools in Dearborn, Melvindale, these areas where there's high refugee and immigrant populations, and they do presentations at PTA meetings or at pep rallies and they kind of talk about just different health influences, wellness, just everyday life for kids.…

We do a lot of community outreach. At different events, we'll have resource tables. We do trainings out in the community. We do a lot of prevention work in the schools, at the mosques, at the faith-based organizations.…

We also host a domestic violence fundraising event every year. And we've been around for almost 13 years now.… we book a banquet hall, and we do an event where we invite everybody from the community to attend this event…And we raise funds. We get sponsors, we raise funds, we have a nice dinner, we have survivor speeches and stories, and a keynote speaker.

The need for support, education, and training for staff working with refugee and asylum-seeking populations was also an important part of the work within CBOs. It was noted that these staff often have had similar experiences as refugees and immigrants to the United States. In addition, interactions with trainings inclusive of Afghan refugees provide two-way communication and learning experiences for both staff and participants.

….I'm learning even more and more about caring for our staff who many of them are refugees, so they have their own experiences of trauma and then they are re-exposed on a regular basis…I'm learning that part of my role is more about a workforce support management type of thing as much as it is clinical services for refugees… Because it's designed for them, for other people who work directly with refugees, but then also for clinicians who maybe don't work normally with refugees…two individuals within three days have gone to their supervisor with a concern about another member of their team and mental health. That was a real wake up call for me.

Obviously, we have Afghans who are on our team who will be translating, who will be helping with this, and we'll get their perspective, but I have a feeling that in that three hours I am going to be educated more about what the needs of that community are than those people who show up are going to be educated on mental health. I'll be able to learn through the translation process what fits, what doesn't fit.

Suicide prevention and the zero suicide model

While mental health services were available across the various CBOs serving refugees, there were limited programs to specifically address suicide prevention and intervention. As with general mental health services, suicide is highly stigmatized within many cultures and communities. This can be a major barrier to identifying individuals who may be at risk and in need of treatment. This stigma can also affect staff's level of comfort in identifying and assessing suicide risk among their clients.

Table 1 The characteristics of Clinical Practice Guidelines for functional constipation and/or constipation-predominant irritable bowel syndrome

Challenges for Afghan communities during resettlement	Language barriers and feelings of isolation from family and community
	Economic concerns included identifying housing, limited transportation options, low-wage job opportunities
	As children were enrolled in schools, both parents and children experienced new stressors
	On going concerns and anxiety about family left back in Afghanistan including children and spouses
	Need to learn about how to navigate and access medical care
Resources available for Afghan and other refugee communities through CBOs	Resources are available through CBOs for addressing social, economic, legal, health and behavioral health services.
	Referral mechanisms are in place in CBOs to help individuals/families obtain needed resources.
	CBOs employed members of the Afghan community to work with individuals/families seeking services
	Integration of mental health/suicide prevention services within other services or in non-clinical settings to increase awareness and participation
Recommendations for adaptation of the Zero Suicide Model	Materials and assessment tools must be pre-translated and reviewed to ensure accuracy prior to implementation
	For the screening process, we need to consider alternative ways besides the current tools (PHQ9/Columbia suicide assessment) for obtaining information on client's experiences of suicide ideation. Narrative approaches could be one way to obtain screening information.
	Due to limited number of behavioral health providers, specific trainings in screening and/or assessment for suicide risk need to be implemented for other staff
	Discussing mental health issues and suicide may trigger emotions and feelings of stress and anxiety in CBO staff members
	Due to past traumas, a larger percentage of individuals screened/assessed may be at elevated risk for suicide. Need to ensure sufficient resources are available for those individuals
	ZS screening and assessment training for CBO staff who have established trust with the Afghan community. Afghan refugees who are now working as staff must be an integral component of the ZS training, pilot, and implementation

...suicide is seen as what we call haram. It's a shame. The word haram can be used in so many situations, but it's looked down upon. Like in a Christian religion, it's the same. Suicide is looked at as something that you're not supposed to do. It's a shame-based culture so there is that part to it where it's unacceptable, but that doesn't mean it doesn't happen.

What I found too is that, once people adjust and start to get used to doing this, it's a lot less scary because...not everyone is suicidal, so there's a little bit of that reduced fear there....[but] the other side of it is that it's so much better knowing...there's a relief there....

Healthcare providers expressed concerns about the screening protocol within the ZS model which includes use of a suicide screening tool (e.g., Patient Health Question [PHQ]–9) at every client/patient visit. Respondents shared that the use of PHQ-9 or other suicide prevention tools may not be adequate in terms of obtaining needed information from Afghan and other refugee populations.

