The CENTER for VICTIMS of TORTURE

Restoring the Dignity of the Human Spirit

Trauma-Informed Programs for Afghan Communities in Minnesota and Georgia: **A Program Evaluation**

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Table of Contents

ANNEX

1. *Raahat Evidence Brief*
2. *Arman Evidence Brief*

Measures

3. *SOT-PWI-S*
4. *SCFI*
5. *Adapted PDS-V*
6. *Adapted HCSL-25*
7. *Somatic Symptom Scale*
8. *Client Focus Group Questions*
9. *Client Satisfaction Interview Questions*
10. *Staff Survey*
11. *Community Engagement Interview Questions*

EXECUTIVE SUMMARY

Background

For over four decades, Afghanistan has experienced interstate and intrastate conflict, extreme drought, and chronic poverty resulting in the displacement of millions, with approximately 10.9 million people currently still displaced. Most remain within Afghanistan and neighboring countries, although a smaller number have resettled elsewhere, such as the U.S.

In August 2021, the United States military withdrew from Afghanistan and the Taliban retook control, leading to many individuals and families fleeing the country. Through the Operation Allies Welcome program, the U.S. accepted more than 88,500 Afghan parolees between August 2021 and September 2022 (U.S. Department of Homeland Security, 2024). Parole status only grants temporary permission to remain in the U.S., without a direct pathway to a green card. As part of this process, the state of Georgia received more than 1,500 Afghan parolees by October 2022 and Minnesota received more than 1,300 Afghan parolees by September 2022 (Qureshi, 2022; Minnesota Department of Human Services, 2024).

Four decades of conflict, political instability, and forced displacement have negatively impacted many Afghan's mental health, both for those in-country and those displaced (Schwartz et al,. 2023). Additionally, some research indicates that rates of intimate partner abuse are higher among Afghan communities experiencing forced migration and resettlement compared to more stable communities (Wachter et al., 2025). Many Afghans have no pre-existing ties to the United States, and face multiple barriers to self-sufficiency, including challenges in navigating mental health and other healthcare needs (Reihani et al., 2021).

Recently many Afghan refugees in the U.S. face termination of Temporary Protected Status (TPS), creating insecurity and raising potential concerns over deportations and legal challenges. While some Afghans have been granted Special Immigrant Visas (SIVs) or other forms of humanitarian parole, others face uncertainty as their TPS protections expire (U.S. Citizenship and Immigration Services, 2025). Related incendiary anti-immigrant rhetoric has also resulted in a climate of escalating xenophobia and fear, impacting the already fragile mental health of many Afghan community members in the U.S. and beyond.

Services

To meet the associated needs, the Center for Victims of Torture's (CVT) started the Arman and Raahat programs in Georgia and Minnesota, respectively. Programs began in February 2023 following grants received from the Office of Refugee Resettlement (ORR). Activities in both locations aimed to support the overall emotional, social, and physical well-being of Afghan arrivals, including adapting to a new country. The programs provide integrated, strengths-

based, trauma-informed services, including psychoeducation groups, individual and group psychotherapy, and case management services (including healthcare navigation provided by a partner organization). Programs also offered training for providers on trauma-informed and culturally-appropriate care. Additionally, the Arman program provided family therapy services and retained a part-time physician on staff. This programming is coming to a close in late 2024 and early 2025. Although the Raahat and Arman programs share similar goals and cultural groups, they function in two very different state contexts and have unique programmatic features. The purpose of this evaluation is not to compare programs, but to learn from each: examining what strategies were most effective in serving Afghan communities. This program evaluation is being conducted to reflect on services and to advise others in supporting Afghan newcomers to the U.S. moving forward.

Objectives and Methods

Specifically, this mixed-methods program evaluation sought to address four central objectives: (1) understanding patterns of client engagement with CVT services, (2) assessing impact of CVT services on well-being, (3) identifying barriers and facilitators to participation in CVT services, and (4) gathering community-informed recommendations to inform future programming. Data sources included *service utilization data, clinical assessments at intake and follow-up, surveys with staff, client satisfaction interviews, client focus groups and community engagement interviews*. **Data from a total of 360 *unique individuals* (172 Raahat clients and community members; 179 Arman clients, and 9 staff across programs) was utilized for this evaluation.**

Results

Service utilization and engagement. Arman clients received a median number of 9 services, which includes intake and follow-up assessments at each time point as well as the services themselves (e.g., individual psychotherapy sessions, psychotherapy groups). Men received slightly more services than women (median of 13 for men vs. 9 for women). At Raahat, clients received a median number of 7 services with no differences by gender (median of 8 for women vs. 6 for men). For both programs, group therapy had the highest level of engagement, with 96.6% missing fewer than 10% of sessions for Raahat and 63.6% of clients missing fewer than 10% of sessions for Arman.

Mental health. Despite a difference in baseline mental health status between the two programs (62% of Arman clients categorized as experiencing “high” or “moderate distress” at baseline vs. just 5% of those engaging with Raahat), the evaluation shows that 89% (Arman) to 100% (Raahat) of clients reporting “high” or “moderate distress” reported improvement from baseline to follow-up. For Arman, among the clients who were initially “low” or “no distress,” 31% reported improved mental health at follow up; 38% maintained the same status; and 31%

regressed (reported worse mental health). For Raahat, clients who were initially "low distress" or "none" at baseline, 26% reported improved mental health, 61% remained stable (in the "low" or "no distress" categories), and 13% regressed, shifting from "low" or "no distress" to a higher distress category. It is noteworthy that many CVT clients experience ongoing and new stressors during the period they are accessing services. Without a baseline comparison group, it is difficult to determine if even those clients 'regressing' may have still fared better with CVT services than without in the face of new stressors encountered. Overall, results suggest that CVT services likely made positive contributions to mental health, especially for those with higher symptoms at baseline (89-100% improvement), and for those reporting low rates of distress at intake (26-32% improvement, 38-61% stable/no change). Qualitative data from satisfaction interviews and focus groups further suggested improvements in mental health and increased knowledge about emotional regulation techniques and coping skills. Many clients reported feeling better able to manage stress, regulate emotions and gain insight into their emotional experiences as a result of engaging with CVT services. Staff also observed notable mental health and social wellbeing improvements in clients. Participants from both programs also emphasized how socializing with others plays a key role in mental health, especially in addressing feelings of loneliness and isolation.

Social well-being is defined as building and maintaining healthy relationships and having meaningful, authentic interactions with others. Social well-being emerged as a key area of improvement for clients in both programs. Those utilizing services described CVT as a supportive space where they built connections, noted as especially valuable for those living in areas with few other Afghans. Aligned with client feedback, both Arman and Raahat staff perceived substantial changes to clients' social well-being, attributing changes to group services that emphasized community connection and practical support.

Case Management to increase access to basic needs. Many community members approached CVT in need of critical resources such as food and housing. In Arman, where a majority of clients had such needs at baseline, 81% reported a positive change at follow up. This was similar for Raahat, where 85% of those who approach CVT in need of critical resources reported improvements in access to resources over time. This suggests that Arman's social services helped improve clients' capacity to meet their own needs and that the Raahat program was effective in supporting clients in the greatest need of accessing resources.

Physical well-being. Clients emphasized improvements in physical well-being over the course of engagement with CVT services. At Arman, access to an in-house physician likely supported improvements in physical health. For example, in a standardized assessment, 88% of Arman clients reporting "high" or "moderate distress" at baseline reported improved physical well-

being after receiving services. Physical improvements include reductions in pain, headaches, and improved sleep quality, among other areas. At Raahat, both clients and staff described improvements in fatigue and headaches (potentially stress-related symptoms), attributing these improvements to the enhanced coping strategies acquired through CVT services.

Appreciation and desire for more skill-building opportunities for adjusting to life in the U.S. Clients expressed appreciation for and interest in services that facilitate cultural adjustments, provide practical skill training, and address other barriers to services. Both Arman and Raahat clients emphasized in interviews and focus groups the importance of English language classes. Raahat clients further suggested additions to meet the needs of children; specific community-based activities; and education to encourage adaptation to living in the U.S. such as driving and building a credit score. Raahat staff provided programmatic recommendations such as a larger portion of the budget allocated towards direct program activities, providing in-home services, and hiring a long-term Pashto interpreter.

Barriers and facilitators to accessing services. The same barriers to participation were experienced in both Arman and Raahat and were identified in interviews and focus groups with clients. Transportation emerged as a common challenge, with clients facing logistical issues or discomfort with unfamiliar systems. Childcare responsibilities and lack of available childcare support at programs limited attendance for families. Staff also described barriers affecting client participation in CVT programming, such as insufficient Pashto-speaking staff, challenges aligning service hours with clients' work schedules, and clients' lack of familiarity with psychotherapy, highlighting the importance of additional outreach and education. Despite challenges, there were several components that facilitated Arman and Raahat client engagement. Transportation assistance, referrals from trusted individuals, and the in-person format helped build strong relationships and foster continued involvement.

Conclusion

Evaluation limitations and strengths. This evaluation utilized a mixed-methods approach to gather diverse perspectives from a variety of stakeholders including those receiving services, those not receiving services, and staff. While the evaluation has limitations, such as a lack of a control comparison, the findings offer insight into the lived experiences, evolving needs, and expressed priorities of Afghan clients and community members. The evaluation underscores the importance of community-centered, culturally responsive, accessible, and holistic programming to promote long-term well-being and successful integration for recent newcomers to the U.S.

Recommendations. The final section of the evaluation provides a summary of recommendations derived from feedback across a variety of stakeholders focused on mechanisms for aligning programming with community needs.

Utilization of findings. The findings from this Program Evaluation can be used to inform key stakeholders such as CVT staff, funders, and partner organizations about needs, preferences and what works for mental health program design to address the needs of recently arrived Afghan communities across the United States.

BACKGROUND

Socio-political context

For over four decades, Afghanistan has experienced interstate and intrastate conflict, extreme drought, and chronic poverty resulting in the displacement of approximately 10.9 million people (UNHCR, 2024). Most recently, in August 2021, the United States military withdrew from Afghanistan and the Taliban retook control, leading to many individuals and families fleeing the country. Through the Operation Allies Welcome program, the U.S. accepted more than 88,500 Afghan parolees between August 2021 and September 2022 (U.S. Department of Homeland Security, 2024). Parole status only grants temporary permission to remain in the U.S., without a direct pathway to a green card (Batalova & Montalvo, 2024). As part of this process, the state of Georgia received more than 1,500 Afghan parolees by October 2022 and Minnesota received more than 1,300 Afghan parolees by September 2022 (Qureshi, 2022; Minnesota Department of Human Services, 2024). Of these evacuees, half reported a medical concern and almost a quarter of participants indicated having a mental health concern (Frumholtz et al., 2024). Additionally, many other Afghans have arrived in the U.S. since 2021 and before that time, including those arriving as refugees and Special Immigrant Visas (SIV) holders.

Mental health concerns

Four decades of conflict, political instability, and forced displacement have negatively impacted many Afghan's mental health, both for those who fled and stayed in the country (Schwartz et al., 2023). A 2021 household survey conducted across Afghanistan found a high prevalence of depression and anxiety symptoms among the general population. Nearly half of participants (47%) reported high levels of psychological distress in the past month and 39% reported substantial impairment due to mental health (Kovess-Masfety et al., 2021). In the same study, women in Afghanistan reported higher levels of psychological distress, functional impairment, and suicidal ideation than men (Kovess-Masfety et al., 2021). Additionally, some research indicates that rates of intimate partner violence (IPV) are higher among Afghan groups experiencing forced migration and resettlement compared to more stable communities (e.g., 56% compared to 80% physical IPV prevalence in the past year) (Wachter et al., 2025).

Barriers to mental health service engagement

Many Afghans have no pre-existing ties to the United States, and face multiple barriers to self-sufficiency, including challenges in navigating mental health and other healthcare needs. Specific barriers identified in the literature include stigma, limited trust, communication challenges, and healthcare navigation, among others.

Stigma

Mental health stigma refers to the negative attitudes, beliefs, and discriminatory behaviors directed towards individuals struggling with mental health challenges. Research has shown that stigma can negatively influence decision making around mental health service seeking and utilization (Nine et al., 2022; Reihani et al., 2021). Though there have been mental health care initiatives previously implemented in Afghanistan, these have been insufficient relative to the need and have not typically addressed stigma (Alemi et al., 2023).

Trust

A recent qualitative study identified limited trust as a barrier for Afghan refugees and Special Immigrant Visa (SIV) holders to seek health services or to share mental health concerns with providers (Reihani et al., 2021).

Communication

An additional challenge for resettled Afghans seeking health services generally is communication. Rarely are trained medical interpreters skilled in Dari and Pashto available (Reihani et al., 2021). This is especially challenging in a mental health care setting where cross-cultural variations in terminology around trauma exposure and symptoms may make it difficult for providers to fully understand and address client needs.

Healthcare Navigation

Navigating complex medical systems, insurance, and transportation serve as additional barriers for Afghans seeking health services (Reihani et al., 2021). Such challenges are often exacerbated by insufficient infrastructure and funding to support multi-sectoral needs typically required for successful refugee resettlement (Frumholtz et al., 2024).

Recent Events (January - June 2025) | Recently many Afghan refugees in the U.S. face termination of Temporary Protected Status (TPS), creating insecurity and raising potential concerns over deportations and legal challenges. While some Afghans have been granted Special Immigrant Visas (SIVs) or other forms of humanitarian parole, others face uncertainty as their TPS protections expire. Related incendiary anti-immigrant rhetoric has also resulted in a climate of escalating xenophobia and fear, impacting the already fragile mental health of many Afghan community members in the U.S. and beyond.

CVT services addressing needs | To meet the associated needs detailed in this background section, the Center for Victims of Torture's (CVT) Arman and Raahat programs were created in February 2023 following a grant received from the Office of Refugee Resettlement (ORR). The programs are named after feelings and emotions that staff aimed to impart on clients. In Farsi/Dari and Pashto, Arman means "hope" and Raahat means "tranquility, comfort, and ease."

CVT hired culturally aware and linguistically aligned team members and trained them in trauma-informed care. Raahat collaborates with its subgrantee partner, Afghan Cultural Society (ACS), while Arman partners with the International Rescue Committee (IRC) to deliver services, and refer eligible and interested clients to CVT services. Clients also learn about programming through program outreach efforts including face-to-face conversations with community members, distribution of flyers in areas where Afghans mostly visit like international or Afghan markets, word-of-mouth, program community events, and through partner organizations. Informal community events are intended to provide a space for members to meet and gather, while also learning about available services and resources in these programs.

The programs aim to support the overall emotional, social, and physical well-being of Afghan arrivals, including the integration into a new country. Individual and group psychotherapy serve as direct interventions to alleviate trauma symptoms. The Arman program provides an additional family therapy service and has a part-time physician on staff. Family therapy was initially included as a core service for Raahat as well, but there were no interested families. At Raahat, clients may choose to access one or more core services before or after attending a psychoeducation group: individual psychotherapy, group therapy, case management, and healthcare navigation.

In addition to psychotherapeutic interventions, both programs offer psychoeducation groups, community-building events, outreach efforts, and provider training that contribute indirectly to mental health improvement by raising awareness, enhancing education, reducing stigma, and fostering engagement in mental health services. By training service providers, the program seeks to enhance their capacity to deliver trauma-informed care. Improved access to care is expected to enhance both physical and emotional well-being. The programs' focus is to improve mental health both directly—by providing psychotherapy—and indirectly—by encouraging engagement in mental health services, strengthening social support networks, and expanding access to trauma-informed care. By enhancing physical and mental health outcomes, the program aims to contribute to the stability and resilience of the Afghan community.

METHODS

Objectives

A mixed-methods evaluation was designed to address four primary objectives related to the Arman and Raahat program: (1) understanding patterns of client engagement with CVT services, (2) assessing impact of CVT services on well-being, (3) identifying barriers and facilitators to participation in CVT services, and (4) gathering community-informed recommendations to inform future programming. This evaluation utilized a robust mixed-

methods approach to gather diverse perspectives for a variety of stakeholders including those receiving services, those not receiving services, and staff.

Data Sources

Data from a total of 360 *unique individuals* (172 Raahat clients and community members; 179 Arman clients, and 9 total staff) was utilized for this evaluation. This included:

Table 1. Number of Participants by Method

	Arman	Raahat
Service utilization data	n=179	n=168
SOT-PWI-S	n=42	n=40
Mental Health and Social Functioning	n=14	–
Client focus group	n=10	n=7
Client Satisfaction interviews	–	n=27
Staff survey	n=4	n=5
Community engagement interviews	–	n=4

We employed a combination of quantitative and qualitative data collection strategies from varying groups of stakeholders. Quantitative data sources included service utilization records, standardized clinical assessments, and surveys with clients and staff. Qualitative data were gathered through focus groups and community engagement interviews to explore participant experiences, contextualize survey findings, and surface nuanced insights into program effectiveness and relevance.

Community engagement was conducted 1-on-1 through interviews allowing community members to share their personal thoughts without being influenced by other people. Client perspectives were gathered and triangulated from two methods: satisfaction interviews and the focus group. This qualitative data provided further context to the service utilization and SOT-PWI-S data on service use and outcomes of the larger client population. This multi-pronged approach allows for a comprehensive evaluation of both the measurable outcomes and lived experiences associated with Arman and Raahat programming.

Procedures

The Raahat client focus group discussion was conducted in English with real-time interpretation provided by a bilingual interpreter fluent in both English and Dari. The session was recorded and transcribed in English. The Arman client focus group was conducted entirely in Dari, then audio-recorded, transcribed, and translated into English for analysis. Similarly, community engagement interviews were conducted in Dari, audio-recorded, and subsequently transcribed and translated into English to support qualitative analysis. The client satisfaction interviews were administered in Dari through on-the-spot oral translation of the English questionnaire by a bilingual facilitator proficient in both languages.

Service Utilization Data

Descriptive quantitative analysis was conducted to summarize service utilization from the start of the program in 2023 until June 2025 by key demographic characteristics of individuals screened and enrolled in services. Demographic and service data are routinely captured by staff in CVT's electronic health record system, Credible. Data on the following variables were collected from Credible: 1) number of individuals screened, 2) number of individuals enrolled, 3) number and type of services accessed, 4) intake and closure dates, 5) number and reason for no-shows, 6) age, and 7) sex.

Engagement categories were developed based on preliminary data distributions to clients not attending appointments (referred to as "no-shows"), defined as follows: highly engaged: 10% or fewer no-shows, moderately engaged: 11-25% no-shows, and minimally engaged: 26% or greater no-shows. Descriptive statistics were calculated using SPSS version 30.

