

Suicidality Among Refugees

Overview of InfoGuide

Suicidality, including suicidal ideation, attempt, and completion, impacts individuals (clients, staff, providers), families, communities, organizations, and the larger resettlement society. By raising awareness, providing education, and enacting prevention programs, the resettlement community can more effectively address suicide among refugees resettling in the U.S. Furthermore, through consistent, continuous conversations with staff and clients, providers can reduce the stigma around suicidality and accessing services to address it.

This guide will introduce various components that affect refugees' risk for self-harm. While some refugee populations are more at risk than others, **this guide will navigate through the individual, family, community, and programmatic aspects and influences as they pertain to risk of suicide.** Because refugees do not resettle in a vacuum and are affected by all aspects of their past and present, it is important to consider all of these systems. Taking all identities into account will help clarify some of the struggles and provide a deeper understanding of your refugee client or patient.

Preview of Part I: “Suicide Precaution: What Can I Do?”

NPCT's previous Information Guide “Suicide Precaution: What Can I Do?” provides detailed suggestions for resettlement workers when working with a client who exhibits suicidal ideation. The guide includes risk factors, warning signs, do's and don'ts in crisis situations, and a suicide protocol example for high, moderate, and low risk clients. For information about interacting with a client, please see the InfoGuide [here](#).



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This information guide was created June 2016 as a supplementary tool to an NPCT webinar on this topic presented by Sharmila Shetty with the Centers for Disease Control and Prevention; Chhabilal Sharma, a psychiatrist who has worked with many refugee patients; and Henny Ohr with the Ethnic Minorities of Burma Advocacy and Resource Center. The webinar is archived on our website, www.gcjfcc.org/refugee under [Webinars](#). For more details about **how to respond to a client exhibiting suicidal ideation** please see our information guide “Suicide Precaution: What Can I Do?” on our website under [Information Guides](#). The [National Partnership for Community Training](#) is a program of Gulf Coast Jewish Family & Community Services. NPCT is a training and technical assistance program which supports refugee resettlement workers and service providers through national capacity building and collaborative efforts. This publication was funded by the Office of Refugee Resettlement. For more information on this document and for research purposes, please contact partnership@gcjfcc.org or (305) 275-1930.