Yeah, I would say that question's (PHQ9) not a great question. I don't get a lot out of that question, meaning most clients say no, and they're shocked that I would ask them that, and maybe a little embarrassed...But I could say that the way I've maybe gotten to that information is more like, "Do you care about tomorrow?" Or one client, I'm thinking about him. He said, "God will do what he wants to do to me, or it's in God's [hands]..." I don't know. I know he brought God in. And then he also says, "I don't care about tomorrow pretty much. I don't care what happens to me." That's how he would say, "I don't care what happens to me.

A substantial percentage of the Afghan population might be at elevated risk due to experienced stress and trauma before, during, and after resettlement. Therefore, a triaging tool is crucial to serving these clients. Behavioral healthcare respondents at HFH noted the potential burnout faced by therapists due to working with clients that are experiencing severe mental health issues and are at a higher risk for suicide. The respondents also noted that training, support, and experience are essential to staff being comfortable and effective in suicide prevention screening.

I think, what about in the community? Someone calls our contact center, wouldn't be able to wait long enough until they get answered. Yet, someone who had a fight with their spouse last night, who was crying, will get in. I think that's what, at least for us, and we searched all over in terms of a triaging tool, and there's really not a good one. What we're trying to do is we are developing questions that can be used by nonclinical people, and use that, pilot that....

Discussion

The three core components of the HFH Zero Suicide (ZS) model includes: (1) support of regular suicide screening by all health providers at all patient touchpoints; (2) support for patients at risk for suicide with a safety crisis plan and follow-up; and (3) direct treatment of suicide in addition to treatment for underlying conditions (e.g., depression). The HFH ZS model has consistently been shown to be successful in decreasing suicides [23, 25]. However, the model has been used in health systems and clinics and requires adaptation to be effective in CBOs and to serve the needs of diverse refugee communities.

The overall purpose and goal of the study were to determine the perceived feasibility of introducing the ZS model within CBOs serving refugee communities and identification of adaptations to the model to maximize effectiveness within CBOs. Existing mental health programs and services at CBOs included screening and assessment, individual and group therapy, psychiatric care, and programs for survivors of torture, and integrated programs in maternal and child health. While participating CBOs had strong referral mechanisms and collaborative relationships with other organizations, there is a need for the development of mental health specific referral services to address suicide risks among Afghan and other refugee and asylum-seeking communities.

Similar to other social groups, suicide is considered a sin in Islamic culture. For some Afghan refugees, stigmatized mental health-related issues can result in refusal to disclose information and/or participate in treatment. The respondents discussed mental health needs in relation to depression, anxiety, stress, and trauma in the Afghan refugee community. Mental health assessments were provided at the hotels when the refugees arrived in Michigan. However, the purpose of these assessments was sometimes unclear to the respondents who had little or no experience with behavioral health programs. At temporary accommodations in hotels or housing, the primary concerns remained focused on basic needs such as food, transportation, job opportunities and access to education for children. Some Afghan refugees supported large families, often including those family members still in Afghanistan. Most often, men were the only wage earners in the household.

The respondents shared their experiences and associated trauma both before leaving Afghanistan and throughout the immigration process. Leaving family, community and in some cases children behind was an emotional toll. The uncertainty surrounding safety and well-being of loved ones, as new developments in Afghanistan unfolded, added stress and fear. Over time, mental health services were adapted and made more readily available to the Afghan community through CBOs and other organizations. These services included programs for specific needs, e.g., Survivors of Torture (SOT), Stress, Trauma, and Anxiety Research Clinic (STARC) at Wayne State University, and the integration of mental health services through other programs, e.g., maternal child health.

Identified challenges in providing mental health services to the Afghan community included lack of accessible translation services and insufficient education about mental health and available resources. CBOs have hired Afghan staff to facilitate service delivery and have provided education and training about mental health to community members. Referrals within and across CBOs are an important way of ensuring clients/patients receive needed health, social, economic, and legal services and fosters partnerships between organizations. Referral mechanisms are essential to providing the care pathways necessary to address the needs of individuals experiencing post-traumatic stress.

Overall, our data indicate that given the elevated levels of post-traumatic stressors, anxiety and depression within these populations, there is a need within CBOs for specialized suicide prevention, such as the ZS model. The data also indicates that integration of at least some components of the ZS model is feasible within CBO settings. However, prior to piloting and implementation, it is necessary to adapt components of the model for integration within CBOs to best serve the needs of Afghan and other refugee and asylum-seeking communities. From the data collected, recommendations were developed for adaptation of the model for integration within CBOs. CBOs outreach occurred to gather information about their current and planned programs targeting mental health in the Afghan and other refugee communities. Additional funding was obtained to pilot the ZS model in three CBOs serving both Afghan and Ukrainian communities. The Stakeholders' Advisory Board was expanded and was an integral part of the piloting phase. The pilot is underway and will include process evaluations to further knowledge about the need and feasibility of implementing the Zero Suicide model in CBOs.