Survivor of Torture Psychosocial Well-Being Index - Short version (SOT-PWI-S)

The Survivor of Torture Psychosocial Well-being Index (SOT-PWI) is an assessment framework for measuring wellbeing (crisis state to stability continuum) across multiple domains. An associated brief measure was developed by the authors and ORR for grantee reporting. Baseline and follow-up data were collected on four domains: *physical health, mental health, access to resources, and housing conditions*. Although follow-up data was limited, the available findings provide preliminary insights into initial client presentations and observed changes over time. The assessment measure utilizes a four-point scale for the access to resources and housing conditions domains, where 1 equals 'in crisis' or most vulnerable, and 4 equals 'safe' or most secure. For physical and mental health domains, 1 equals 'high distress' or greatest symptomology, and 4 equals 'no distress' or no symptomology. For example for mental health status, 1 indicates that a client has an untreated mental health condition that interferes with their daily life and/or their ability to care for themselves or their family, while 4 demonstrates that the client does not report any mental health concerns and/or are able to cope with life

stresses and accomplish personal goals. These metrics are assessed at intake and at the end of services. See Annex for SOT-PWI-S matrix.

Mental Health and Social Functioning Measures

Mental Health and Social Functioning Indicators were collected in a different manner for **individual psychotherapy clients** and only are reported on for Arman. Raahat is in process for finalizing collection of follow-up data, which will not be presented in this report but will be included in future reports. The outcomes for individual psychotherapy clients were derived from four assessments: Social Circumstances and Functioning Inventory (SCFI), Hopkins Symptom Checklist (HSCL-25), Posttraumatic Diagnostic Scale (PDS-V), and CVT's Somatic Symptom Scale. Social functioning (including domains such as basic needs, stabilization, employment, social support, adjustment, and community engagement) was assessed with a 34-item standardized instrument rated on a 7-point Likert scale. Symptoms of Major Depressive Disorder and Generalized Anxiety were assessed with the Hopkins Symptom Checklist-25 (HSCL-25), using an adapted 4-point Likert scale to capture both presence and severity. Posttraumatic stress symptoms were measured with Part 3 of the Posttraumatic Diagnostic Scale (PDS), which includes 17 PTSD items adapted to align with DSM-V diagnostic criteria. Somatic Symptoms were evaluated using a 5-item internally developed scale. All measures were administered by a trained assessor. Together, these tools offer a comprehensive view of client needs and progress, and enable a deeper understanding of individual improvement and adaptation throughout the course of care. See Annex 4 to 7 for HSCL-25, PDS-V, Somatic Symptom and SCFI measures.

Client Focus Group

Qualitative data was collected through an in-person focus group session with current clients. For Raahat, the focus group was conducted with seven clients following a psychotherapy group session. For Arman, the focus group included 10 female participants who had completed a six-week psychoeducation group, held once per week. Discussion topics included access to the program, participant satisfaction, perceived changes in emotional well-being and social life, program relevance, preferred format (online or in-person), and suggestions for improvement. Participant quotes were used to assess client experiences, evaluate program effectiveness, and guide future programming. See Annex 8 for client focus group questions.

Client Satisfaction Interviews

In only the Raahat program, client satisfaction interviews were administered verbally via telephone to 27 participants to assess their perceptions of how the program had impacted their overall well-being. Participants were asked a series of closed-ended questions regarding observed changes in their mental health, emotional well-being, and physical health. Responses

were rated using a 5-point Likert scale ranging from 1 ("large negative change") to 5 ("large positive change"). Following each closed-ended item, clients were invited to elaborate on their experiences through open-ended, narrative responses. In addition to assessing perceived changes in well-being, the survey included questions about the cultural relevance of the program and solicited recommendations for future services. This mixed-format approach allowed for both quantifiable measures of satisfaction and qualitative insights into client experiences and priorities. See Annex 9 for client satisfaction interview questions.

Satisfaction interviews were conducted alongside ongoing client satisfaction surveys, which function as a validation check on the provision of culturally responsive, trauma-informed services. These surveys consistently yield highly positive feedback. We therefore use them primarily to identify exceptions to this trend and to address any concerns that emerge. As expected, variation across survey responses was minimal, and for this reason the survey data are not included in the results presented here.

Staff Survey

An online survey, incorporating both closed- and open-ended items, was administered to staff in the Arman (N=4) and Raahat (N = 5) programs. The survey aimed to gather staff perspectives on the acceptability and appropriateness of program services, the extent to which services align with client presentations and evolving needs, recommendations for programmatic improvements, and areas of unmet need within the client population.

Staff assessments of client improvements in health and well-being were captured using a 5-point Likert scale ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). Respondents rated statements such as, *“The services offered by this project effectively address mental health concerns,”* across three domains: mental health, social well-being, and physical well-being. To assess the perceived effectiveness of specific service components, staff rated their agreement with statements such as, *“I have seen the benefit of individual psychotherapy for the clients we serve,”* across four service areas: individual psychotherapy, case management, psychoeducation groups, and healthcare navigation.

Staff were also asked to rate their agreement with statements about cultural relevance and service priorities, including, *“The program services are culturally relevant to the Afghan community members we serve,”* and “*Family and domestic violence are concerns that should be addressed by this program.”* See Annex 10 for staff survey questions.

In advance of the present evaluation, the evaluation team conducted a focus group with program staff. The focus group resulted in entirely overlapping content with the staff survey.

For that reason, the report does not include the focus group data, but it does, however, benefit from that triangulation between data collection types and slightly differing staff representation.

Community Engagement Interviews

In only the Raahat program, further qualitative data was collected through individual interviews with four community members who had not previously participated in the program. One individual was recruited through an invitation shared in an Afghan community WhatsApp group, while the other three were invited individually by a Raahat staff member to participate in the study.

The interviews explored community members' awareness of the program, their initial impressions after being introduced to it, and whether they believed such services are needed in the community. Additional topics included mental health needs, stigma around mental health, barriers to participation, cultural and linguistic relevance, and anticipated future needs. Quotes from the interviews were used to triangulate other evaluation methods and understand how the program can reach and meet the needs of the larger Afghan community. See Annex 11 for community engagement interview questions.

RESULTS

Service Utilization

In this section, we explore client utilization of Arman and Raahat services using data from CVT's electronic health record system. Due to limitations in the data, this analysis focuses on utilization by adult clients only. It is beyond the scope of this evaluation, but it is recommended that those providing services to Afghan communities in the future reflect on how those utilizing services may differ from those eligible for services and the broader population in the surrounding areas.

Arman Service Utilization

First, we will explore the service utilization data from the Arman program. Of the 179 individuals referred and screened for the program, 115 (64.2%) individuals subsequently enrolled in services (see Table 2). Screened individuals may not have enrolled for reasons such as not being eligible for services, or no longer being interested in services. Screenings were completed by significantly more women (77.7%) than men (22.3%). There were no notable differences in enrollment rate by gender (64.0% for women vs. 65.0% for men).

Table 2. Arman Screenings and Enrollment by Gender

	# Screened	# Enrolled	% Enrolled
Women	139	89	64.0%
Men	40	26	65.0%
Total	**179**	**115**	**64.2%**

The majority of clients (83.5%) were between 18 and 44 years of age followed by 45 to 64 years (15.7%) (see Table 3). Only one client (0.9%) was aged 65 or older. The mean and median ages of participants were slightly above 35 years old. There were no significant age differences observed between those screened and those enrolled in the program.

Table 3. Arman Client Age

Age Category	%
18-44 years	83.5% (n=96)
45-64 years	15.7% (n=18)
65 years and older	0.9% (n=1)
Total	100.0% (n=115)

Median values are reported on the total number of services provided because there was an outlier who had 51 services that skewed the mean value. The total number of services includes intake and follow-up assessments as well as the services themselves (e.g., individual psychotherapy sessions, psychotherapy groups). The median number of services received was 9 (see Table 4). Men (13 services) received slightly more services than women (9 services).

Table 4. Arman Average Number of Services

Arman (n=115)	
Median (Range)	9.0 (2, 51)
Mean (SD)	13.7 (11.1)
Gender	
Women (n=89)	
Median (Range)	9.0 (3, 49)
Mean (SD)	13.0 (10.2)
Men (n=26)	
Median (Range)	13.0 (2, 51)
Mean (SD)	16.3 (13.5)

Most clients engaged with Arman for multiple sessions. When reviewing the type of services accessed: mental health (i.e., therapy or groups) or social work services (i.e., case

management), the median number of clients receiving mental health services (6 services) was higher than social work services (2 services) (see Table 5). Both women and men engaged in a similar amount of mental health services (6 services). For social work services, men (5 services) had higher engagement than women (2 services), which contributed to the higher number of services accessed by men overall compared to women as seen in Table 4.

Table 5. Arman Average Number of Services by Type

(n=115)	Mental Health	Social work
Median (Range)	6.0 (1, 26)	2.0 (0, 26)
Mean (SD)	7.7 (5.0)	4.9 (6.0)
Gender		
Women (n=89)		
Median (Range)	6.0 (2, 25)	2 (0, 26)
Mean (SD)	7.9 (4.6)	4.2 (5.8)
Men (n=26)		
Median (Range)	6.0 (1, 26)	5.0 (1, 24)
Mean (SD)	7.2 (6.1)	7.1 (6.4)

Clients were highly (60.0%) or moderately (33.9%) engaged, missing fewer than 25% of their appointments (see Table 6). Only 6.1% of clients were minimally engaged, missing 26% or more of their scheduled appointments. Women had a slightly higher rate of minimal engagement (6.7%) compared to men (3.8%).

Table 6. Arman Engagement by Gender

	Engagement Categories, n(%)		
(n=115)	**Minimally engaged**	**Moderately engaged**	**Highly engaged**
Women	6.7% (n=6)	36.0% (n=32)	57.3% (n=51)
Men	3.8% (n=1)	26.9% (n=7)	69.2% (n=18)
Total	6.1% (n=7)	33.9% (n=39)	60.0% (n=69)

Overall, the majority of clients in age groups 18-44 and 45-64 were moderately and highly engaged. In comparison to younger participants (18-44 years), older clients (45-64 years) were more highly engaged (77.8% for age 45-64 vs. 57.3% for age 18-44) (see Table 7).

Table 7. Arman Engagement by Age

	Engagement Categories, n(%)		
(n=115)	**Minimally engaged**	**Moderately engaged**	**Highly engaged**
18-44 years	6.3% (n=6)	36.5% (n=35)	57.3% (n=55)
45-64 years	5.6% (n=1)	16.7% (n=3)	77.8% (n=14)
65+ years	0.0% (n=0)	100.0% (n=1)	0.0% (n=0)
Total	6.1% (n=7)	33.9% (n=39)	60.0% (n=69)

Within each service type, at least half of clients were highly engaged – missing fewer than 10% of sessions – with group therapy having the highest level of engagement at 63.6% (see Table 8). The high engagement in group therapy aligns with focus group data that identified the social wellness benefits of group services. All services except for medical had 6-7% of clients with minimal engagement. Medical services had 0% minimally engaged, suggesting that those who seek medical services highly prioritized their physical health needs.

Table 8. Arman Engagement by Service

	Engagement Categories, n(%)		
(n=115)	**Minimally engaged**	**Moderately engaged**	**Highly engaged**
Individual psychotherapy	7.2% (n=6)	38.6% (n=32)	54.2% (n=45)
Family therapy	7.7% (n=2)	42.3% (n=11)	50.0% (n=13)
Group therapy	6.8% (n=3)	29.5% (n=13)	63.6% (n=28)
Medical services	0.0% (n=0)	42.9% (n=9)	57.1% (n=12)
Social services	7.2% (n=6)	38.6% (n=32)	54.2% (n=45)

Raahat Service Utilization

Next, we will examine the service utilization data from the Raahat program. Of the 168 individuals screened for the program, 120 (71.4%) individuals subsequently enrolled in services. Screenings were completed by substantially more women (68.5%) than men (31.5%), though women were slightly less likely to enroll after screening (63.5% vs. 88.7% for men) (see Table 9).

Table 9. Raahat Screenings and Enrollment by Gender

	# Screened	# Enrolled	% Enrolled
Women	115	73	63.5%
Men	53	47	88.7%
Total	**168**	**120**	**71.4%**

The majority of clients (85.8%) were between 18 and 44 years of age, with 14.2% being 45-64 years old (see Table 10). No clients aged 65 or older participated in the program. The mean and median ages of participants were just over 30 years old, with no significant age differences observed between those screened and those enrolled in the program. The underrepresentation of older adults likely reflects the broader Afghan community in Minnesota as the median age of Afghans arriving between October 2021 and February 2022 was 18 years with a range of 17 days to 73 years (Frumholtz et al., 2024).

Table 10. Raahat Client Age

Age Category	%
18-44 years	85.8% (n=103)
45-64 years	14.2% (n=17)
65 years and older	0.0% (n=0)
Total	100% (n=120)

Due to an outlier who received 45 services, we rely on median values to report the number of services provided. This count includes intake and follow-up assessments as well as the services themselves (e.g., individual psychotherapy, psychoeducation group). The median number of services received was 7. There were minimal differences in number of services by gender (median of 8 for women vs. 6 for men, see Table 11).

Table 11. Raahat Average Number of Services

Raahat (n=120)	
Median (Range)	7 (2, 45)
Mean (SD)	9.5 (8.2)
Gender	
Women (n=73)	
Median (Range)	8 (2, 45)
Mean (SD)	11.2 (9.0)
Men (n=47)	
Median (Range)	6 (2, 36)
Mean (SD)	6.9 (5.9)

In contrast, an observed difference in the median number of services exists between mental health (3 services) and social work (1 service) (see Table 12). Further analysis indicates that this difference is driven by women's higher engagement in mental health services, where they participated in a median of five sessions, compared to men’s median of one. For social work services, both genders showed a median participation of one service.

Table 12. Raahat Average Number of Services by Type

(n=120)	Mental Health	Social work
Median (Range)	3 (0, 40)	1 (0, 25)
Mean (SD)	5.3 (6.7)	2.5 (3.8)
Gender		
Women (n=73)		
Median (Range)	5 (0, 40)	1 (0, 16)
Mean (SD)	7.4 (7.5)	2.1 (3.2)
Men (n=47)		
Median (Range)	1 (0, 16)	1 (0, 25)
Mean (SD)	2.1 (3.2)	3.1 (4.7)

Overall, the majority of clients (73.3%) were highly engaged, missing fewer than 10% of their appointments (see Table 13). Only 10.8% of clients were minimally engaged, missing 26% or more of their scheduled appointments. There were minimal gender differences in engagement, with men showing a slightly higher rate of minimal engagement (14.9%) compared to women (8.2%).

Table 13. Raahat Engagement by Gender

	Engagement Categories		
(n=120)	**Minimally engaged**	**Moderately engaged**	**Highly engaged**
Women	8.2% (n=6)	17.8% (n=13)	74.0% (n=54)
Men	14.9% (n=7)	12.8% (n=6)	72.3% (n=34)
Total	10.8% (n=13)	15.8% (n=19)	73.3% (n=88)

Engagement rates showed minimal differences by age (see Table 14). Older clients, aged 45-64 years, were slightly more likely to be moderately to highly engaged (76.5% highly engaged, 23.5% moderately engaged), while younger participants (18-44 years) were slightly more prone to minimal engagement (12.6%).

Table 14. Raahat Engagement by Age

	Engagement Categories		
(n=120)	**Minimally engaged**	**Moderately engaged**	**Highly engaged**
18-44 years	12.6% (n=13)	14.6% (n=15)	72.8% (n=75)
45-64 years	0.0% (n=0)	23.5% (n=4)	76.5% (n=13)
65+ years	0.0% (n=0)	0.0% (n=0)	0.0% (n=0)
Total	10.8% (n=13)	15.8% (n=19)	73.3% (n=88)

Regarding service types, group therapy demonstrated the highest level of engagement, with 96.6% of clients missing fewer than 10% of sessions (see Table 15). Correspondingly, no clients (0%) were minimally engaged in group therapy. This high engagement in group therapy aligns with client interview and focus group data, emphasizing the importance of group-based services. Conversely, group psychoeducation showed the lowest rates of high engagement at 71.8% and the highest rate of minimal engagement at 14.1%. Social work services and individual psychotherapy had similar high engagement rates at 80.3% and 76.0%, respectively.

Table 15. Raahat Engagement by Service

	Engagement Categories		
(n=120)	**Minimally engaged**	**Moderately engaged**	**Highly engaged**
Individual psychotherapy	8.0% (n=2)	16.0% (n=4)	76.0% (n=19)
Group psychoeducation	14.1% (n=11)	14.1% (n=11)	71.8% (n=56)
Group therapy	0.0% (n=0)	3.4% (n=1)	96.6% (n=28)
Social services	2.8% (n=2)	16.9% (n=12)	80.3% (n=57)

Mental Health

In the following section, we outline the perspectives of the community, clients and staff regarding the needs for and impact of programming on their emotional and mental well-being.

Arman Mental Health

Impact from the Client and Staff Perspective

First, we summarize the client and staff perspectives on the impact of Arman programming on emotional and mental well-being, drawing on data from the SOT-PWI-S, the client focus group, and staff survey. The SOT-PWI-S matrix, client focus group questions, and staff survey tool are all included in the annex.

SOT-PWI-S

The response options for the mental health indicator ranges from 1 of "high distress" – a client has an untreated mental health condition that interferes with their daily life and/or impedes their ability to care for themselves or their family – to 4 of "no distress" – no mental health concerns and/or are able to cope with life stresses and accomplish personal goals. Baseline mental health assessments revealed that 33% of the clients were categorized as "high distress" and 29 % as "moderate distress". Together, these high-risk groups represented 62% of the sample. The remaining 38% of clients rated their mental health as "low" or "no distress" (see Table 16).

Table 16. Arman Mental Health at Baseline

Risk Level	% Baseline (N=42)
High Distress	33% (n=14)
Moderate Distress	29% (n=12)
Low Distress	24% (n=10)
No Distress	14% (n=6)

Regardless of their baseline status 66.7% of clients (n=28) reported improvement in their mental health from baseline to follow-up. Of the 26 clients who reported being "high" or "moderate" at baseline, 88.5% (n=23) reported improvement in their mental health over time, while 11.5% (n=3) did not change their status from baseline to follow up (see Table 17). Among the 16 clients who were initially "low" or "no distress," 31.3% (n=5) further improved their mental health; 37.5% (n=6) maintained the same status; and 31.3 % (n=5) regressed. It is not clear what may have contributed to a regression in mental health, although it is noteworthy that many CVT clients experience ongoing and new stressors during the period they are accessing services. Without a baseline comparison group, it is difficult to determine if even those clients 'regressing' may have still fared better with CVT services than without in the face of new stressors encountered. Overall, results suggest that CVT services likely made positive contributions to mental health, especially for those with higher symptoms at baseline (89% improvement), and for those reporting low or no distress at intake (32% improvement, 38% stable/no change).

These results were replicated in the mental health and social functioning assessments (see Annex 2 for the Arman Evidence Brief).

Table 17. Arman Change in Mental Health Status from Baseline to Follow-up

	Change in Status		
Distress	**% regressed**	**% stay the same**	**% improved**
Moderate / High (n=26)	0% (n=0)	11.5% (n=3)	88.5% (n=23)
None / Low (n=16)	31.3% (n=5)	37.5% (n=6)	31.3% (n=5)

Client Focus Group

The Arman focus group participants were from a women's psychoeducation group. See Annex 8 for the client focus group questions. In response to questions, some group members expressed appreciation for learning coping techniques like breathing exercises. They also shared that they "feel happy" noting that "we've improved" and that the group had "...a very good impact on our mental and emotional health. We applied what [Arman staff member] said and we got better."