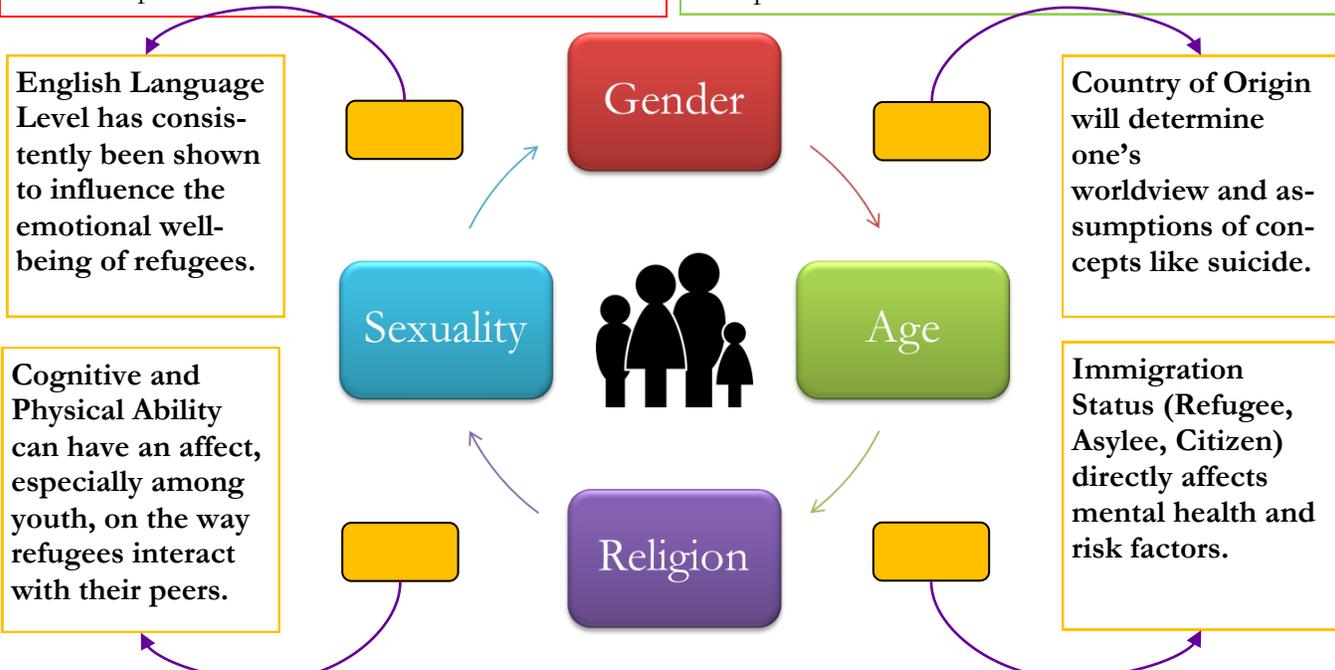
How Identities Can Affect Suicidality

Gender

Two incomes are often required to meet financial expectations post-resettlement, and both men and women within the same family regularly need to find employment outside of the home. However, Bhutanese refugees tend to assume and expect the male head of household to provide the majority of income for the family. The gender role shift (for example, when wives interact with men outside of the family at their place of work) can cause conflict within the home of resettled refugees. In some communities, such as the Iraqi and Somali refugee communities, women tend to be more isolated than men. Social isolation can often lead to sadness and/or depression. It is good practice to resettle communities close to one another to help avoid complete isolation.

Age

Refugee youth have multiple stressors before, during, and after the resettlement process in the U.S., including migration stress, acculturation stress, and traumatic stress. These components make refugee youth at high risk for developing further mental health concerns. There have been more documented completed suicides among adult refugees than among refugee youth. Some of the risk factors shown for those who complete suicide include not being able to provide financially for the family, language barrier, and family or close friends who have attempted or completed suicide. It is important to understand the role changes and implications for so many youth who learn the culture and language more quickly than their parents.



English Language Level has consistently been shown to influence the emotional well-being of refugees.

Cognitive and Physical Ability can have an affect, especially among youth, on the way refugees interact with their peers.

Sexuality

Gender

Age

Religion

Country of Origin will determine one's worldview and assumptions of concepts like suicide.

Immigration Status (Refugee, Asylee, Citizen) directly affects mental health and risk factors.

Sexuality

One study found LGBTQI refugees and asylees often have experienced significant verbal and physical abuse during childhood. Since many refugees come from countries that uphold laws criminalizing minority sexual orientations or gender expressions, finding supportive spaces is difficult. LGBTQI refugees who have experienced such abuse are at a higher risk for developing complex trauma and other mental health concerns. A report by the Amsterdam Law Forum revealed that LGBTQI refugees exhibit signs of suicidal thoughts and isolation, with few health care providers in their home or host countries to discuss their concerns. This group is also at a higher risk for experiencing violence and poor health care access.

Religion

Different religious teachings hold varying views on suicide. In general, the Islam and Christian faiths have a fairly strict perspective on suicide, notably condemning the act. Among Somali Muslims, suicide is considered an act against god, which can ultimately act as a protective factor for Muslim refugees who may be considering suicide. However, Iraqi Muslims resettled in the Seattle area discussed in a focus group that they would be more open to a physician asking about suicidal thoughts in the U.S., because the culture is seen as different and the physician's questions may be accepted (Regester, et al. 2011). While Hinduism does not condone suicide (Karmic theory suggests great difficulties in future lives would be a consequence), the act itself is not perceived as harshly as other religions.

Family and Community Dynamics

Many refugees are part of communal cultures that value close family connections. Refugees may experience negative mental health symptoms when those family connections have been broken or damaged, due to war, death, and/or internal conflict. In fact, conflict within a family unit or drastic changes of traditional familial roles has been shown to have negative mental health effects among some refugee populations (Shinina, et al. 2011; Beauvais, et al 2005; and, Schuchman & McDonald 2004). The family unit is a core unit of strength for many resettling refugees, which means it has potential for great support and great harm. Being aware of the protective and risk factors can help families, communities, and providers implement preventative strategies and act quickly to provide support for those clients most at risk.

Family/Community Protective Factors:

An established community can provide a great deal of support for newly arriving refugees.

- One report showed 26% of Bhutanese refugees would speak with a friend or relative if they were experiencing suicidal ideation
- Twenty-one percent of Bhutanese refugees would discuss with a doctor if they had thoughts of suicide
- A strongly-held ethnic identity acts as a protective factor for refugees
- Religious or spiritual values provide stability and social opportunities that have positive mental health effects
- Refugee youth benefit from quality school involvement and connections to pro-social organizations

Family/Community Risk Factors:

- A CDC report revealed 50% of Bhutanese refugees who completed suicide had a friend or family member who had previously attempted suicide
- Social isolation can cause depressive symptoms and increase existing negative mental health symptoms among Somali refugees
- Social role upheaval is a risk factor for Burmese refugees
- Refugees from Iraq with immediate family members remaining in Iraq have been shown to have higher levels of symptoms of PTSD and depression
- “Copy cat effect” may take place among those populations familiar with various methods or who have close connections with someone who has attempted or completed suicide

Stigma

Stigma around mental health and suicidality is a substantial barrier for many refugees struggling with suicidal ideation. **It is important to remain aware of the negative connotations that suicide carries when working with refugee clients.** Some view suicidal ideation as a sin against God or proof of insanity, which can discourage those struggling with ideation to voice concerns or access care. When working with refugee clients, infusing language that normalizes mental health, including feelings of hopelessness and sadness, may help de-stigmatize symptoms and accessing services.