Conclusion

At a global level, the numbers of displaced persons have increased 50% over the past five years [1]. While the need for behavioral health services for these communities is recognized, there remain challenges to the implementation of accessible, acceptable, and adaptable programs. Within Michigan, community-based organizations (CBOs) have developed strong relationships

with refugees and asylum seekers. The current project was designed to build on these existing infrastructures within CBOs and determine the feasibility of integrating an evidence-based suicide prevention program. Through the feasibility study, it was clear that adaptations were needed to support introduction of the ZS model in CBOs and that those adaptations would have to account for diverse refugee communities and varied resources and structures within each CBO.

Limitations

The study was qualitative and focused on interviews with CBO staff and behavioral health experts. The funding targeted Afghan refugees who arrived in the US in the past few years under the "Operation Allies Welcome" program. Therefore, the generalizability of these data about the experiences of refugees and perceptions of behavioral health services is limited. Current work on this project has expanded to include other socio-cultural groups and representatives of refugee communities.

Abbreviations

GHI	Global Health Initiative
HFH	Henry Ford Health
UNHCR	United Nations High Commissioner for Refugees
PTSD	post-traumatic stress disorder
WHO	World Health Organization
PHQ	Patient Health Questionnaire
ZS	Zero Suicide
CBOs	community-based organizations (CBOs)
SAB	Stakeholders' Advisory Board
STARC	Trauma and Anxiety Research Clinic
SOT	Survivors of Torture

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12889-025-23776-z.

Supplementary Material 1.

Acknowledgements

We would like to thank the State of Michigan, Office of Global Michigan, Department of Labor and Economic Opportunity (LEO) for funding this work, as well as their support throughout the past year. We would also like to thank our partners including ACCESS, Samaritas, Freedom House, Catholic Charities, US Committee for Refugees and Immigrants, Arab American and Chaldean Council, and the Islamic Center of America, as well as HFH Behavioral Health Services and Wayne State University, STARC program, for their time and for sharing their experiences and expertise.

Authors' contributions

L.K. and B.A. conceptualized the study. L.K., S.S. and E.W. collected the data. L.K. and S.S. analyzed the data. L.K., S.S. and M.R. wrote the first draft of the manuscript. All authors, including C.B. and J.K., contributed to writing and editing. E.W., Y.A., and S.R. coordinated the study.

Funding

The study was funded through the State of Michigan Department of Labor and Economic Opportunity, Office of Global Michigan.

Data availability

Data is provided within the manuscript or supplementary information files.

Declarations

Ethics approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki and approved by the Henry Ford Health Institutional Review Board (IRB # 16168). No identifiable information was collected on the data. All data was stored in a passcode protected file on HFH computers. All staff are CITI certified, and the PI (Linda Kaljee) will ensure that confidentiality is maintained to the highest standards.

All informed consent was obtained prior to data collection from the participant. The informed consent process was completed at the time of interview, either in a virtual (WebEx) or physical space (conference room at HFH or at one of our identified community-based organizations that serve this community). The consent form was provided to the participant, and time as given for the participant to read the document and ask questions. If willing to participate, the participant was asked to sign the document and once signed, they received a copy of the consent. If not willing to sign, the individual was not eligible to participate.

If the interview was virtual (WebEx), the consent document was made available through REDCap. A link was provided to the participant via email. Study staff ensured electronic consents were completed prior to conducting interviews. Contact information for the Study Coordinator(s) was provided to the potential participant if they had any questions regarding the consent or the study in general.

The PI (Linda Kaljee) ensured that all persons obtaining consent were trained and all persons completed the CITI ethical training course required by HFH.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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Received: 19 March 2025 / Accepted: 27 June 2025
Published online: 14 August 2025

Reference

1. Worldwide levels of forced displacement hit new high. UNHCR| UN News. news.un.org. 2024. Available from: https://news.un.org/en/story/2024/06/1150981
2. Rubin BR, Afghanistan. The forgotten crisis. Refugee Surv Q. 1996;15(2):1–35.
3. Kovess-Masfety V, Keyes K, Karam E, Sabawoon A, Sarwari BA. A national survey on depressive and anxiety disorders in Afghanistan: a highly traumatized population. BMC Psychiatry. 2021. https://doi.org/10.1186/s12888-021-03273-4.
4. Hollander AC, Bruce D, Burström B, Ekblad S. Gender-related mental health differences between refugees and non-refugee immigrants - a cross-sectional register-based study. BMC Public Health. 2011;11:180.
5. Husain F, Anderson M, Lopes Cardozo B, et al. Prevalence of war-related mental health conditions and association with displacement status in postwar Jaffna district, Sri Lanka. JAMA. 2011;306(05):522–31.
6. Bentley JA, Thoburn JW, Stewart DG, Boynton LD. The indirect effect of somatic complaints on report of posttraumatic psychological symptomatology among Somali refugees. J Trauma Stress. 2011;24(4):479–82.
7. Arsenijević J, Schillberg E, Ponthieu A, Malvisi L, Ahmed WAE, Argenziano S, et al. A crisis of protection and safe passage: violence experienced by migrants/refugees travelling along the Western Balkan corridor to Northern Europe. Confl Health. 2017;11:6.