"Before, we didn't talk to anyone because we were afraid that they'd laugh or make fun of us. After coming here, we spoke freely."

Several participants shared that they previously avoided discussing emotional issues, but now feel comfortable sharing after participating in the women's psychoeducation group. One participant noted, "Before, we didn't talk to anyone because we were afraid that they'd laugh or make fun of us. After coming here, we spoke freely." The psychoeducation group seems to have given participants a safe space to overcome the stigma of talking about mental health concerns. As one participant noted, [we] "learn well from one another."

When asked *'what should be done to pay more attention to mental health?,'* focus group participants highlighted how social connections can improve one's mental health. For example, one participant suggested that "People should go out, walk, meet friends—that lifts the spirit. Otherwise, sitting at home makes one anxious, ruins the mood, and makes you feel weak." Another participant detailed how the group, where "we got to know friends, made friends, joined groups, and received support," helped her mental health. Clients noted the complex connection between mental well-being and social well-being, suggesting that getting people out of their home and socializing in a safe group setting alone can improve mental health.

Staff Survey

Arman staff reported a high average rating of 4.25, between "somewhat agree" and "strongly agree" to seeing improvements in both clients' mental health and social well-being (see Table 18). Responses in these areas showed less variation (ranging from 3 to 5), indicating that participating staff reported at least a neutral to strong agreement on improvements in mental and social well-being. Staff survey questions can be found in Annex 10. Staff-reported improvements in mental health align with the mental health improvements reported by clients in the SOT-PWI-S and focus group.

Table 18. Arman Staff Observed Improvements in Health and Well-being

	From 1 ("Strongly Disagree") to 5 ("Strongly Agree")		
Saw improvements in (n=4):	**Mean**	**Min**	**Max**
Social Well-being	4.25	3	5
Mental Health	4.25	3	5
Physical Well-being	4.00	3	5

Three staff self-identified what they believe to be strengths in their approach to supporting client mental health including facilitating client stabilization, meeting basic needs, addressing intense symptoms, teaching coping skills, and providing support in clients' relationships with family and community. One respondent also noted that the potential for mental health services could have been greater were it not for restrictions applied to services by clinic leadership. Note: It is not clear if this refers to inclusion criteria for services or something else.

Arman staff reported the highest mean rating for perceived benefits from individual psychotherapy (4.75), with responses tightly clustered (minimum 4, maximum 5), indicating strong agreement (see Table 19). Since the Arman focus group was conducted with psychoeducation group clients, there is limited information on client perceptions of the impact of individual psychotherapy services to support the staff's viewpoint. However, based on the SOT-PWI-S results, the overwhelming majority of clients (n= 28, 66.7%) improved their mental health status following services (see Table 17).

Table 19. Arman Observed Benefits of Specific Services

Seen benefits from (n=4):	From 1 ("Strongly Disagree") to 5 ("Strongly Agree") Mean	Min	Max
Individual Psychotherapy	4.75	4	5
Psychoeducation Groups	4.00	2	5
Case Management	4.00	3	5
Healthcare Navigation	4.25	2	5
Other Services	4.00	2	5

One Arman staff member offered a qualitative response to one of the items about services. This staff member suggested that family therapy may better address the presenting issues for most clients. There were no specific questions about family therapy on the staff survey focused on perceived benefits of services.

Raahat Mental Health

Needs from the Community Perspective

Community engagement interviews were only for the Raahat program is based (see Annex 11 for interview questions). Collecting this information provided an opportunity to better understand the mental health support needs within the Minnesotan Afghan community from the perspective of those not currently receiving services.

Two community member interviewees directly linked existing mental health needs to the "difficulties and psychological pressures [Afghan people] have faced from war and humiliation." These participants emphasized the potential for CVT programs to help individuals "adapt to the environment and atmosphere of the U.S. ... so they can live more peacefully and calmly like others and be successful." This perspective highlights adaptation to a new social context as a fundamental approach to addressing mental health challenges. The second participant reinforced this, stating that the program may "help [clients] adapt more easily to the American system and help them get through their mental and physical health problems more comfortably," drawing a connection between adaptation and both mental and physical well-being. This participant also advocated for in-person therapy services to address community mental health needs.

Another participant focused on intergenerational trauma, explaining that "Afghans have various levels of psychological states that directly affect their children." An example was provided where "sometimes [parents] shout at their children or get angry excessively without realizing

how harmful shouting is to the child, and sometimes they can't control themselves." This highlights a potential need for psychotherapy or psychoeducation for parents, parenting support, and direct services for children— an area described as "very necessary" by the interviewee.

In contrast, another interviewee expressed a more fatalistic view, suggesting that the deep-rooted nature of mental health concerns, particularly those related to violence, renders them insurmountable. This individual stated, "the reality is that Afghans have many psychological problems due to their social life, but the root of the violence problem among Afghans comes from our religious beliefs, and for this reason, many things cannot solve this." Despite these varied outlooks, ranging from optimistic to fatalistic, all interviewees agreed that previous trauma and challenges adjusting to a new country has resulted in significant mental health concerns within the community.

Impact from the Client and Staff Perspectives

In this next section, we summarize the client and staff perspectives on the impact of Raahat programming on their emotional and mental well-being. Data is derived from SOT-PWI-S, satisfaction interviews, client focus group, and staff survey.

SOT-PWI-S

Baseline mental health assessments revealed that 0% of clients who completed the assessment were categorized as "high distress" and only 5% as "moderate" (see Table 20). Conversely, 45% were rated as "low distress" and 50% as "no distress." These data suggest that clients entered the program with generally high levels of perceived mental well-being. It is possible that clients may be underreporting mental health distress for various reasons including minimizing for various reasons and/or mental health stigma (and associated feelings of shame). These findings are also notable as they appear to contrast with insights from the community engagement interviews, which suggested broader mental health needs. Program structure may also help explain the low levels of mental health distress. Whereas the Arman program represents an expansion of CVT's established, intensive clinical services, Raahat operates as a standalone program in partnership with ACS, an organization that primarily delivers lighter-touch psychosocial interventions. These programmatic distinctions may help explain why only 5% of Raahat clients entered the project "in distress," perhaps reflecting differences in referral pathways, service intensity, and program design.

Table 20. Raahat Mental Health at Baseline

Risk Level	% Baseline (N=40)
High Distress	0% (n=0)
Moderate Distress	5% (n=2)
Low Distress	45% (n=18)
No Distress	50% (n=20)

For clients who initially reported being "high distress" or "moderate" (n=2), 100% (n=2) showed improvement in their mental health (see Table 21). Among the larger group of clients who were initially "low distress" or "none" (n=38), 26.3% (n=10) reported improved mental health. However, 60.5% (n=23) remained in the "low" or "no distress" categories, and 13.2% (n=5) regressed, shifting from "low" or "no distress" to a higher distress category.

It is noteworthy that many CVT clients experience ongoing and new stressors during the period they are accessing services. Without a baseline comparison group, it is difficult to determine if even those clients 'regressing' may have still fared better with CVT services than without in the face of new stressors encountered. Overall, results suggest that CVT services likely made positive contributions to mental health, especially for those with higher symptoms at baseline (100% improvement), and for those reporting low rates of distress at intake (26% improvement, 61% stable/no change).

Table 21. Raahat Change in Mental Health Status from Baseline to Follow-up

	Change in Status		
Distress	**% regressed**	**% stay the same**	**% improved**
Moderate / High (n=2)	0% (n=0)	0% (n=0)	100% (n=2)
None / Low (n=38)	13.2% (n=5)	60.5% (n=23)	26.3% (n=10)

Satisfaction Interviews & Client Focus Group

Findings from client satisfaction interviews (N=27) and focus group (N=7) specifically related to participants' mental health are presented below. In response to the single quantitative item on the satisfaction interview, *"Since starting services with Raahat, have you noticed changes in your emotions (e.g., feeling more or less sad, more or less calm, more or less happiness)?,"* the mean score was 4.16, placing the average score at "moderate positive change." Importantly, no

respondents rated their change below “no change.” This suggested that clients had a highly positive subjective appraisal of the impact of Raahat services on their mental well-being.

Based on the open-ended item that asked about the specific experiences of clients related to changes in emotional well-being, clients reported several positive outcomes which they associated with psychotherapeutic interventions, including improved self-knowledge, emotional regulation, and coping skills. One client explained, “I learned more about myself, how to manage my emotions, and how to stay calm. I was happier in the afternoons on days I talked to them.” Another stated, “we learn skills to manage our emotions and cope with stress.” These responses indicate that clients learned and applied these psychotherapeutic skills, suggesting a need for such interventions.

“Before coming, I had things on my heart that I had no one to talk about. After attending the program and talking about those things, I feel relieved, like a weight is off my shoulders.”

Feedback on positive changes in emotional well-being was similar during the client focus group discussion. Clients consistently used words like “calmer,” “happier,” and “relieved” to articulate their feelings. One focus group participant vividly illustrated this explaining, “Before coming, I had things on my heart that I had no one to talk about. After attending the program and talking about those things, I feel relieved, like a weight is off my shoulders.” Clients also expressed sentiments such as, “I look forward to Monday so we can come to the program.” For some, attendance was seen as vital as one client explained, “I need to attend this program because it makes me feel calmer.” The program’s ability to offer a safe environment for discussing personal challenges and feelings— a resource previously seemingly lacking for many— emerged as a key factor in its positive impact.

Only one participant specifically discussed the importance of addressing trauma through the client satisfaction interview, noting both its difficulty and importance. They explained, “discussing my traumas brought up painful memories, but the sessions helped me feel better afterward.” Given that this is a highly trauma-affected population, it is notable that only one client brought up trauma-focused work. However, this may be due to a variety of factors including the potential difficulty of discussing trauma during an interview with someone they just met.

A frequently reported benefit of the Raahat services, particularly for group sessions, was the importance of the group as a social space. In both the client satisfaction interviews and the

focus group, clients specifically mentioned having a space to talk, engaging in peer sharing, and building friendships.

Clients not only discussed social well-being in the context of mental health outcomes, but linked social connection with improved mental health. One client from the satisfaction interview emphasized the importance of these groups for women, stating, “The program provided an opportunity to talk about our emotions, learn about other women’s struggles, gain insights from their experiences, and, overall, a chance to get out and decompress, especially since I was a stay-at-home mom.” Another woman from a satisfaction interview explained, “We really enjoyed the women’s group sessions because we made many new friends, had fun together, and shared helpful resources. As a housewife, it was also an opportunity for me to get out of the house and connect with others.”

One client highlighted the critical role of social support for her emotional well-being in her satisfaction interview, explaining, “When I first came to the U.S., I lived in an area with only one other Afghan family. I felt extremely lonely and could do nothing but cry…. Since participating, I’ve been feeling much better. I’ve had the chance to get to know other Afghan women, build friendships, and talk about our problems with both the group and our counselor.” The reduction of feelings of isolation was also reflected by clients in the focus group, where many participants often attributed loneliness to a scarcity of individuals sharing their language or cultural heritage. For instance, one focus group participant reflected, “It was easier in my home country to move from one place to another place and still not feel lonely or isolated because everywhere people spoke my language.” Another focus group participant conveyed their experience: “there are no Afghan or Iranian women near me, and I feel very isolated. I attended [Raahat services] to meet other women, and I am very happy about it.” The program's social component thus provides a powerful mechanism for clients to navigate emotions such as sadness, loneliness, and isolation.

“[T]he program has helped me a lot since I moved to the U.S. about six months ago. Adjusting to a new country is always challenging, but the support I’ve received has made a big difference.”

Lastly, one client reinforced the program’s role in supporting adaptation to the U.S. context in their satisfaction interview, echoing comments from other clients about the importance of social support in their adjustment, as well as remarks from community members on the critical link between adjustment support and mental well-being. This client explained, “the program has helped me a lot since I moved to the U.S. about six months ago. Adjusting to a new country is always challenging, but the support I’ve received has made a big difference.”

Three clients expressed lower satisfaction with or described barriers to services when discussing mental health in their satisfaction interviews. One client noted discontinuing services due to a lack of interest in mental health topics, instead preferring English language services. This further underscores the need for services that support adaptation to the U.S. context. Another client wished to continue services after screening but was denied because "The program declined to enroll me in therapy services due to my sisters already being in the program. They said they could not have three people from the same family participating." This suggests a need for closer examination of policies regarding participation. Finally, only one client was unsure if the services they received were helpful, explaining they were in mourning following the recent death of their son. While most feedback was positive, some clients highlighted programmatic suggestions such as more inclusive eligibility policies, greater trust when having explicit discussions of trauma, and a broader scope of services offered to support client needs and successful adaptation to the U.S.

Staff Survey

In the Raahat staff survey, the mean rating for observed improvements in mental health was 3.60, falling in between "neither agree nor disagree" and "somewhat agree" to seeing improvements in client mental health (see Table 22). This was notably lower than ratings for other areas of potential client improvement, such as social and physical well-being. Further supporting this, responses related to mental health showed a smaller range between the minimum (2) and maximum score (4). This pattern suggests staff agree to observing less pronounced progress in clients' mental health. These findings align with both the low number of clients who reported a need for mental health services at baseline and the infrequent discussion of mental health changes (relative to themes of social well-being) in client interviews and focus groups.

Table 22. Raahat Staff Observed Improvements in Health and Well-being

	From 1 ("Strongly Disagree") to 5 ("Strongly Agree")		
Saw improvements in (n=5):	**Mean**	**Min**	**Max**
Social Well-being	4.20	2	5
Mental Health	3.60	2	4
Physical Well-being	3.60	1	5

According to four qualitative responses from Raahat staff regarding mental health improvements, several factors may contribute to these lower levels of observed progress. These include challenges in communicating the value of psychotherapy to clients, difficulties

engaging and retaining clients in psychotherapy services, client concerns beyond the scope of available services (e.g., English language proficiency, financial literacy in the U.S. context), and the perception that the emphasis on reaching a high number of clients may prioritize breadth over the intensity of care needed for significant mental health improvement.

Raahat staff reported a mean rating of 4.00 for observed improvements in client well-being from psychotherapy, indicating a "somewhat agree" level of perceived benefit. However, staff viewed psychoeducation groups as more beneficial, with a mean rating of 4.20 (Table 23). This pattern aligns with staff reporting greater observed improvements in social well-being compared to mental health, consistent with the service types they found most effective. Furthermore, these findings resonate with clients' emphasis on the value of social and group-based services generally and also specifically to support mental and emotional well-being. Case management and healthcare navigation will be discussed separately.

Table 23. Raahat Observed Benefits of Specific Services

	From 1 (“Strongly Disagree”) to 5 (“Strongly Agree”)		
Seen benefits from (n=5):	**Mean**	**Min**	**Max**
Individual Psychotherapy	4.00	3	5
Psychoeducation Groups	4.20	4	5
Case Management	4.40	4	5
Healthcare Navigation	4.20	4	5
Other Services	3.50	1	5

Qualitative responses provided further context for the quantitative findings. Among Raahat staff, three provided further feedback for individual psychotherapy, which they had rated lower in the quantitative assessment. One staff member cited difficulty in maintaining client engagement in psychotherapy, while another recalled only a few instances where individual psychotherapy significantly empowered clients “to improve their own life.” Descriptions of psychoeducation groups focused on specific positive outcomes related to interpersonal connection, including reducing cultural shock and social isolation, fostering friendships and social networks, and promoting a sense of belonging.

Social Well-Being

In the following section, we outline the client and staff perspectives on the impact of programming on social well-being.

Arman Social well-being

Impact from the Client and Staff Perspectives

First, we summarize the client and staff perspectives on the impact of Arman programming on social well-being, drawing on data from the SOT-PWI-S, the client focus group, and staff survey. Social well-being covers aspects ranging from basic needs to social engagement.

SOT-PWI-S

Baseline assessments indicated that the overwhelming majority of clients were facing difficulty accessing resources with 76% of clients who completed the assessment categorized as "in crisis" or "vulnerable" (see Table 24). Responses to the assessment range from 1 of "in crisis" – being unaware or unable to access services – to 4 of "safe" – having the ability to independently access services to address unmet needs. Twenty-four percent of clients (n=10) rated as "stable" and "safe." This high number of clients "in crisis" or "vulnerable" demonstrates a great need for support in accessing social services among Arman clients. Among all SOT-PWI-S metrics including physical and mental health, the greatest need existed in social well-being for Arman clients. Only 24% rated their social well-being as "stable" or "safe."

Table 24. Arman Access to Resources Baseline

Risk Level	% Baseline (N=41)
In Crisis	59% (n=24)
Vulnerable	17% (n=7)
Stable	12% (n=5)
Safe	12% (n=5)

Although the majority of clients were "in crisis" or "vulnerable" at baseline, 80.6% (n=25) improved by the follow-up timepoint (see Table 25). This suggests that Arman's social services helped improve clients' capacity to meet their own needs. Among clients initially categorized as "stable" or "safe," 80.0% of clients (n=8) reported no change in their resource access and 10.0% (n=1) regressed.

Table 25. Arman Change in Access to Resources from Baseline to Follow-up

	Change in Status		
Risk Level	**% regressed**	**% stay the same**	**% improved**
In Crisis/Vulnerable (n=31)	6.5% (n=2)	12.9% (n=4)	80.6% (n=25)
Stable/Safe (n=10)	10.0% (n=1)	80.0% (n=8)	10.0% (n=1)

Responses for the housing baseline assessment range from 1 of "in crisis" – being homeless or having an unsafe and unsanitary home to 4 of "safe" – having decent and long-term housing. No clients were "in crisis" or "vulnerable" at baseline, and the majority (86%) were "safe" (see Table 26). Baseline assessments suggest that housing was not a primary issue among Arman clients.

Table 26. Arman Housing Conditions Baseline

Risk Level	% Baseline (N=42)
In Crisis	0%
Vulnerable	0%
Stable	14% (n=6)
Safe	86% (n=36)

Overall, Arman clients were housing secure with 83.3% remaining in the same status of "stable" or "safe" (see Table 27). Four clients (9.5%) regressed from their initial "stable" or "safe" status to a higher risk level status, and 3 clients (7.1%) improved to "stable" or "safe."

Table 27. Arman Change in Housing Conditions from Baseline to Follow-up

	Change in Status		
Risk Level	**% regressed**	**% stay the same**	**% improved**
In Crisis/Vulnerable (n=0)	—	—	—
Stable/Safe (n=42)	9.5% (n=4)	83.3% (n=35)	7.1% (n=3)

Client Focus Group

The psychoeducation group clients from the focus group highlighted not only making connections within the group, but improving their relationships with family and neighbors. One

participant shared that the group "was very helpful because we learned how to be good friends and have good relationship[s] with family and neighbors." Another participant explained that she learned "how to treat our children, how to talk to them, and how to be happy." The Arman psychoeducation group created a safe space where participants can connect with one another and learn ways to improve their personal relationships inside and outside the home.