A few examples of normalizing comments:

- *“Many refugees coming to the U.S. have symptoms similar to what you have just described.”*
- *“Sometimes Americans share their experiences of depression and suicidality with a mental health provider to help allay their distress.”*
- *“Sharing your struggles with someone you trust, like a friend, family member, or doctor can improve your health.”*

In addition to normalizing the struggles refugees are experiencing, it is imperative to provide culturally appropriate resources when applicable. Know what resources are available in your community. Depending on your locale, those may include a multi-lingual hotline, mutual assistance program, resettlement agency, mental health provider, community leader/liason trained in suicide prevention, etc. If your client has knowledge of resources, understands the role of each resource, and can access that resource on their own or with the help of a community member, they will have healthy alternatives when experiencing with suicidal ideation.

Prevention becomes key in this area, as many refugee communities do not talk about suicidal ideation prior to the occurrence of a completed suicide. Considering the heavy stigma of initiating these discussions, culturally appropriate and sensitive approaches to a suicide prevention initiative are paramount. Examples listed on the following page should be incorporated as components of a larger suicide prevention policy, addressing multiple levels of prevention (the individual, community leaders as trainers, staff, and mainstream providers). Take your own community into context and individualize the approach to your clientele’s specific needs and culture(s).

Prevention Program Planning Checklist

Review the following suggestions recommended for all sites and check the boxes of those specific options and questions you will include in the creating and implementation of your agency's prevention plan.

Trauma-Informed Practices

Prior to and/or concurrently with implementing a prevention program, ensure that your current agency and staff maintain a trauma-informed approach. Refugees are at a high risk of being re-traumatized, but resettlement workers can help avoid further trauma by taking calculated, intentional steps within their daily practices. The following are a few examples:

- If your office has a main lobby or entryway, consider having refreshments and children's activities
- When discussing difficult or controversial topics with your clients, be aware of the inherent power differential and shape the conversation so your clients can voice their opinion
- Because many clients wait for long periods of time to speak with a provider or case worker, it is helpful to inform clients of the approximate wait time, the reason for the wait, and if it's better to come back another time or speak with another provider

Policy/Protocol

It is imperative to have a protocol in place for suicide prevention and intervention to prepare staff members for unexpected circumstances and to provide clients with an outline of what would happen in the event of suicidal ideation, attempt, and/or completion.

- Discuss the following questions with staff and stakeholders when outlining policies
 - When is it ok to break confidentiality, specifically if someone is threatening to harm themselves?
 - What role does each staff member play in the event of suicidal ideation or completion?
 - Is everyone a mandated reporter?
 - Do supervisors need to be consulted first?
 - What number(s) do staff need in a crisis situation?
 - Who coordinates safe spaces for sharing and grieving in the event of a completion?
 - What resources are available to those struggling with thoughts of hurting themselves, symptoms of depression, and/or an attempt or completed suicide by a friend or family member?

Screening

Standardized screening procedures can help de-stigmatize the often-difficult questions surrounding suicidality and normalize the concept of asking for help when needed.

- Include question(s) at initial agency or site intake
- Begin the discussion at the health screening with a physician
- Have an ongoing conversation, asking pointed questions at intervals (home visits, therapy sessions, doctor's appointments, etc.)

Community Involvement

In order for an initiative to be an effective mode of preventing suicide, the community will need to be consulted and act as an integral component in educating the broader population. A community-led model is helpful with many refugee populations if it includes training a few community members who then educate the larger population. Two examples of trainings provided to refugee community leaders are:

- Mental Health First Aid Training (MHFA)
- Question, Persuade, Refer (QPR)

Provider Network

Build and/or increase your network of mental health providers. Working in the field of resettlement requires help from as many providers and partners as possible.

- When building a prevention program, reach out to your mainstream providers for their input
- Discuss referral processes, crisis protocols, and staff training opportunities
- Engage with the mental health professionals within your community to leverage their knowledge and expertise



Resources

[Mental Health First Aid Training](#) is a suicide prevention course that incorporates a basic level of instruction about mental health disorders, common symptoms, and appropriate responses. This training has been utilized among various refugee community members and resettlement workers.

[Question, Persuade, Refer Training](#) is a suicide prevention course, including specific examples of how to intervene in a crisis situation. The Refugee Health Technical Assistance Center created a [toolkit for QPR trainers](#) who are providing the training to refugee community leaders. The toolkit includes an orientation to the refugee populations, materials for the training, and handouts to be used in-class.

[Resource List](#): The Substance Abuse and Mental Health Services Administration (SAMHSA) developed a general resource list including screening tools and trainings.

[SAMHSA's National Suicide Prevention Lifeline](#)
1-800-273-TALK (8255)

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