8. Song S, Teichholtz S. Mental Health Facts on Refugees, Asylum-seekers, & Survivors of Forced Displacement. 2019 [cited 2024 Dec 18]. Available from: https://www.psychiatry.org/getmedia/9d2de01e-babc-4e04-8f01-16f3f75ff1cd/Mental-Health-Facts-for-Refugees.pdf
9. Vijayakumar L, John S, Jotheeswaran Abhugra D, Ayonrinde O, Tolentino E, Valsraj K, Ventriglio A. Suicide among refugees: the silent story. In: Bhugra D, editor. Oxford textbook of migrant psychiatry. Oxford University Press; 2021. pp. 543–52.
10. Sulaiman-Hill CMR, Thompson SC. Afghan and Kurdish refugees, 8–20 years after resettlement, still experience psychological distress and challenges to wellbeing. Aust N Z J Public Health. 2011;36(2):126–34.
11. Vijayakumar L. Suicide among refugees– a mockery of humanity. Crisis. 2016;37(1):1–4.
12. World Health Organization. Stigma– a major barrier to suicide prevention in Afghanistan. WHO-Regional Office for the Eastern Mediterranean. 2023 [cited 2024 Dec 18]. Available from: https://www.emro.who.int/afg/afghanistan-news/stigma-a-major-barrier-to-suicide-prevention.html
13. World Health Organization. Suicide. World Health Organization. World Health Organization; 20 [cited 2024 Dec 18]. Available from: https://www.who.int/news-room/fact-sheets/detail/suicide
14. Ingabire CM, Richters A. Suicidal ideation and behavior among Congolese refugees in Rwanda: contributing factors, consequences, and support mechanisms in the context of culture. Front Psychiatry. 2020. https://doi.org/10.3389/fpsyt.2020.00299.
15. Nine SB, Najm AF, Allan EB, Gronholm PC. Mental health stigma among community members in Afghanistan: a cross-sectional survey. Int J Soc Psychiatry. 2021;68(7): 002076402110361.
16. Oriya S, Alekozai T. The impact of persons with mental health problems on family members and their coping strategies in Afghanistan. Intervention. 2022;20(1):28–35.
17. Slewa-Younan S, Yaser A, Guajardo MGU, Mannan H, Smith CA, Mond JM. The mental health and help-seeking behaviour of resettled Afghan refugees in Australia. Int J Mental Health Syst. 2017;11:49.
18. Copolov C, Knowles A. Everything was stuck in my inside and i just wanted to get it out: psychological distress, coping, and help-seeking for young adult Australian Hazaras from refugee backgrounds. Transcult Psychiatry. 2021;60(1): 136346152110596.
19. Alemi Q, James S, Cruz R, Zepeda V, Racadio M. Psychological Distress in Afghan Refugees: A Mixed-Method Systematic Review. Journal of Immigrant and Minority Health. 2013 Jun 20 [cited 2024 Dec 18];16(6):1247–61. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3912229/
20. Barrett M. Michigan among top 5 states for most refugees in the last decade. mlive. 2021 [cited 2024 Dec 18]. Available from: https://www.mlive.com/public-interest/2021/09/michigan-among-top-5-states-for-most-refugees-in-the-last-decade.html
21. Statewide Update Afghan Placement Assistance. Office of Global Michigan. 2022 Mar [cited 2024 Dec 18]. Available from: https://www.michigan.gov/ogm/-/media/Project/Websites/ogm/OGM-Afghan-Arrivals.pdf
22. Stapelberg NJC, Sveticic J, Hughes I, Almeida-Crasto A, Gaee-Atefi T, Gill N, et al. Efficacy of the zero suicide framework in reducing recurrent suicide attempts: cross-sectional and time-to-recurrent-event analyses. Br J Psychiatry. 2021;219(2):427–36.
23. Richards JE, Simon GE, Boggs JM, Beidas R, Yarborough BJH, Coleman KJ, et al. An implementation evaluation of zero suicide using normalization process theory to support high-quality care for patients at risk of suicide. Implement Res Pract. 2021;2:1–14.
24. Zero, Suicide. www.henryford.com. Henry Ford Health System; 2018. Available from: https://www.henryford.com/services/behavioral-health/zero-suicide
25. Turner K, Sveticic J, Almeida-Crasto A, Gaee-Atefi T, Green V, Grice D, et al. Implementing a systems approach to suicide prevention in a mental health service using the zero suicide framework. Australian New Z J Psychiatry. 2020;55(3):241–53.

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