Staff Survey

Four staff rated witnessing social well-being improvements a high average of 4.25 between "somewhat agree" and "strongly agree" (see Table 18). In the qualitative responses, staff had varying views on which services contributed towards social well-being with one staff member noting that "except the therapy sessions, we didn't have social well-being activities for clients," while another highlighted that "Groups and occasional client celebration events are good opportunities that we provide for them to socialize." This variation on which services contribute to social well-being may allude to the complex relationship between social well-being and mental well-being, noted by clients as well.

Arman staff "somewhat agree" (mean of 4.0) with seeing benefits from case management with a narrow range between the minimum (3) and maximum (5) rating, suggesting neutral to strong agreement on benefits (see Table 19). Psychoeducation groups were also rated 4.0 and healthcare navigation was slightly higher between "somewhat agree" and "strongly agree" (mean of 4.25). However, psychoeducation groups and healthcare navigation had greater variation in responses with a minimum rating of 2 and maximum of 5.

Raahat Social Well-Being

Impact from the Client and Staff Perspectives

We review the impact of the Raahat program on social well-being from the client and staff perspectives based on data from the SOT-PWI-S, satisfaction interviews, the client focus group, and staff survey.

SOT-PWI-S

Baseline assessments of Raahat clients' access to resources indicated that a significant portion were experiencing challenges. Specifically, 17% of clients who completed the assessment were categorized as "in crisis" and an additional 15% were deemed "vulnerable" (see Table 28). The majority of clients (66%) were rated as "stable" and only 2% as "safe." The combined percentage of clients "in crisis" or "vulnerable" suggests a substantial need for resource access support. This finding underscores the importance of programming designed to assist clients in obtaining necessary resources such as housing, food, and healthcare navigation.

Table 28. Raahat Access to Resources Baseline

Risk Level	% Baseline (N=41)
In Crisis	17% (n=7)
Vulnerable	15% (n=6)
Stable	66% (n=27)
Safe	2% (n=1)

The Raahat program demonstrated significant positive outcomes for clients initially facing resource access challenges. Among those who initially reported being "in crisis" or "vulnerable," 84.6% (n=11) showed improvement in their access to resources, while 15.4% (n=2) maintained their baseline status, and no clients regressed (see Table 29). This strongly suggests the Raahat program was effective in supporting clients in the greatest need of accessing resources and social benefits.

Conversely, among clients initially categorized as "stable" or "safe," the majority (64.3%, n=18) reported no change in their resource access. However, a notable 28.6% (n=8) reported a decline, shifting from "stable" or "safe" to a relatively higher risk category. This unexpected finding warrants further investigation to understand the contextual factors contributing to this decline and to identify potential support mechanisms for these clients. Overall, the program yielded improved resource access for the majority of participating clients.

Table 29. Raahat Change in Access to Resources from Baseline to Follow-up

	Change in Status		
Risk Level	**% regressed**	**% stay the same**	**% improved**
In Crisis/Vulnerable (n=13)	0% (n=0)	15.4% (n=2)	84.6% (n=11)
Stable/Safe (n=28)	28.6% (n=8)	64.3% (n=18)	7.1% (n=2)

Baseline assessments of clients' housing conditions indicated that nearly all clients were "stable" or "safe." Specifically, no clients who completed the assessment were categorized as "in crisis," and an additional 2% (n = 1) were "vulnerable" (see Table 30). These statistics suggest that housing was not a primary presenting concern among Raahat clients, which may be due to other organizations that support the Afghan community with housing.

Table 30. Raahat Housing Conditions Baseline

Risk Level	% Baseline (N=41)
In Crisis	0% (n=0)
Vulnerable	2% (n=1)
Stable	54% (n=22)
Safe	44% (n=18)

The Raahat program demonstrated significant positive outcomes for one client who was initially facing housing challenges, with their housing condition improving to "stable" (see Table 31). This suggests the Raahat program was effective in supporting the client in the basic need of housing through the submission of public housing applications.

Table 31. Raahat Change in Housing Conditions from Baseline to Follow-up

	Change in Status		
Risk Level	**% regressed**	**% stay the same**	**% improved**
In Crisis/Vulnerable (n=1)	0% (n=0)	0% (n=0)	100% (n=1)
Stable/Safe (n=40)	15.0% (n=6)	60% (n=24)	25% (n=10)

Satisfaction Interviews & Focus Group

Findings from client satisfaction interviews (N=27) and focus group (N=7) specifically related to participants' social life and well-being are presented below. In the single quantitative item, *"Since starting services with Raahat, have you noticed changes in your social well-being?"*, the mean score was 4.48, placing the average score nearing "strong positive change." No one rated their change below "no change." This suggested that clients had a highly positive subjective appraisal of the impact of Raahat services on their mental well-being.

"We really enjoyed the women's group sessions because we made many new friends, had fun together, and shared helpful resources."

In both the satisfaction interviews and the focus group, all respondents described the Raahat program as an important opportunity to connect with other members of the Afghan community, directly addressing aspects of social well-being. For many, this connection provided a fundamental reason to leave their homes, as highlighted by one satisfaction interview participant, “We really enjoyed the women’s group sessions because we made many new friends, had fun together, and shared helpful resources. As a housewife, it was also an opportunity for me to get out of the house and connect with others.” Another respondent explained, “I live in an area where there aren’t many Afghans, so the program gave me the opportunity to meet other community members and build friendships.” This aspect of the program was particularly critical for clients living in areas with limited co-ethnic populations or shared language, significantly mitigating social isolation.

In the focus group specifically, participants frequently described the program as cultivating a sense of “family” and providing a vital space for socialization and open discussion. They also highlighted the program’s role in fostering a supportive social environment where they felt comfortable asking questions without fear of judgment. One respondent articulated this by explaining, “Though I know some other Afghan women in the vicinity, it was really difficult for me to ask them about things I did not know for the fear of being judged or being made fun of for me not knowing.” For this focus group participant, it seems the Raahat program created a safe space to seek information from both program staff and other Afghan clients.

Relatedly, focus group participants underscored the value of this supportive environment, particularly for adapting to a new culture. As one participant explained, “Navigating the differences in culture has been difficult and the program has helped me a lot in that regard to adapt to the new ways of doing things.” The social and group context of the Raahat program was highly important for respondents in reducing isolation, building community, and assisting with cultural adaptation.

A key strength identified was the Raahat program’s duration, which facilitated deeper relationship building. The majority of satisfaction interview respondents reported forming meaningful friendships through Raahat that extended beyond program activities. One respondent explained she “made several very close friends, especially because the program sessions lasted longer than those of other programs.” Another respondent noted, “The program helped me get to know many Afghan women and make friends. We regularly visit each other's homes.” The perceived value of these connections was evident in a participant's persistence in attending: “I made several friends while attending the program... I continued participating in the program even though they didn't provide Uber transportation the second time I attended…. This shows how much I value the program.” This underscores the value of

establishing close friendships in a new cultural context which can be vital for social well-being and can provide support for other aspects of well-being and safety and security.

Additionally, two satisfaction interview respondents specifically mentioned that the program supported their English language acquisition, further enhancing social well-being and reducing isolation in a new country where English is the common language.

Staff Survey

In the Raahat staff survey, observed improvements in client social well-being received the highest mean rating of the three categories (mental, physical, and social), at 4.20 (on a scale of 1 "strongly disagree" to 5 "strongly agree"). This indicates staff, on average, clearly saw improvements in clients' social well-being (see Table 22). These findings align with the prominent and consistent reporting of improvements in social connectedness and well-being attributed to the Raahat program in both client interviews and focus groups.

Raahat staff offered particularly clear examples of the connection between their services and improvements in social well-being. One staff member explained, "We play a crucial role in helping clients get out of the house, learn about resources and coping strategies, and make new friends." Another detailed the provision of two types of social support groups—one focused on lighter, fun activities (e.g., a swimming group) and the other was more intensive therapeutic groups. Both types were described as creating "peaceful environments where participants can have fun, build connections, form new friendships, and most importantly, enjoy themselves."

Raahat staff perceived case management (mean of 4.40) as the most impactful service, followed by psychoeducation groups (mean of 4.20) and healthcare navigation (mean of 4.20). All three of these services seem to be related to social well-being and functioning. With a minimum rating of 4 and a maximum of 5 for each, staff were uniformly in agreement that these were meaningful services for Raahat clients. Notably, all three services were rated higher than psychotherapy (mean of 4.00, see Table 23). This pattern is consistent with the staff reported observations of greater improvement in clients' social well-being compared to their mental health, aligning with the service types they found most effective. Regarding social support services, staff emphasized the significant impact of concrete support, noting its benefit when clients successfully accessed new resources like housing, food stamps, medical appointments, and other essential services. One staff member also highlighted the value of community education and community events in providing clients with enjoyment and fostering connection. Overall, staff reports align with client reports, indicating that key areas of positive outcomes and critical services are directly related to enhancing social connection and supporting adaptation to a new socio-cultural environment.

Physical Health

In the following sections, we describe evaluation results related to physical health and well-being. There were reported program differences on physical health-related services across locations.

Arman Physical Health

Impact from the Client and Staff Perspectives

In this section, we summarize the client and staff perspectives on the impact of Arman programming on their physical well-being, drawing on data from the SOT-PWI-S, the client focus group, and staff survey. The Arman program had a physician on staff for basic medical services.

SOT-PWI-S

Responses to SOT-PWI-S physical health metrics ranged from 1 of "high distress" – having urgent and unaddressed medical needs or is unable or unaware of how to access routine medical care – to 4 of "no distress" – being able to manage medical needs independently. At baseline, 59% of clients who completed the assessment were categorized as "high" or "moderate distress," suggesting high physical health needs (see Table 32). In contrast to Minnesota, Georgia does not provide insurance or connect refugees and asylum seekers with health care services, which is critical context for understanding the high levels of physical health need in the client population.

Table 32. Arman Physical Health Baseline

Risk Level	% Baseline (N=41)
High Distress	27% (n=11)
Moderate Distress	32% (n=13)
Low Distress	17% (n=7)
No Distress	24% (n=10)

On the whole, the data suggests that the majority of clients maintained or improved their physical health following services. The majority of clients with a baseline as "high" or "moderate distress," 87.5% (n=21) demonstrated an improvement in their physical health, while 8.3% remained the same status (see Table 33). This suggests that the in-house medical

professional improved physical health for clients who engaged in medical services. The moderate to high engagement (see Table 8) among medical service clients may also have contributed to high improvement rates. In contrast, 41.2% of clients (n=7) reporting "low" to "no distress" at baseline regressed to a higher risk level. Future evaluations could explore the volatility of physical health status over time to mitigate regression from baseline to follow-up.

Table 33. Arman Change in Physical Health from Baseline to Follow-up

	Change in Status		
Risk Level	**% regressed**	**% stay the same**	**% improved**
Moderate / High (n=24)	4.2% (n=1)	8.3% (n=2)	87.5% (n=21)
None / Low (n=17)	41.2% (n=7)	35.3% (n=6)	23.5% (n=4)

Client Focus Group

In the client focus group, there were no explicit mentions of perceived physical health impacts. One participant did, however, highlight a "good thing [the Arman program] did was give us exercise" in response to *since joining the Arman program, have you noticed any changes in your emotional or mental state?*

Staff Survey

Arman staff rated physical well-being improvements as the lowest observed improvement, but it is notable that they still rate observed improvements above "neutral" (4.00). Observed improvements in physical well-being showed limited variability in staff ratings (ranging from 3 to 5), suggesting all surveyed staff observed at least neutral to strong agreement on improvements in physical well-being.

All three qualitative responses on this topic attributed physical well-being to the role of the in-house medical professional. One staff member specifically noted that Arman's medical service served as a good physical health stopgap while clients learned to navigate the broader medical system. Notably, none of the Arman staff responses mentioned observing non-medical services as contributing to physical well-being.

Raahat Physical Health

Impact from the Client and Staff Perspectives

For direct physical health services, the Raahat program could refer to the nurse practitioner at the St. Paul Healing Center. In addition, their partner organization, Afghan Cultural Society,

provided healthcare navigation services. Despite less programmatic services offered in this domain, relevant findings pertaining to client physical health and well-being were observed.

SOT-PWI-S

Baseline physical health assessments revealed that 0% of clients who completed the assessment were categorized as "high distress" and only 8% as "moderate distress" (see Table 34). Conversely, 15% were rated as "low distress" and the strong majority of 77% as "no distress." These data indicate that clients entered the program with high levels of physical well-being.

Table 34. Raahat Physical Health Baseline

Risk Level	% Baseline (N=39)
High Distress	0% (n=0)
Moderate Distress	8% (n=3)
Low Distress	15% (n=6)
No Distress	77% (n=30)

For clients initially categorized as "high" or "moderate distress," 66.7% (n=2) demonstrated an improvement in their physical health, while 33.3% (n=1) experienced a decline (see Table 35). Among the larger group of clients who were initially assessed as "low" or "no distress," 16.7% (n=6) reported improved physical health, and the majority 75.0% (n=27) maintained their status in "low" or "no distress." A smaller proportion, 8.3% (n=3), reported a decline, shifting from "low" or "no distress" to a higher risk level. Overall, the data indicates that most clients either maintained good physical health or saw an improvement from baseline to follow-up. In the subsequent section, we report on client and staff observations about programmatic reasons for improved physical health.

Table 35. Raahat Change in Physical Health from Baseline to Follow-up

	Change in Status		
Risk Level	**% regressed**	**% stay the same**	**% improved**
Moderate / High (n=3)	33.3% (n=1)	0% (n=0)	66.7% (n=2)
None / Low (n=36)	8.3% (n=3)	75.0% (n=27)	16.7% (n=6)

Satisfaction Interviews

Findings from client satisfaction interviews (N=27) related to participants' physical health are presented below. For the single quantitative item, *"Since starting services with Raahat, have you noticed changes in your physical health?"*, the mean score was 3.59. This average score falls between "no change" and "some positive change" on the rating scale, and no participants reported a negative change. This suggests clients held a slightly positive subjective appraisal of Raahat services' impact on their physical health.

> *"For example, the techniques I learned, such as breathing exercises, have helped me feel better. My headaches have lessened, and I feel less tired."*

In response to open-ended questions, respondents reported a reduction in fatigue and headaches, conditions that can be associated with depression and stress. One respondent directly linked this to a stress management technique: "For example, the techniques I learned, such as breathing exercises, have helped me feel better. My headaches have lessened, and I feel less tired." Respondents also described increased activity levels and greater independence, which both support and are supported by improvements in physical health. For instance, one respondent explained, "I have become more independent after participating in the program and can do things I wasn't able to do before." Once more, the data highlights the relationship between social connection, social functioning, and physical health outcomes for the respondents.

Staff Survey

An unexpected finding from the Raahat staff survey is that perceived improvement in physical well-being (mean = 3.60) matched that of mental health (mean = 3.60) placing this score between "neither agree nor disagree" and "agree" (see Table 22). This is surprising given the strong emphasis on mental health within the program and the limited focus on physical health initiatives.

While the mean scores are identical, the range of responses differed significantly. Staff showed more agreement on mental health improvements with ratings falling between 2 and 4. However, perspectives on physical well-being varied more widely, with responses spanning from 1 to 5.

Staff highly rated healthcare navigation as a key resource supporting client physical health with a mean of 4.20 placing this score between "agree" and "strongly agree" (see Table 23). The narrow range of responses, from a minimum of 4 to a maximum of 5, indicates significant agreement among staff regarding its perceived effectiveness. These findings suggest healthcare navigation may be a particularly impactful resource for improving clients' physical well-being.

There was a considerable range in how staff perceived the connection between services and client health outcomes. One staff member noted a perceived lack of direct involvement, stating that they do not "do anything for physical well-being." Another felt that while clients were "already doing about as well as they could be at accessing necessary [health resources] before receiving Raahat services," they also described supporting clients in accessing resources like food stamps and food pantries that support physical well-being. Conversely, one staff member articulated a clear conceptual link between the program and overall health outcomes, describing how the program "guides each client on how to eat healthily, sleep well, breathe properly, and stay physically active to support better mental health." This staff member also highlighted how group activities like swimming and cricket provided "opportunities for participants to engage in physical exercise in a fun and supportive environment." These varied responses demonstrate a range in the extent to which Raahat staff see connections between their programming and physical health outcomes, as well as the interconnected impact of mental health and social services on physical well-being.

It is not clear if the program was implemented in a way that addresses physical health needs. Nevertheless, one staff member offered examples of its specific benefits, explaining that this service "allows people to speak with someone in their own language and share concerns, whether it's finding a primary care doctor or pediatrician, paying a medical bill, or applying for or renewing insurance. This is particularly important for families where no one speaks English."

Community Needs and Gaps

In the following section, ongoing community needs and gaps will be outlined from the perspectives of the community, clients, and staff to provide recommendations for the future. Data is gathered from the community engagement interviews, satisfaction interviews, client focus groups, and staff survey.

Arman Community Needs and Gaps

Client and Staff Perspectives

First, we summarize community needs and gaps identified by Arman clients and staff in the client focus group and staff survey.

Client Focus Group

English Language Classes **|** In the client focus group, there were two clients who suggested English language classes saying that "We don't know the language. If there were a course that taught us the language, that would be great."

Increased Length and Frequency | Participants also recommended increasing the length and frequency such as coming for "...two days a week and one day was for learning, that would be better" or "If it had continued longer or had sessions twice a week, it would have been better."

Staff Survey

Financial and Legal Assistance | One Arman staff member recommended the addition of financial support and legal assistance stating "Financial needs to meet current demands, this surpasses any other needs that clients present with. Some legal needs particularly surrounding family reunification." Due to funder restrictions the program was not allowed to provide legal services.

Family and Domestic Violence | Arman staff largely agreed with the statement, *"Family and Domestic Violence are concerns that should be addressed by this program*," with average ratings of 4.0 on a 5-point Likert scale. One staff member explained, "Family violence is very prevalent within the clients served and sometimes impacts ability to achieve success in the therapeutic process."

Raahat Community Needs and Gaps

Community, Client and Staff Perspectives

In the following section, ongoing community needs and gaps are detailed from the perspectives of the Afghan community in Minnesota, Raahat clients, and Raahat providers through the satisfaction interviews, client focus group, community engagement interviews, and staff survey.

Client Focus Group, Satisfaction Interviews & Community Engagement Interviews

Programs for Children | During satisfaction interviews and the focus group, while Raahat did have children's programming, clients nonetheless emphasized the critical need for support tailored to their children. They specifically requested a children's program in Dari to ensure cultural and linguistic accessibility, along with literacy classes for children. One focus group participant explained the impact of social isolation, stating, "My kids would like to attend such a group because there's no one from Kabul or Mazar to talk to here." This suggests that children may experience social isolation similar to that reported by parents. Clients also expressed a desire for a structured social program, perhaps one or two hours in length, that would allow children of similar ages to learn from each other and foster friendships, mirroring a successful model already offered for women. The timing of programming was also a key consideration, with one participant noting, "[some of my kids] might benefit from … a program if held on

weekends because other days they go to school." Furthermore, there was a clear demand for parenting support, including classes on child psychology and topics such as how to support children with behavioral issues and other aspects related to effective child-rearing.

Social Activities | Participants of client satisfaction interviews, the focus group, and community engagement interviews all expressed a need for more social and physical health activities. Existing activities included: swimming, make-up and health, English classes, sewing, and Zumba dance. Additional interests expressed by clients included soccer, swimming classes for women, and gym classes. Participants directly linked these activities to improved well-being with one respondent explaining, "I would suggest the program offer swimming or gym classes for clients to alleviate stress and feel better." Community engagement interviews further underscored the need for social and physically active opportunities with participants highlighting the unique context of Minnesota. One respondent emphasized, "Since Minnesota has very cold and long winters and Afghans have a strong cultural tradition of visiting and social gatherings, if the program can provide a warm indoor place where Afghans can come together, for example like the indoor volleyball program organized by CVT and EICS, similar programs would help."

Beyond structured physical activities, focus group participants were interested in outings or tours. They particularly hoped for opportunities to explore different parts of the city and participate in social activities with their group and family members. A focus group participant articulated this desire explaining, "We could benefit from something that could take us on a tour to learn about places." This sentiment aligns with a community member's observation: "It's really hard to come into a society that is so different, where everything is unfamiliar. It takes time and effort to adapt." These types of social activities could therefore facilitate both adapting to a new environment and fostering social connections.

Information about Living in the U.S. | Participants of client satisfaction interviews, the focus group, and community engagement interviews consistently highlighted a critical need for services that support integration into and adaptation to life in the U.S. The most commonly requested service was English language classes. Language ability is a primary driver of social isolation and is critical for integration, both of which significantly impact mental health and overall well-being. A community engagement participant explained, "Afghans who are newly arrived initially have problems interacting and communicating beyond their native language. A part of this program, if it focuses on language education, can be a good tool to help them adapt to life in America."

Relatedly, participants broadly requested educational classes on navigating life in the U.S. An interview participant suggested "a program on how to navigate life in the U.S., such as using

public transportation, applying for jobs, and other useful topics." Financial literacy in the U.S. was a specific focus for a community engagement participant, who noted, "One thing that causes problems for Afghans and leads to mental and psychological issues: financial problems and lack of sufficient financial knowledge. Not only do they lack enough financial education, they basically have none. Especially in the U.S., financial education is a key thing — for example, how to maintain your credit score and improve it, how to manage and organize your income. For example, in the U.S., if you don't have savings for three to six months, you can very easily become homeless for any reason, such as losing your job …. [we should] teach people how to maintain their credit, manage their income, build a budget, and how to turn their money into assets. Unemployment can cause psychological problems like depression."

Another consistently raised service was support in learning how to drive or attain a driver's license. A community engagement participant explained that this is particularly difficult for preliterate and non-English language speakers: "Getting a permit to drive was very difficult. They need help with that. There should be courses for those who can't read or write, including hands-on training for driving." Given the typically weak public transportation infrastructure in most U.S. states, driving is critical for both financial and social well-being.

Finally, workforce development was another key support requested. A community engagement participant explained that beyond the financial importance of work, there are also significant mental health connections: "Afghans who newly arrived mostly focus on work. Information should be provided to help them find work and build communication with organizations and companies to find their way in job seeking. This is the root of the problem. From the beginning, when people come, entering the workforce early helps prevent depression." Broadly, these evaluation findings are consistent with research that shows that navigating U.S. systems and processes are a critical barrier to integration, accessing services, and ultimately enhancing wellbeing (Reihani et al., 2021).

Staff Survey

Family and Domestic Violence **|** In the Raahat staff survey, staff largely agreed with the statement, *"Family and Domestic Violence are concerns that should be addressed by this program,"* with average ratings of 4.0 on a 5-point Likert scale, aligning with "agree." One staff member strongly affirmed this, stating, "I could not agree with this statement more, and I would be eager to participate in the development of this. It is by far the most acute need experienced by our clients and we are not meeting that need sufficiently." However, one staff member expressed reservations regarding the program's capacity to provide such support and the potential negative implications for clients. This staff member commented that "'the program is not equipped with the specialized expertise required to address these issues

directly" and warned that "Involvement in such sensitive matters may also discourage individuals from seeking mental health support, especially if they feel the program is too involved in their personal lives. It would be more appropriate for a separate, specialized organization to handle domestic violence cases." This reflects the literature, which suggests that rates of intimate partner violence (IPV) are higher among Afghan groups experiencing forced migration and resettlement compared to more stable communities (e.g., 56% compared to 80% physical IPV prevalence in the past year) (Wachter et al., 2025). Overall, staff reported a clear need for domestic violence services; however, this topic was not raised by clients or community members during interviews or focus groups. This discrepancy may be due to the stigma associated with discussing domestic violence, though the specific reason is not known.

Facilitators and Barriers

In the following section, facilitators and barriers to accessing services are highlighted from the perspectives of the clients and staff to further provide recommendations for similar programs.

Arman and Raahat Facilitators and Barriers

Community, Client, and Staff Perspectives

There were a number of facilitators and barriers that spanned both Arman and Raahat programs in Georgia and Minnesota, respectively. Transportation and childcare were specifically asked in the focus groups, while the rest were unprompted.

Client Focus Group, Satisfaction Interviews & Community Engagement Interviews

Word of Mouth and Referral Outreach **|** This section details how clients and community members learned about the Arman and Raahat programs, emphasizing the crucial role of informal networks and positive initial perceptions. In the focus groups, participants reported a variety of initial contacts with the Arman and Raahat program including program outreach, personal connections, and referrals. More specifically for Arman, clients joined following suggestions from friends and the International Rescue Committee. For Raahat in particular, caseworkers, sponsors, and other Afghan women were significant motivators. This highlights the importance of word-of-mouth and trusted community networks in their decision to join.

Specifically for Raahat in the community engagement interviews, prior awareness of the program was generally limited. Participants often learned about it through informal channels like WhatsApp groups or personal encounters just weeks before the discussion. While their

knowledge of specific Raahat services was low, initial reactions to the program's description were overwhelmingly positive. One participant expressed this sentiment clearly: "I didn't know about these services. If I had known, I definitely would have participated." There was a consensus that such programs are critically needed to help Afghan newcomers adapt to the U.S. environment, alleviate psychological burdens from past traumas, and foster integration. The perceived value was high, particularly for its potential to create opportunities for community connection and support. A community member echoed client respondents regarding the importance of social connection, observing, "it makes people very happy when they see a fellow countryman in a foreign land where we don't know much about the culture and language. When I first arrived in the U.S. and saw an Afghan for the first time, I was so happy—it felt like I had seen all my family members. Programs like this are great because they create opportunities for us to come together and talk with each other."

Trust and rapport **|** Trust and rapport played a significant facilitator for participation for both Arman and Raahat clients, with the majority joining services following a referral from a trusted source. The central importance of trust building is consistent with research that limited trust as a barrier for Afghan refugees and Special Immigrant Visa (SIV) holders to seek health services or to share mental health concerns with providers (Reihani et al., 2021). Strong referrals were particularly important for building this trust. For Arman, three participants from the focus group were introduced through a specific staff member from the International Rescue Committee, while the other two were recommended through a friend.

For Raahat, participants consistently expressed a high level of trust in the program staff, which proved crucial for overcoming initial hesitations and ensuring continued engagement. One Raahat participant explained, "Similarly, I trusted my caseworker to take me in a good place. They would never suggest a bad program to us. That is why I came without any hesitation." Another participant noted her initial fear of taxis but how a familiar and trusted face helped alleviate it: "The first time I was coming here, I had doubts and was fearful. I also never used taxis (Uber) and was afraid of where the taxi would take me since it was a long distance. I was very scared. After getting out of the car, I saw [a known staff member] and felt at peace, knowing I was in the right place." Conversely, one participant mentioned a friend whose husband prevented her from joining due to mistrust of the program's motives: "I have a friend with whom I talked to about the program several times but her husband does not allow her to come. Her husband has this idea that the project is for the people in the project to make money through people like us."

Raahat community engagement participants explained that building trust is a gradual process, achieved through sincere and effective service delivery, kind interactions, and providing truly

needed programs. A community engagement participant described, “In my opinion, trust builds over time. The longer the program lasts, the more it can help build strong and better trust.” They also noted that general distrust in the community, stemming from past ineffective programs by various organizations, can reduce willingness to participate. This highlights a need for sustained programming that acts with integrity and consistently meets the needs of the community.

In-Person Format **|** When asked whether clients would prefer in-person or virtual, all Arman and Raahat clients preferred in-person. One Raahat participant shared, “we prefer here [in-person] because I can't set up the computer. Also, we want to come to see each other; it positively affects our mental health.”

Hours of Operation **|**Work schedules presented significant barriers to participation, with inflexible program timings often conflicting with clients’ work, especially for men. One Raahat community engagement interview respondent explained that, “the timing wasn’t suitable for me, and no one asked us what time would work. It was organized without a survey.” This suggests a need for a more flexible program schedule (including evenings and weekends) and perhaps a needs assessment prior to program establishment.

Transportation **|** A common barrier reported by participants, particularly in initial attendance, was transportation. Transportation was provided by both programs and was therefore not a barrier to access. Program assistance with transportation emerged as a strong motivator for continued attendance. One participant in Raahat noted the special importance of transportation for women, “Definitely important, especially transportation. Since most men work, especially if the participants are women, there should be at least the opportunity for women to participate without relying on men.” Although transportation was provided, clients in the Raahat program expressed fear or unfamiliarity with taxi services and Uber, echoing sentiments like one focus group participant who stated, "I was fearful because in Turkey, taxi drivers would abduct Afghans and take their organs. That's why I was initially a little worried." Other Raahat clients reported logistical issues, such as not knowing how to use a phone to order taxis, highlighting that "it's helpful that the program assists with taxis." Some participants even experienced unreliability with U.S. taxi services, noting, "My problem is that when I go home, the taxi takes me to the wrong address."

Childcare **|** Both Arman and Raahat cited childcare as a barrier. An Arman client shared that “One barrier was children, but the program said they would take care of them." A Raahat participant also explained, “Regarding childcare—many Afghan families have four or five children. It’s difficult to attend a program and take care of kids at the same time.”

Staff Survey

Hours of Operation **|** Identified as a barrier by clients as well, both Arman and Raahat staff highlighted the program's hours of operations as a challenge. The hours of operations for services conflict with male clients' work schedules in particular, with staff highlighting that working over 60 hours weekly is common and leaves little energy or time for program engagement. Consequently, staff also recognized the inability to offer services during nights and weekends, which restricts access for children and teens in school as well as those with regular work hours.

Transportation & Childcare **|** Consistent with client experiences, staff recommended continuing to provide transportation and childcare services, and occasionally driving vulnerable clients to external social service appointments.

Staffing and Language Access **|** A practical limitation mentioned by Arman and Raahat staff was language barriers. For Raahat, in particular, there was an absence of a professional in-person Pashto interpreter, which restricted connection with the Pashtun community. This gap is commonly reported in the research literature (Reihani et al., 2021). Raahat staff also strongly advocated for employing therapists who speak the clients' languages, while acknowledging that some clients prefer American staff due to privacy concerns.

Raahat Barriers and Facilitators

Community, Client, and Staff Perspectives

This section outlines the barriers and facilitators clients experienced when accessing Raahat programming in particular. We specifically asked about stigma in the community engagement interviews. Other barriers reported were unprompted.

Client Focus Group, Satisfaction Interviews & Community Engagement Interviews

Lack of familiarity with mental health **|** Community engagement interview respondents were asked *Do you think there is stigma around mental health in the Afghan community?* and uniformly acknowledged that stigma can be a barrier to accessing services. One participant explained, "Yes, the stigma exists, even in American society. For example, some people don't share their mental health problems in public... The stigma is stronger among Afghans. It is important to address this issue with care and build empathy among those who share common pain." Some participants pointed to a lack of awareness about mental health within the Afghan community. One person explained, "People don't think it helps until they receive medication or

don’t believe they have any problem ... This issue has deep roots. Afghans are completely skeptical because they lack sufficient awareness.”

One respondent offered a valuable suggestion to mitigate this stigma: “To improve this, I think if mental health issues are presented in the form of games or activities where people see themselves in a natural setting, so that it becomes normal and they don’t feel separated or different, that would help. If it’s done as a game, it won’t be taken seriously as a ‘problem,’ and they can be supported through other activities.” This suggestion resonates strongly with the broader client requests for more social events, physical well-being activities, and community outings, highlighting a potential pathway to destigmatize mental health support through integrated, engaging programming.

Staff Survey

Beyond confirming client-reported challenges, Raahat staff offered unique insights into operational and systemic barriers and facilitators.

Program Design and Incentives **|** Raahat staff advocated for allocating a greater portion of the budget to direct program activities over support staff and administrative costs, aiming to provide more meaningful incentives for community engagement and involving clients directly in the project planning process. They also suggested trying in-home services as a way to potentially reduce participation barriers, a novel idea not explicitly raised by clients.

Partnerships **|** Raahat staff, in particular, also emphasized the importance of collaborating with several partners to connect members with mental health services and build trust within the community. For instance, establishing consistent referral sources and/or offering a number of mini sub-grants to multiple community-based organizations.

Internal Program Dynamics **|** Staff pointed to internal team dynamics as creating barriers to providing impactful care. This included concerns about staff turnover, unclear expectations, and team structure issues. They stressed the need for a clearer internal structure regarding responsibilities, management, oversight, and accountability.

Program Responsiveness **|** Staff hoped to establish a more agile, responsive program model that is capable of real-time adjustments based on community feedback, suggesting a more dynamic approach to program improvement. They proposed investing in programming that cultivates relationships and credibility, especially with hesitant groups, directly addressing the client-expressed need for trustworthy and welcoming environments.

Gender-Specific Barrier | One staff member specifically noted that women sometimes face the additional barrier of needing and not receiving their husband's permission to attend programming.

LIMITATIONS

This evaluation is subject to several limitations that should be considered when interpreting its findings.

A primary limitation is the small sample size for several key data collection methods. For instance, the staff survey did not include staff who left the program nor staff from partner organizations, restricting the generalizability of these insights to the entire staff. The qualitative data from the client focus groups and community engagement interviews also represent a limited subset of the overall client and community populations, which may not fully capture the diverse experiences and opinions within the larger group of Afghan newcomers. The sample of clients surveyed are not representative of all who are eligible for services.

The evaluation relies heavily on self-reported data from clients, staff, and community members through interviews, focus groups, and surveys. While invaluable for understanding lived experiences, self-reported information can be influenced by recall bias, social desirability bias, or courtesy bias, a general desire to offer positive feedback.

Several methodological constraints limit the conclusions that can be drawn. In the service utilization data, a single service for a client may be capturing multiple services. This occurred as service data was retroactively added for certain clients and there was not enough capacity to enter each service individually so a single group service may reflect attendance for more than one group service.

The clinical assessments and SOT-PWI-S data are limited, particularly regarding follow-up information, providing only preliminary insights into client improvements. While results are promising, without a control comparison group it is difficult to determine the role Arman and Raahat services played in improving well-being outcomes relative to other factors.

The recruitment method for some community engagement participants (three out of four were individually invited by a Raahat staff member) introduces a potential for selection bias. Individuals known to or recommended by staff might hold more favorable views or specific experiences that do not represent the broader community's perspectives or challenges in accessing the program. Additionally, the evaluation's focus on current clients excludes

perspectives from individuals who opted not to participate or discontinued services. This omits crucial insights into initial deterrents or reasons for early withdrawal.

Some focus group participants had limited exposure to the full range of Arman or Raahat program services, having engaged in only one type of service. As a result, their feedback might primarily reflect their experience with that specific service rather than offering a comprehensive view of the entire program's effectiveness.

CONCLUSION

In summary, despite these limitations, this evaluation provides a triangulated data analysis drawn from client, community, and staff perspectives. These insights offer valuable guidance for future program planning and design. Findings can also be utilized to craft recommendations, not only for CVT to reflect on internal programming, but to support other service providers working to address the needs of Afghan community members in the U.S., see section below.

SUMMARY & RECOMMENDATIONS

In this section, we summarize the specific recommendations offered by clients, community members, and staff.

Arman and Raahat

Arman and Raahat clients, community members, and staff overlapped in their recommendations for program development.

Client and Community Member Recommendations

- Provide English language classes;
- Build trust and rapport with the community;
- Continue to provide transportation assistance;
- Keep services in-person; and
- Offer childcare facilities / services so parents can attend more easily.

Staff Recommendations

- Hire interpreters or staff who speak shared languages, specifically Pashto.
- Expand programming and services to address family and domestic violence.

Raahat

Given that the Raahat program had supplementary client satisfaction interviews and client engagement interviews, there were several recommendations in addition to the ones above.

Client and Community Member Recommendations

Clients and community members consistently identified similar needs and recommendations for program development.

Suggested additions to meet the needs of children

- Children's program in Dari;
- Literacy classes for children;
- Social programs for children of similar age to learn and build friendships, similar to the women's group model;
- Weekend programs for children to accommodate school schedules; and
- Parenting support and education classes.

Interest in Community-based activities

- Social and physical health activities, such as soccer, swimming classes for women, indoor volleyball, and gym classes;
- Outings or tours to help clients explore the city;
- Increased frequency of social meetings and recreational activities; and
- Addressing stigma around mental health by integrating mental health topics into engaging activities or games to normalize discussions.

Interest in education to better adapt to living in the U.S.

- Driver's education classes;
- Workforce development classes; and
- Financial literacy classes, covering topics like credit scores, income management, budgeting, and asset building.

Identified practical needs to support service utilization

- More flexible program schedule, including evenings and weekends

Staff Recommendations

- Continue to provide transportation and childcare services, including occasionally driving vulnerable clients to external social service appointments;
- Offer evening and weekend services to improve access for working individuals, children, and teens;

- Build trust and rapport by collaborating with strong, motivated community partners and investing in community-based and social events;
- Provide more meaningful incentives for community engagement and involve clients directly in project planning;
- Explore in-home services as a strategy to reduce participation barriers;
- Establish strong relationships with several providers; and
- Employ therapists who speak clients' languages.

Planned Utilization of Findings

The insights gained from this Program Evaluation can be used to inform key stakeholders, including CVT leadership, funders, policymakers, Afghan community organizations, and service providers. The findings can play a role in contributing to future program design, funding proposals, policy advocacy efforts, and community engagement initiatives.

The findings will likely be useful in designing evidence-based programs that address the needs of Afghan Parolees, refugees and other displaced populations in the United States. By integrating these insights into funding proposals, organizations can advocate for extended and expanded services, fostering new partnerships and securing grants to enhance program sustainability in Georgia, Minnesota, and other parts of the United States.

The findings can also service refugee support networks in terms of policy advocacy to highlight emerging needs, particularly in light of recent changes in U.S. immigration policy. By demonstrating the necessity of targeted interventions, the assessment can support advocacy efforts aimed at securing sustainable funding and policy measures that enhance access to mental health and social services for Afghan humanitarian parolees.

By centering client voices and leveraging data-driven insights, this evaluation aims to contribute to a more effective, inclusive, and sustainable support system for the Afghan community.

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Social Pathways to Mental Well-being among Afghan Survivors in Minnesota

Context

For more than four decades, Afghans have endured war, political instability, drought, and poverty, leading to the displacement of millions. An estimated 10.9 million remain displaced, primarily within Afghanistan and neighboring countries. Smaller numbers have resettled elsewhere. After the 2021 U.S. military withdrawal and Taliban takeover, over 88,500 Afghan parolees resettled to the U.S., including more than 1,300 in Minnesota. Past exposure to conflict-related stressors, current insecure legal status, anti-immigrant rhetoric, and shifting immigration policies contribute to fragile mental health among many of these newcomers.

Results from a 2021 national survey indicate 47% of Afghans reported high rates of psychological distress in the past month, and 39% reported substantial associated functional impairment (Kovess-Masfety et al., 2021; Alemi et al., 2023). Yet, limited trust in providers, mental health stigma, language challenges, and complex healthcare systems create barriers to treatment (Nine et al., 2022; Reihani et al., 2021; Frumholtz et al., 2024).

In hopes of providing the required support, the Raahat program in Minnesota was launched in 2023. The program aims to help Afghan families rebuild their lives and strengthen connections in Minnesota through integrated, trauma-informed, and culturally responsive services including: psychoeducation groups, individual and group psychotherapy, and case management.

Evidence Collected

A mixed-methods evaluation sought to assess the impact of Raahat services on well-being, and on barriers and facilitators to participation. Data sources included service utilization records; assessments at intake and follow-up; interviews and focus groups with clients; survey with staff; and interviews with Afghan community members (see Table 1).

Table 1. Methods and Sample Size

Service Utilization Data: Demographic and service data routinely captured by staff in electronic health record system.	n = 168
Survivor of Torture Psychosocial Well-Being Index - Short version (SOT-PWI-S): Intake and follow-up assessment matrix measuring quality of life across domains of health, access to resources, and housing.	n = 40
Client focus group: Focus groups with current clients on service access, well-being, and recommendations for the program.	n = 7
Client satisfaction interviews: Telephone interviews with clients on how the program impacted their overall well-being.	n = 27
Staff survey: An online survey, incorporating both closed- and open-ended items, administered to program staff.	n = 5
Community engagement interviews: Interviews with community members who had not previously participated in the program.	n = 4

Interpretation of Evidence

Key Finding #1: Staff and clients emphasized improvements in social well-being as a result of CVT services, noting the value of social connection and community support to mitigate feelings of loneliness and isolation.

Client Perspective | In the satisfaction interviews and focus group, clients described isolation, loneliness, and sadness due to difficulty meeting people who shared the same language or cultural background. They explained that group services supported these connections, strengthened social support and built community to help improve their overall emotional well-being.

> *When I first came to the U.S., … I felt extremely lonely and could do nothing but cry.… Since participating, I've been feeling much better. [I got] to know other Afghan women, build friendships, and talk about our problems with both the group and our counselor.* - Client

> *There are no Afghan or Iranian women near me, and I feel very isolated. I attended [Raahat services] to meet other women, and I am very happy about it.* - Client

> *We really enjoyed the women's group sessions because we made many new friends, had fun together, and shared helpful resources. As a housewife, it was also an opportunity for me to get out of the house and connect with others.* - Client

Staff Perspective | Staff reported clients showing the greatest improvement in social well-being (see Table 2). Staff described how CVT services helped clients leave the house, access resources, learn coping strategies, and build friendships.

Table 2. Staff Observed Improvements

Saw improvements in (n=5):	*From 1 ("Strongly Disagree") to 5 ("Strongly Agree")*		
	Mean	Min	Max
Social Well-being	4.20	2	5
Mental Health	3.60	2	4
Physical Well-being	3.60	1	5

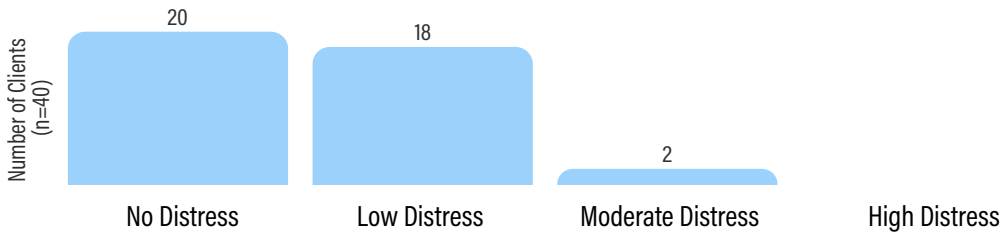
> *[Our groups were] peaceful environments where participants can have fun, build connections, form new friendships, and most importantly, enjoy themselves.* - Staff

> *We play a crucial role in helping clients get out of the house, learn about resources and coping strategies, and make new friends.* - Staff

Key Finding #2: Despite low levels of mental health distress at baseline, emotional benefits were achieved and intersected with gains in social well-being.

Client Perspective | At baseline, 45% of clients reported low distress and 50% reported no distress. This may reflect minimizing, stigma-related under-reporting or may be a true result. Clients were also asked whether they had noticed changes in their emotions since starting Raahat services, using a 5-point scale from 1 ("large negative change") to 5 ("large positive change"). Despite low levels of reported mental health distress at baseline, the average response was 4.16, indicating a "moderate positive change" in mental well-being. Most clients maintained self-reported positive mental health or improvement from baseline to follow-up.

Figure 1. Reported Mental Health Distress at Baseline



Clients emphasized the following benefits resulting from CVT services: improved self-knowledge, emotional regulation, and coping skills. Clients also emphasized the value of group psychotherapy sessions as social spaces for peer sharing, friendship building, and emotional support, experiences they described as essential to both social and mental well-being.

> *I learned more about myself, how to manage my emotions, and how to stay calm. I was happier in the afternoons on days I talked to them. - Client*

> *We learn skills to manage our emotions and cope with stress. - Client*

> *The program provided an opportunity to talk about our emotions, learn about other women's struggles, gain insights from their experiences, and, overall, a chance to get out and decompress - Client*

Key Finding #3: Services that aimed at fostering social connection and adapting to life in the U.S. were seen as beneficial by staff and clients.

Service Utilization | Notably, clients had more active engagement in group interventions. Specifically, group therapy demonstrated the highest level of engagement, with 96% of clients missing fewer than 10% of sessions, while with individual psychotherapy, 76% of clients missed fewer than 10% of sessions.

Client + Community Perspective | Clients and community members emphasized the role of CVT services in supporting adjustment to life in the U.S. They also suggested that CVT offer additional services related to navigating life in the U.S. including learning the English language, improving financial literacy, and attaining a driver's license.

> *The program has helped me a lot since I moved to the U.S. about six months ago. Adjusting to a new country is always challenging, but the support I've received has made a big difference. - Client*

> *Getting a permit to drive was very difficult.... There should be courses for those who can't read or write, including hands-on training for driving." - Community member*

> *Navigating the differences in culture has been difficult and the program has helped me a lot in that regard to adapt to the new ways of doing things. - Client*

Staff Perspective | Case management was identified by staff as the most beneficial service (mean = 4.40), followed by psychoeducation groups (mean = 4.20), and healthcare navigation (mean =4.20; see Table 3). Staff described psychoeducation groups as reducing cultural shock and social isolation, fostering friendships, and promoting belonging. For case management and healthcare navigation, they highlighted the value of concrete support in a new environment, such as access to housing, food, healthcare, and other essential resources.

Table 3. Staff Observed Benefits of Specific Services

Seen benefits from (n=5):	*From 1 ("Strongly Disagree") to 5 ("Strongly Agree")*		
	Mean	Min	Max
Case Management	4.40	4	5
Psychoeducation Groups	4.20	4	5
Healthcare Navigation	4.20	4	5
Individual Psychotherapy	4.00	3	5

Conclusion

Both clients and staff described substantial emotional benefits from Raahat services. The services identified as most beneficial for mental health and overall well-being were those that seem to have strengthened social connection and supported adaptation to a new socio-cultural environment.

Staff and clients agreed that improvements in social well-being was one of the most important outcomes linked to specific types of CVT programming. Results suggest that social and group-based services may play a key role in fostering emotional well-being, building connection, providing a safe space for peer support, and facilitating cultural adaptation.

Statement about Interpreting Evidence

While results are promising, without a control comparison group it is difficult to determine the role Raahat services played in improving observed changes relative to other factors. Additionally, analysis is based on a subsample of program participants and staff and relied heavily on self-reported data, which may be influenced by recall or social desirability bias.

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Impact of CVT Services on Afghan Clients in Georgia: Mental Health Improvements and Key Insights

Program Description

In August 2021, rising violence in Afghanistan displaced many Afghans, with over 1,500 resettling in Georgia as humanitarian parolees. High rates of PTSD, anxiety, and depression affect this community, and language and cultural barriers often hinder access to care (Qais Alemi, 2023). Effective MHPSS interventions are essential to address exposure to potentially traumatic events and improve well-being among Afghans in Georgia (Shameran Slewa-Younan, 2017).

In Clarkston, Georgia, CVT provides culturally adapted interdisciplinary services to address challenges resulting from the conflict. This includes individual psychotherapy to recently resettled Afghans.
The program aims to reduce mental health symptoms and improve wellbeing and coping skills among Afghan conflict survivors. The anticipated outcomes and impacts are:

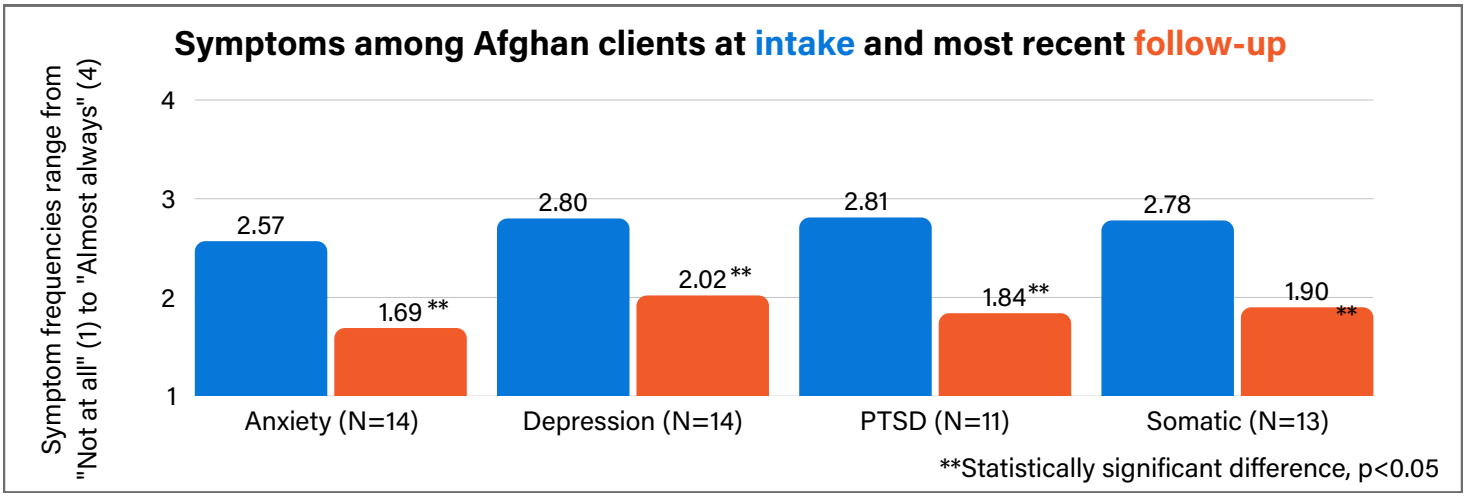
- Reduction in PTSD, depression, and anxiety symptoms and somatic issues
- Improved psychosocial functioning

Evidence Collected

Data were collected between May 2023 and February 2025 through pre- and post-intervention assessments using standardized psychological measures, including the Posttraumatic Stress Diagnostic Scale (PDS) and the Hopkins Symptom Checklist-25 (HSCL-25). Clients are contacted for a follow-up assessment every 6 months while they participate in services. Data reported here compare symptom levels at intake to symptom levels at each client's most recent follow-up assessment.^ As data collection is ongoing, this brief may be updated in the future.

Interpretation of Evidence

- **Key Findings:**
  - Clients showed a statistically significant reduction in mental health symptoms after initiating psychotherapy and other supportive services with CVT.



^ Most of the data in this analysis (for 9 of 14 clients) comes from a 6-month assessment. For three clients, 12-month assessment data was used, and for two clients, data from a 3-month assessment (which is no longer collected).

As shown in the preceding chart, pre-post data indicate a significant reduction in mental health symptoms after the start of CVT individual psychotherapy and associated services. Specifically, clients reported marked statistically significant decreases in all symptom areas, with the largest decreases in post-traumatic stress and somatic symptoms.

At the time of this analysis, 58 clients had received individual psychotherapy. Among them, 48 had reached the six-month timepoint, 14 of whom provided follow-up data, resulting in a response rate of 29%.

Impact in Clients' Own Words

Between September 2023 and January 2025, CVT conducted a survey with Afghan clients in Georgia focused on service experience. Of 17 respondents (out of 23 contacted, for a response rate of 74%), 94% reported agreement with treatment goals, and indicated improvements in physical health, mental health, and/or mood since start of services. See illustrative quotes below:

"Remembering my therapist's words during work helped me calm down when I was feeling angry. I wish we had such clinics ... where I lived before. That would have helped a lot of people."

"I am doing much better, and I am happy with the help I have received from staff at CVT."

"My therapist asks me questions and we discuss what I want to focus on."

Conclusion

Based on pre-post data, follow-up respondents report significant reduction in mental health symptoms after starting to receive individual therapy and related services from CVT. Specifically, significant reductions are reported in symptoms of depression, post-traumatic stress, anxiety, and somatic concerns.

The evidence suggests the culturally adapted integrated mental health services CVT provides may play an important role in supporting mental health and wellbeing among Afghan community members in Georgia.

Statement about Interpreting Evidence

While results are promising, without a control comparison group it is difficult to determine the role CVT services played in reducing symptoms relative to other factors. Additionally, analysis is based on a subsample (29%) of those who participated in services and were able to be reached during follow ups conducted 3, 6, or 12 months after service initiation (noting the 3-month follow-up is no longer administered).

A bias analysis of clients who received follow up assessments vs. those who did not revealed that clients who got at least one follow-up assessment were, to statistically significant levels, slightly older than those who did not (43 vs. 31) and had higher PTSD symptoms at intake (average of 2.9 vs. 2.4). The two groups did not differ significantly by gender; immigration status; time in the U.S.; personal exposure to conflict, war, or combat; or other intake symptom levels.

The limited follow-up response rate as well as the profile of who participates in follow-up assessments is related to clients closing out of services with CVT, which happens for a variety of reasons, or being challenging to reach for a follow-up conversation outside of normal service receipt.

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Annex 3. Survivor of Torture Psychosocial Well-being Index- Short (SOT-PWI-S)

Area of Need	***Levels of Need***			
	(1) In Crisis	**(2) Vulnerable**	**(3) Stable**	**(4) Safe**
Housing	Client: • Is homeless; • Describes home environment as unsafe, unsanitary or unhealthy.	Client: • Reports housing is available but undesirable and/ or short-term; • Feels uncomfortable with current housing situation; • Provides a service of significantly greater value than provided room and board.	Client: • Reports housing is decent but short-term; • Provides a service of equal or lesser value than provided room and board.	Client: • Reports housing is decent and long-term; • Has personal resources or means to maintain housing.
Physical Health	Client • Is unable to manage serious physical health needs; • Reports daily functioning is impaired by chronic illness or disease; • Reports untreated life-threatening chronic illness or disease.	Client: • Is inconsistent in managing physical health needs; • Reports untreated but curable condition, chronic illness, or disease.	Client: • Is able to manage physical health needs with support; • Is receiving medical care to stabilize or cure a condition, chronic illness or disease.	Client: • Reports good physical health; • Reports illness or disease does not impair daily functioning.
Mental Health	Client:	Client:	Client:	Client:

	• Demonstrates pattern of severe emotional instability or violence against self or others; • Reports inability to care for self or family due to current mental health challenges; • Communicates plan, intent, and/or access to means that present clear risk of harm to self or others.	• Describes occasional bouts of emotional instability and/or threatening behavior toward self or others; • Reports decreased capacity to care for self or family due to current mental health challenges; • Reports some form of suicidal ideation but denies plan, intent, or means.	• Demonstrates coping skills that help but do not fully resolve current mental health challenges; • Is mostly able to care for self or family with support; • Is currently receiving treatment from a mental health professional.	• Describes regular involvement in activities that bring them purpose and pleasure; • Does not report any mental health concerns at this time.
Access to Community Resources	Client: • Is unaware or unable to access community resources.	Client: • Is aware of community resources but reports significant barriers in accessing services; • Is unwilling or unable to make use of available resources.	Client: • Has taken steps toward accessing services; • Reports some service barriers still need to be addressed; • Community resources are limited.	Client: • Can access a full range of services to address unmet needs.

Annex 4. CVT Social Circumstances & Functioning Inventory (CVT-SCFI)

Example introduction: "I'll be asking you a little about your life here in (enter state). Remember there are no right or wrong answers… I just want to know what you think."

Stabilization and Safety

1.

a. Housing Stability
Prompt: Do you have housing that is stable? Where do you sleep? Are you able to pay your rent? Is anyone asking you to leave?

☐ (1) Homeless (e.g., does not know where they will sleep at night)

☐ (2) Unstable housing (e.g., rotates between hosts or shelters)

☐ (3) Somewhat stable housing (e.g., informal or short-term agreements)

☐ (4) Stable housing (e.g., has a formal lease)

b. Housing Safety
Prompt: Do you have housing that is safe? Do you feel safe?

☐ (1) Homeless (does not know where they will sleep at night)

☐ (2) Unsafe housing (e.g., poses safety risks)

☐ (3) Somewhat safe housing (e.g., not supportive of psychological and/or physical wellbeing)

☐ (4) Safe housing

2. Basic Food Needs
Prompts: Do you have enough food to eat? How do you meet this need? How do you buy food? Where do you get food?

☐ (1) Needs are not met at all; has very little access to food

☐ (2) Some needs are met through donation or assistance, but has food needs that are unmet

☐ (3) Needs are met through donation or assistance (includes food stamps, host provision, food from food shelf, gift cards from CVT)

☐ (4) Needs are met without donation or assistance

3. Affording Medical Care outside of CVT

Prompts: How are you paying for medical care when you need it? Do you have health insurance? Where is this insurance from (e.g. from CVT or work?) Are you able to get dental/vision care with that insurance?

☐ (1) Not able to afford medical care (includes the use of the ER without insurance)

☐ (2) Rarely able to afford medical care (e.g., free/sliding fee clinics or out of pocket fees)

☐ (3) Able to afford medical care through public assistance or insurance program

☐ (4) Able to afford medical care through employer health insurance

4. Utilization of Medical Services when needed

Prompts: How often do you access medical care / go to the doctor when you need to?

☐ (1) Never or rarely; will not access medical services when there is a need

☐ (2) Sometimes; will access medical services for urgent medical needs

☐ (3) Frequently; will access medical services for urgent *and* ongoing medical needs

☐ (4) Always; will access medical services whenever there is a medical need, including preventative care

5. Access to Clothing

Prompts: Do you have enough clothes/have the clothes that you need? How do you buy clothes? Where do you receive your clothes?

☐ (1) No access to clothing and has unmet needs for clothing

☐ (2) Some clothing needs are met through assistance/donations but still has unmet needs

☐ (3) Able to meet clothing needs through assistance/donations and/or limited purchases

☐ (4) Able to meet clothing needs through purchases

6. **Transportation**
Prompts: Aside from getting to/from CVT, how do you get where you need to go? How did you get here? How do you get other places? Do you travel with others or by yourself? If you have a place to go, how are you going to get there?

☐ (1) Transport needs largely unmet (e.g., no ability, means or knowledge, random rides from support network with no control over when)
☐ (2) Needs partially met through rides with friends and family (e.g., reliant on others, rides are sometimes available when needed but not consistently)
☐ (3) Uses or can use public transit but needs some assistance from others (e.g., receiving bus passes, consistently receives rides from friends, family, support network)
☐ (4) Able to reliably provide transportation for their needs (includes driving, biking, walking, bus, etc)

7. **Legal Safety**
Prompts: Where are you in the process of receiving immigration status in the US? Have you had an interview or received your decision for asylum? Do you have a green card or are you a citizen? What immigration papers do you have?

☐ (1) Undocumented or deportation pending
☐ (2) Applied for asylum, awaiting interview or decision; and/or holds a temporary status such as DED, TPS, a student visa, or humanitarian parolee
☐ (3) Has asylee or refugee status
☐ (4) Has green card or is a United States citizen

8. **Basic Needs (To what extent do you feel like your basic needs are being met in the way that you prefer? e.g., food, shelter, clothing and transportation)**
Prompts: To what extent do you feel like your basic needs are being met in the way that you prefer (e.g., food, shelter, clothing and transportation)?
Note: Capture "burden" clients might feel. Needs might be "met" but the client might still feel a sense of "burden." E.g. has stable and safe housing, but does not have privacy; host family provides food, but client wants to contribute, etc.

☐ (1) Not at all (feels basic needs are not met at all)
☐ (2) Somewhat (feels some basic needs are met, but has remaining unmet needs)
☐ (3) Mostly (feels basic needs are generally met, but not in the way the client completely prefers – e.g. food needs are met by food shelf but foods they would

like to eat are not available, unable to contribute to host family for meals, etc.)

☐ (4) Completely (feels all basic needs are met in the way they prefer)

9. Self-Advocates to meet basic needs

Prompts: Are you able to ask for help outside CVT for basic needs (e.g., through family and friends, etc.)? Not including anyone at CVT, can you find other services if you need them? Can you find other assistance? For example, if you need a ride, are you able to ask a neighbor, friend, or anyone else for help?

☐ (1) Does not ask for help to meet their needs

☐ (2) Sometimes asks for help to meet their needs

☐ (3) Asks for help to meet their needs whenever needed

☐ (4) Self-sufficiently meets basic needs (rarely needs to advocate to meet their needs)

10. Ability to engage with social service agencies/programs to the degree client needs them

Prompts: ***Other than CVT*****,** who has helped you with finding employment or finding benefits? Are you able to engage with social services *outside CVT* when needed? Are there other agencies that help you? Is anyone helping you find a job or open your mail and fill out forms? Who has given you rides? Who has helped with food and housing?

☐ (1) Not able to engage with social service agencies independent of CVT

☐ (2) Able to engage with agencies with substantial support (e.g. from lawyer, neighbor, child,)

☐ (3) Able to engage with agencies with limited support

☐ (4) Able to independently engage with agencies

☐ (5) Never or rarely needs to engage with agencies outside CVT

Stabilization and Safety Notes:

Education and Employment

11. English Proficiency (How well do you speak English?)

Prompts: What is your English level? Can you speak a bit of English?

☐ (1) None to very little (may know "hello," "thank you," etc.)

☐ (2) Knows basic conversational phrases, but still has trouble speaking or comprehending

☐ (3) Proficient enough for daily life functions (e.g., can make a doctor's appt. or ask for help on the bus)

☐ (4) Fluent (e.g., functions regularly in English; describes self as fluent)

12. Seeking English Proficiency

Prompts: How interested are you in learning English? What efforts are you making to learn English? Do you attend ELL classes? Are you taking English classes? How often?

☐ (1) Not interested/not able to learn English at this time (e.g., focusing on basic needs first, challenges with memory)

☐ (2) Some effort seeking ELL opportunities

☐ (3) Trying to learn English informally (e.g., book from the library, watching TV, app)

☐ (4) Currently enrolled in formal language learning (e.g., ELL classes, working with tutors)

☐ (5) N/A – client defines self as fluent

13. Seeking educational opportunities (other than ELL)

Prompts: How interested are you in exploring or enrolling in educational opportunities in the US? Do you want to have more education in the United States, other than English classes? What steps are you doing to make this possible if you want to do this?

☐ (1) Not interested in learning about or enrolling in educational opportunities **(Skip to #15)**

☐ (2) Interested in learning about educational opportunities

☐ (3) Enrolled in an education program and participating

☐ (4) Graduation/completion imminent or has already graduated / completed

14. Access to educational opportunities (other than ELL)

Prompts: Are you able to participate in educational activities or find educational resources (e.g., visiting a library; independent studying; attending classes)?

☐ (1) No access to educational activities or resources

☐ (2) Occasionally accesses educational activities or resources (e.g., once per month or less)

☐ (3) Often accesses educational activities or resources (e.g., 2-4 times per month)

☐ (4) Regularly accesses education activities or resources (e.g., once a week or more)

☐ (5) N/A

15. Work Authorization (Where are you in the process of getting permission to work in the US?)

Prompts: Do you have a work permit? Are you eligible to work in the US?

☐ (1) No work authorization. **(Skip to #17)**

☐ (2) Authorization is pending (e.g., client is in mandatory waiting period or has applied for EAD and is awaiting receipt of permit)

☐ (3) Has had work authorization and is pending renewal

☐ (4) Has work authorization

16. Employment status - Stability

Prompts: How would you describe your job/s?

☐ (1) Not employed but hopes to be (e.g. work authorization pending, unemployed but searching and applying for jobs, etc.)

☐ (2) Employed part-time (e.g. works up to 39 hours per week)

☐ (3) Employed and works at least 40 hours a week, but by holding multiple part-time jobs

☐ (4) Client has a stable, full-time position

☐ (5) Not employed but does not want to be at this time (e.g. seniors, unable to work due to disability, works in the home, full-time students, etc.)

17. Access to job training opportunities

Prompts: Are you able to participate in job training opportunities (e.g., early employment training or counseling; volunteering at an organization)? If employed, are you interested in job training opportunities to switch careers?

☐ (1) No access to job training opportunities (e.g. interested but cannot attend at this time due to transportation, childcare challenges, etc. or does not have information/resources needed)

☐ (2) Occasionally accesses job training opportunities (e.g., once a month or less)

☐ (3) Often accesses job training opportunities (e.g., 2-4 times per month)

☐ (4) Regularly accesses job training opportunities (e.g., once a week or more)

☐ (5) Does not want access at this time

Education and Employment Notes:

Faith and Spirituality

We like to ask questions around faith and spirituality because we know this can be very important for some of our clients, and for others not at all. There is no right or wrong answer to these questions.

18. Do you have faith in a higher power?

☐ (1) Yes

☐ (2) No **(skip to #22)**

19. Attendance at faith, spiritual or healing services

Prompts: How often do you attend any worship, prayer or healing services in the community?

☐ (1) Never attends services

☐ (2) Rarely attends (less than once a month)

☐ (3) Sometimes attends (once per month)

☐ (4) Regularly attends (two or more times per month)

☐ (5) N/A

20. Engages in individual spiritual beliefs, rituals or practices

Prompts: How often do you engage in the rituals and practices related to your beliefs on faith or spirituality (e.g., pray, meditate, worship, read)?

☐ (1) Never engages

☐ (2) Engages once a month

☐ (3) Engages once a week

☐ (4) Engages daily

☐ (5) N/A

21. Beliefs on faith and spirituality as a source of strength

Prompt: What role do beliefs on faith or spirituality have in your life? Are these beliefs a source of strength to you? Is your faith as something that helps you get through the day or is a source of strength?

☐ (1) Blames beliefs on faith or spirituality for traumatic experience(s)

☐ (2) Ambivalent about beliefs on faith or spirituality

☐ (3) Beliefs on faith and spirituality are a source of strength

☐ (4) Beliefs on faith and spirituality are the greatest source of strength

☐ (5) N/A

Faith and Spirituality Notes:

Adjustment to New Culture and Community

22. Engagement in learning about the host culture

Prompts: How engaged are you with current events in the U.S. (e.g., current events; local state or U.S. news; state of U.S. politics)? What do you know about what is going on in the Twin Cities, the state of Minnesota, and the United States? How do you find out about the news? Where do you find out about the news?

☐ (1) Does not have interest, is avoidant, or does not have the ability to learn about the host culture

☐ (2) Ambivalent about learning about the host culture (or lack of access to learn more about greater community)

☐ (3) Sometimes seeks to learn about the host culture (less than once a month)

☐ (4) Regularly seeks to learn about the host culture (more than once a month)

23. Engages in activities for wellbeing

Prompts: What types of activities do you engage in for wellbeing (e.g., watching a movie, take a walk outside, being outdoors)?

☐ (1) No interest or participation in activities for your own wellbeing

☐ (2) Ambivalent about participating in activities for your own wellbeing

☐ (3) Sometimes engages in activities for your own wellbeing (more than once a month)

☐ (4) Regularly engages in activities for your own wellbeing (more than once a week)

24. Engages in activities and events

Prompts: In the community, what types of activities do you engage in (e.g., shopping, going to the park, gym membership, library outings, museums)?

☐ (1) Never participates in such activities (including no interest or no access)

☐ (2) Sometimes participates in such activities (e.g., once a month or less)

☐ (3) Regularly participates in such activities (e.g., 2-4 times per month)

☐ (4) Frequently participates in such activities (e.g., more than once a week)

Adjustment to New Culture & Community Notes:

Social Connections with Friends and Family

25. Social connections outside of family

Prompts: How would you describe your current friendships outside of family? Do you have strong relationships with people you spend time with outside of family (e.g., friends, neighbors, coworkers)? How often do you spend time/talk with your friends? Do you feel as though your friends are supportive to you? Do you spend time with anyone outside of your family? If you do, how would you rate this relationship—is this someone you spend time with regularly and can trust?

☐ (1) Has no support outside of their family

☐ (2) Has little support outside of their family

☐ (3) Has moderate support outside of their family

☐ (4) Has strong support outside of their family

26. Communications with family members

Prompts: How often do you talk to your family members? Do you have communication with your family members? Who? How often do you communicate with your family members?

Note: Acknowledge that this can be a difficult topic and it's ok if they don't want to discuss. This should be immediate family; clarify if necessary.

☐ (1) No communication with family members (e.g., none)

☐ (2) Occasional interaction with family members (e.g., less than 6 times a year)

☐ (3) Has communications regularly (e.g., approximately 1-2 times per month)

☐ (4) Has communications on a frequent and regular basis (e.g., at least once a week)

☐ (5) No immediate family to be in contact with **(skip to #29)**

27. Felt connection to family

Prompts: How would you describe your relationship with your family? How much emotional support do you have from family members? How do you feel your connections are with other members of your family? Do you have contact with your family? Do you have strong relationships with your family members?

☐ (1) No sense of connection to family or possibility to connect in the future

☐ (2) Disconnected from family (e.g., divorce, ongoing conflict)

☐ (3) Connected to family, but with tensions (e.g., with role expectations and family duties)

☐ (4) Stable connections and supportive family environment

28. Reunification with family members

Prompts: Do you plan on reunifying with your family (spouses or children under 21 years only)? Is your family here with you in the United States? If not, have you started a process to re-unify with them? What is this process and who is helping you with this process?

☐ (1) No chance of being reunited in foreseeable future (e.g., asylum application process has not yet begun or has no plans to apply)

☐ (2) Low chance of being reunited (e.g., asylum application is pending)

☐ (3) Formal re-unification process has been initiated, but have not heard back

☐ (4) United with majority or all of family in the US

☐ (5) N/A (no "immediate" family (i.e., spouse or child(ren) under 21 years) to be reunited with)

Social Connections with Friends & Family Notes:

Community Service and Trust

29. Trust of others

Prompts: How do you describe your trust of others that you interact with in the community? How many people in your life would you tell important information to? Do you believe that people are more likely to harm or to help you when you are out in public?

Note: If only CVT and / or other professional staff indicate "2". Sometimes participants will identify people they don't trust that fall under "street smarts" than general distrust. If these are the only examples provided of distrust, score as 4.

☐ (1) Distrusts all others

☐ (2) Able to identify one or two people they trust

☐ (3) Some trust of others (e.g., cautious in giving trust)

☐ (4) General trust of others

30. Participates in social interactions

Prompts: What type of social activities do you participate in? How often do you participate in these types of events? e.g., chat with friends, drinking tea with others)?

☐ (1) Never

☐ (2) Rarely (e.g., less than once a month)

☐ (3) Sometimes (e.g., at least monthly)

☐ (4) Frequently (e.g., at least weekly)

31. Participates in larger social events

Prompts: What type of community events do you participate in? How often do you participate in these types of events? e.g., such as weddings, funerals, birthdays, festivals, religious commemorations / celebrations, etc.?)

☐ (1) Never

☐ (2) Rarely (i.e., 1-2 times a year)

☐ (3) Sometimes (i.e., more than twice a year)

☐ (4) Frequently (i.e., at least once a month)

32. Attendance at meetings, gatherings or demonstrations about political or community issues

Prompts: Do you attend political, community/neighborhood or school meetings?

☐ (1) Does not attend
☐ (2) Rarely attends (less than two times per year)
☐ (3) Occasionally attends (two or more times per year)
☐ (4) Frequently attends (more than once per month)
☐ (5) Not interested in attending

33. Community service

Prompts: We like to ask questions related to community service because we know this can be very important for some of our clients, and for others not at all. There is no right or wrong answer to these questions. Do you spend time serving in the community (e.g., helping at an organization, group, church, or home)

☐ (1) Does not serve in the community
☐ (2) Rarely serves in the community (less than twice a year)
☐ (3) Occasionally serves in the community (less than once per month)
☐ (4) Regularly serves in the community (more than once per month)
☐ (5) Not interested in serving

Community Service & Trust Notes:

Annex 5. Adapted Posttraumatic Diagnostic Scale (PDS-V)

Intro Script:
We are going to move on to a new set of questions. These questions are all about symptoms that people sometimes have after living through a bad or traumatic event. As you think of a bad experience that you may have had, you can tell me how often these symptoms may have bothered you in the last month. This is a little different than the last questions, in which asked you to think about the past week. Now we are going to think about the past month. A month is a long time, so you can do your best to remember.

Interviewer key for making assessments:
Not at all: No times per month or only one time
Rarely: Once in a while or several times per month
Sometimes: Half the time over a month
Almost always: Often or many times during the month

How often in the last month have you:	Not at all	Rarely	Some times	Almost always
1. Unwanted upsetting memories about the trauma *Prompts:* Pictures of thoughts in your mind when you don't want them; images, thoughts, or perceptions (not so much FEELINGS). Memories from the past that come back on their own.	☐	☐	☐	☐
2. Bad dreams or nightmares related to the trauma *Prompts:* Dreaming about your experience while asleep. Having a bad dream or nightmare or nightmare that is about the past.	☐	☐	☐	☐
3. Reliving the traumatic event or feeling as if it were actually happening again *Prompts:* Experiencing as if you are really there—back in the specific location; a memory that is so real that you feel you are back in the place where the bad thing happened and you forget you are here; experiencing illusions, hallucinations, dissociative flashbacks. **NOTE:** Ensure that the interpreter/participant is not answering the question in a way that suggests he/she believes that the exact same thing that happened to them is apt to happen to them again. Rather, the question is more about a feeling of being transported back into the situation and feeling symptoms from that.	☐	☐	☐	☐

	Not at all	Rarely	Some times	Almost always
4. Feeling very emotionally upset when reminded of the trauma *Prompts:* Feeling bad when you are remembering bad things that happened (for example you have the memory and then you feel worried, scared, angry, or sad).	☐	☐	☐	☐
5. Having physical reactions when reminded of the trauma *Prompts:* You remember the bad experience and then you feel things in your body, like sweating, fast heartbeat, or a headache.	☐	☐	☐	☐
6. Trying to avoid thoughts or feelings related to the trauma *Prompts:* You don't want to think about it, you try not to let it in your heart **NOTE:** This question can be difficult for participants to understand. Another way to phrase this is:" When the bad experience comes into your mind, how often are you trying to keep the thoughts out of your mind." Clients often respond, "I try, but the thoughts come by themselves"	☐	☐	☐	☐
7. Trying to avoid activities, places, or people that remind you of the bad experience. *Prompts:* For example, trying to stay away from people who will want to talk about the bad things that happened in the past; avoiding tv programs with violence or guns	☐	☐	☐	☐
8. Not being able to remember an important part of the bad experience. *Prompts:* For example – you have a memory of what happened in the past, but for some reason part of that memory is lost, you remember what happened to you, but for some reason you can't remember the details, like what day it was or who was there; the memory is unclear **NOTE:** This is not necessarily about having a bad memory, per se (many participants may say that they are forgetful), but more about not being able to remember important parts of this specific experience.	☐	☐	☐	☐

	Not at all	Rarely	Some times	Almost always
9. Losing interest in activities you used to do *Prompts:* No interest in doing things; saying no to invitations; no interest in work, school, hobbies (name some specifics… this question is a little abstract for Karen thinking) **NOTE:** Often clients will answer no to this question. It is important that you clarify whether no means no interest or no, this is not a problem.	☐	☐	☐	☐
10. Feeling distant or cut off from people around you. *Prompts:* feeling like a stranger, detached. Feeling far away or don't want to be with other people, just want to be alone.	☐	☐	☐	☐
11. Having difficulty experiencing positive feelings *Prompts:* Feeling like you want to cry but you can't; having no feelings; having no emotions	☐	☐	☐	☐
12. Having trouble falling or staying asleep *Prompts:* insomnia, going to sleep and waking up and not being able to fall back to sleep. How many hours of sleep do you get each evening? How many times do you wake up during the evening? Hard time sleeping—can't sleep. **NOTE**: Be sure to distinguish that even though this was discussed previously, you are now referring to the last month and not the last week.	☐	☐	☐	☐
13. Acting more irritable or aggressive with others *Prompts:* Every little thing makes you angry, easily annoyed, little things that used to not bother you are now bothersome; you may suddenly burst in to anger.	☐	☐	☐	☐

	Not at all	Rarely	Some times	Almost always
14. Having difficulty concentrating *Prompts:* for example, it's hard to pay attention during a conversation because your mind is distracted by other thoughts, losing track of a story on television, like it's hard to listen, like information doesn't go through your ears, forgetting what you read)	☐	☐	☐	☐
15. Being overtly alert or on-guard *Prompts:* you may be walking somewhere and frequently checking to see who is behind you, always looking around the apartment to see if someone is there	☐	☐	☐	☐
16. Being jumpy or easily startled *Prompts:* You may respond jumpily to the phone ringing or the door shutting, to someone touching you, or have an exaggerated startle response. Easily shocked or surprised, for example, when someone comes behind you.	☐	☐	☐	☐
17. Seeing yourself, others, or the world in a more negative way *Prompts:* When you think of your life or the future, do you believe that those things are more likely to be bad or good? When you are getting news (such as results from a doctor or teacher) do you expect it will be bad?	☐	☐	☐	☐
18. Blaming yourself or others (besides the person who hurt you) for what happened *Prompts:* Feel like things are your fault/result of your behavior, feel guilty, feel as though you have failure that caused things, have an exaggerated sense of responsibility, and blame yourself. Blame others for bad things that have happened, have an exaggerated sense of other's responsibility in the matter.	☐	☐	☐	☐

	Not at all	Rarely	Some times	Almost always
19. Having intense negative feelings like fear, horror, anger, guilt, or shame *Prompts:* I often ask “In your mind, heart, or body?”	☐	☐	☐	☐
20. Taking more risks or doing things that might cause you or others harm *Prompts:* Example, crossing the road without looking or caring that cars are coming. Knowing that something is dangerous, but just not caring about the risk involved.	☐	☐	☐	☐

Intake Only:

How long have you experienced the problems that you reported above?

☐ Less than 1 year
☐ 1 to 2 years
☐ 3 to 5 years
☐ More than 5 years

How long after the trauma did these problems begin?

☐ Less than 1 month
☐ 1 to 6 months
☐ 7 to 12 months
☐ More than 12 months

Annex 6. Adapted Hopkins Symptoms Checklist (HSCL-25)

Example introduction script:
Sometimes living through difficult life experiences can cause emotional pain, even many years later. I'd like to ask you about some thoughts and feelings that you might be having because of the things that you've lived through.

Each question is about a symptom or a problem that people sometimes have. I will ask you each question one by one. You can first decide whether or not the symptom has bothered you. Then decide how often it has bothered you in the last week. Again, just do your best to remember. Maybe the problem bothered you not at all, rarely, sometimes, or often.

Interviewer key for making assessments:
Not at all: No times per week or only one time
Rarely: Once in a while or 1-2 times/week
Sometimes: Half the time or 2-4 times in a week
Almost Always: Almost always or 5+ times per week

How often in the last week have you:	Not at all	Rarely	Some times	Almost always
1. Felt suddenly scared for no reason. *Prompts:* All of the sudden you are afraid and you don't know where the feeling came from.	☐	☐	☐	☐
2. Feeling fearful *Prompts:* Feeling afraid, feeling as though something is very scary	☐	☐	☐	☐
3. Faintness, dizziness, weakness *Prompts:* Feeling as though you may pass out or that you are spinning in circles or are generally feeling weak (without strength), light dizzy/really dizzy	☐	☐	☐	☐
4. Nervousness or shakiness inside *Prompts:* shaky heart, feeling anxious, feeling unsettled inside	☐	☐	☐	☐

	Not at all	Rarely	Some times	Almost always
5. Heart pounding or racing: *Prompts:* Can you feel your heart beating, do you feel your heart pounding very fast, heart is being shaken, (participants also respond to motion and sound of heart pounding like "too too too too")	☐	☐	☐	☐
6. Trembling *Prompts:* Shaking on the outside of the body (in your hands, for example – show shaking hands)	☐	☐	☐	☐
7. Feeling tense *Prompts:* Feeling sore or tight muscles, like in your neck, shoulders, or back; feeling of being on the edge.	☐	☐	☐	☐
8. Headaches *Prompts:* head pain	☐	☐	☐	☐
9. Spells of terror or panic *Prompts:* suddenly extremely fearful, very afraid, client describes symptoms of panic attack	☐	☐	☐	☐
10. Feeling restless, can't sit still *Prompts:* You may find it hard to sit in a chair and may want to get up and walk around, don't want to sit still, very active, lack of focus, need to move around	☐	☐	☐	☐

Anxiety Notes:

How often in the last week have you:	Not at all	Rarely	Some times	Almost always
1. Feeling low in energy or very slowed down *Prompts:* Feeling as though you have no energy, hard to get things done, slowed speech, thinking or body movements, sustained fatigue without physical exertion, and lack of energy	☐	☐	☐	☐
2. Blaming yourself for things Prompts: Feel like things are your fault/result of your behavior, feel guilty, feel as though you have failure that caused things, have an exaggerated sense of responsibility, and blame yourself.	☐	☐	☐	☐
3. Cry easily Prompts: crying a lot, tearfulness, feeling as though crying is uncontrollable, cries easily	☐	☐	☐	☐
4. Poor appetite Prompts: don't feel like eating, have to make/force yourself to eat, poor appetite, feeling like you're eating too much?	☐	☐	☐	☐
5. Difficulty falling asleep/staying asleep Prompts: how many hours of sleep are you getting each night?, How many times do you wake up each night?, Can you fall back to sleep after waking up?, What are your sleep patterns?, insomnia, can't go back to sleep	☐	☐	☐	☐
6. Feeling sad Prompts: heavy heart, low, down, sad	☐	☐	☐	☐

	Not at all	Rarely	Some times	Almost always
7. Feeling lonely Prompts: Feeling very alone, loneliness	☐	☐	☐	☐
8. Feelings of being trapped or caught Prompts: feeling stuck in your situation like you can't move forward, feeling frustrated, feeling like you can't escape (like an animal in a trap, for example)	☐	☐	☐	☐
9. Worrying too much about things Prompts: fretting/anxiety, too much worry; give examples of worries such as kids, bills, job	☐	☐	☐	☐
10. Feeling no interest in things *Prompts:* you don't want to do anything, things you used to enjoy you don't enjoy anymore, don't want to get out of bed **NOTE:** Often clients will answer no to this question. It is important that you clarify whether no means no interest or no, this is not a problem.	☐	☐	☐	☐
11. Loss of sexual interest or pleasure *Prompts:* We ask all clients this question, but it can sometimes make people feel uncomfortable and you don't have to answer if it makes you feel that way. Sometimes people lose interest in sex when they feel down or sad. Have you had this experience in the past week? **NOTE:** Some clients may respond with statements about not having sexual interest due to advanced age or having a spouse/partner who does not live near/is deceased and "not thinking about sex at all." Include in notes section and score as "not at all" if client does not identify this as a symptom of depression. Other clients might share they are not	☐	☐	☐	☐

sexually active and that they don't think about sex. This can be included in notes and scored as "not at all."				
	Not at all	Rarely	Some times	Almost always
12. Feeling like everything is an effort *Prompts:* You have to try just to get out of bed or to eat or do anything, tasks like getting out of bed or taking a shower feel like a lot of extra work, everything becomes hard work	☐	☐	☐	☐
13. Feelings of worthlessness *Prompts:* life has no value, you are not worthy as a person, you don't feel good enough				
14. Feeling hopeless about the future *Prompts:* Nothing to look forward to, feelings as though nothing will work out well, no hope for the future	☐	☐	☐	☐
15. Thoughts of ending your life **NOTE:** If client reports yes, assess for suicidal ideation and follow crisis plan, as needed.	☐	☐	☐	☐

Depression Notes:

Annex 7. Somatic Symptom Scale

Intro Script:
Okay, now I'd like to ask you a few more questions about some physical symptoms that you may have been having in your body. These questions will refer to just the last week including today.

Interviewer key for making assessments:
Not at all: No times per week or only one time
Rarely: Once in a while or one-two times per week
Sometimes: Half the time or 2-4 times in a week
Almost always: Often or 5+ times in a week

How often in the last week have you:	Not at all	Rarely	Some times	Almost always
1. Do you have headaches? *Prompts*: Does your head hurt? Pressure in your head. **NOTE:** Because we have already asked this question earlier, but because it is important to ask every question independently for research purposes, I usually will say "Can you remind me how often you've had headaches in the last week?"	☐	☐	☐	☐
2. Do you have stomach aches? *Prompts*: Does your stomach hurt or feel queasy?	☐	☐	☐	☐
3. Do you have pain in other parts of your body? *Prompts*: Do other parts of your body hurt (example, arms, legs, back)? Are other areas of your body in pain? Do you ever have achiness in your body? **NOTE:** Take notes about other somatic complaints at the bottom of the measure	☐	☐	☐	☐
4. Do you have dizziness/faintness? *Prompts*: Do you feel like you are spinning in circles or that you may pass out? Do you ever feel light dizziness or dizziness?	☐	☐	☐	☐
5. Do you feel weak? *Prompts:* Do you feel like your strength is gone? Do you feel like it takes much energy and effort to do things? Do you ever feel that your body is lacking of energy?	☐	☐	☐	☐

Annex 8. Client Focus Group Questions

1. General Access
    - How did you first hear about program services offered by CVT?

2. Mental/Emotional Well-being
    - Since starting services, have you noticed any changes in your emotional/mental well-being? If yes, what changes did you notice?
    - Since joining the program, have you seen any changes in your social life (e.g., making friends or spending more time with friends or family)? If yes, what changes?
    - Were the topics discussed in the program relevant to your life and experiences? What other topics do you think should have been discussed?
    - Sometimes, people may feel unsure about seeking or talking about mental health support. Do you feel more open or comfortable now talking about emotional well-being compared to before joining the program?
    - Do you think the community members need more services to help with mental and emotional well-being?

3. Cultural, Language, and Accessibility
    - Was it easy or difficult to access services? What made it easier or harder?
    - Is the transportation convenient for you?
    - Did you receive information in your preferred language? Is interpretation available and works as well as you expect?
    - Would you prefer services in person or on phone/Zoom?

4. Service Experience and Feedback
    - Overall, how satisfied are you with the services you received?
    - How can the program change to serve you better?
    - Are there services that you wish we offered that we currently don’t?
    - Would you recommend our services to a family or friend?
    - Do you have any other thoughts that you would like to share?

Annex 9. Client Satisfaction Survey

Administration Date*

_____

Client ID*

_____

1) Active or Closed client [don't ask, document from records]
( ) Active
( ) Closed

Do not ask client - complete from client list data.
How long have you been coming to Raahat?*
( ) Less than 3 months
( ) 3-6 months
( ) 7-9 months
( ) 10-12 months
( ) 13-18 months
( ) 19-24 months
( ) 25-36 months
( ) 37-48 months
( ) 49-60 months
( ) 61-72 months

Do not ask client - complete from client list data.
What services are you currently receiving from Raahat?*
[ ] Social services only
[ ] Individual therapy only
[ ] Group only
[ ] Community programs only
[ ] Combined SW/MH services

At times we use quotes from clients when sharing about CVT services. We will not use quotes that could identify you. You can still participate in the survey, even if you don't want us to quote you.
Are you willing to allow us to quote you? *
( ) Yes
( ) No

2) Since starting services with Raahat, have you noticed changes in your emotions? (e.g., feeling more or less sad, more or less calm, more or less happiness)
( ) Large Positive Change
( ) Small Positive Change
( ) No Change
( ) Small Negative Change
( ) Large Negative Change

Qualitative notes
Follow up questions:

Can you tell me more about that change in your emotions?
Do you think the Raahat program influenced that change in your emotions? if so, how? (if not, what did influence that change?)
When did you start to notice the change in your emotions?
How has that change in your emotions impacted your daily life?

_____
_____
_____
_____

3) Since starting services with Raahat, have you noticed changes in your overall physical health? (e.g., any health conditions you experience, common conditions might include changes in amount of pain, headaches, stomach issues, management of chronic conditions, fatigue, etc.)

( ) Large Positive Change
( ) Small Positive Change
( ) No Change
( ) Small Negative Change
( ) Large Negative Change

Qualitative notes
Follow up questions:

Can you tell me more about that change in your physical health?
Do you think the Raahat program influenced that change in your physical health? if so, how so? (if not, what did influence that change?)
When did you start to notice the change in your physical health?
How has that change in your physical health impacted your daily life?

_____
_____
_____
_____

4) Since starting services with Raahat, have you noticed changes in your <u>social life</u>? (e.g., going out of the house for leisure, meeting up with friends and family, attending religious services, if applicable)

( ) Large Positive Change
( ) Small Positive Change
( ) No Change
( ) Small Negative Change
( ) Large Negative Change

Qualitative notes
Follow up questions:

Can you tell me more about that change in your social life / activities?
Do you think the Raahat program influenced that change in your social life / activities? if so, how so? (if not, what did influence that change?)
When did you start to notice the change in your social life / activities?
How has that change in your social life / activities impacted you?

_____
_____
_____
_____

5) What other ways do you feel Raahat has impact you and your wellbeing?

_____
_____
_____
_____

6) Only for clients who are closed to services (no longer a CVT client).
Can you tell me about your decision to end services with Raahat? (e.g., Did you and your provide decide together to end services? Did you no longer want to continue services? If so, would you like to share why you exited the program?)

Note to interviewer: emphasize that they can share any reason for ending services and that we want to learn from their experience so we can improve.

_____
_____
_____
_____

7) Is it easy for you to meet with Raahat providers on zoom or by phone or in-person?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
What makes it difficult to meet on zoom or by phone or in person?

_____
_____
_____
_____

8) Are appointments available at times that work well for you?
Probe: Are there days or times that you would prefer to meet with your providers that aren't available at the moment?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
What makes it difficult to schedule appointments?
_____
_____
_____
_____

9) Do Raahat staff respond quickly to your needs?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
Can you tell me more about that?
_____
_____
_____
_____

10) Can you speak freely with your providers to make your own decisions about Raahat services?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
Can you tell me more about that?
_____
_____
_____
_____

11) Were service options here (Raahat) explained in the language that you prefer?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
Can you tell me more about that?

_____
_____
_____
_____

12) Do you know what your goals are for your treatment at Raahat?
( ) No
( ) Yes
( ) Not sure

13) Do you agree with the goals in your treatment plan?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
Can you tell me more about that?

_____
_____
_____
_____

14) Do staff show respect of your culture and beliefs?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
Can you tell me more about that?

_____
_____
_____
_____

15) Do staff members show respect of your privacy (e.g., no one else is there, trust staff won't share information without permission)?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
Can you tell me more about that?

_____
_____
_____
_____

16) Do you feel safe during your appointments?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
How can we help you feel safe during your appointments?

_____
_____
_____
_____

17) Do you think the clinic staff (for example: therapist, social worker, nurse) work together well to care for your needs?
( ) No
( ) Yes
( ) Sometimes
( ) Don't know

Follow up if answers No (0) or sometimes (2):
How can clinic staff work together better to meet your needs?

_____
_____
_____
_____

18) Would you recommend Raahat to a family member or friend?
( ) No
( ) Yes
( ) Sometimes

Follow up if answers No (0) or sometimes (2):
Can you tell me more about that?

_____
_____
_____
_____

19) Have you come into the office to meet with Raahat clinicians before (in-person sessions)?
( ) Yes
( ) No

20) Would you prefer to have therapy sessions by Zoom/Telephone, or in person?
( ) Zoom/Telephone
( ) In-person
( ) Both

21) Would you prefer to have social services sessions by Zoom/Telephone, or in person?
( ) Zoom/Telephone
( ) In-person
( ) Both

22) Do you feel strongly about your preference (Zoom/Telephone, in person, or both)?
( ) No
( ) Yes
( ) Sometimes

23) Do you like virtual sessions (zoom or phone) better / the same / worse than in-person sessions (in the office)?
( ) Virtual sessions are BETTER than in-person
( ) Virtual sessions are THE SAME as in-person
( ) Virtual sessions are WORSE than in-person

24) Can you tell me more about why you prefer (location identified above)? What is better, worse, or the same about meeting on zoom or phone?
_____
_____
_____

25) Are you a parent/caregiver to a child 18 years old or younger?
( ) Yes - parent
( ) Yes - grandparent
( ) Yes - other - write-in: _____*
( ) No

26) CVT is considering expanding to offer family/child services for individuals in the U.S. and/or parenting groups for those who are separated from their children under 18. **Is this something that you/your family would be interested in?**
( ) Yes
( ) No
( ) Maybe

27) If yes, how old is/are your child/children?
[ ] 0-4
[ ] 5-9
[ ] 10-13
[ ] 14-17

28) If yes, do/does your child/children live with you currently?
( ) Yes
( ) No
( ) Some, but not all

29) What types of family or child services would you be interested in? Possible options might include individual therapy or group therapy for children in the US, or parenting groups for parents of children in the US and for those who are separated from their children.

_____
_____
_____
_____

30) Are there services that you wish Raahat offered that we currently don't?

_____
_____
_____
_____

31) Do you have any other thoughts that you'd like to share? (for example: problems you have had with CVT, or ways that we can improve how we meet your needs?)

_____
_____
_____
_____

Thank You!

Annex 10. Staff Survey

Acceptability and Appropriateness of Services

1) The services offered by this project effectively address the mental health concerns (e.g., trauma symptoms, anxiety, depression) I see in clients.
( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

2) Please describe how you see this program impacting or not the mental wellbeing of clients.

_____
_____
_____
_____

3) The services offered by this project support the social wellbeing of clients.
( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

4) Please describe how you see this program impacting or not the social wellbeing of clients.

_____
_____
_____
_____

5) The services offered by this project support the physical wellbeing of clients.
( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

6) Please describe how you see this program impacting or not the physical wellbeing of clients.

_____
_____
_____

7) The program services are <u>culturally relevant</u> to the Afghan community members we serve.

( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

8) Please include any additional comments on the above item here:

_____
_____
_____
_____

9) I have seen the benefit of <u>individual psychotherapy</u> for the clients we serve.

( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

10) Please include any additional comments on the above item here:

_____
_____
_____
_____

11) I have seen the benefit of <u>case management</u> services for the clients we serve.

( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

12) Please include any additional comments on the above item here:

_____
_____
_____
_____

13) I have seen the benefit of psychoeducation groups for the clients we serve.
( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

14) Please include any additional comments on the above item here:
_____
_____
_____
_____

15) I have seen the benefit of healthcare navigation services for the clients we serve.
( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

16) Please include any additional comments on the above item here:
_____
_____
_____
_____

17) I have seen the benefit of other services for the clients we serve.
( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

18) If applicable, please explain which other services you are referencing above.
_____
_____
_____
_____

19) In your experience, what are the client needs that are not adequately addressed by the current services? (Open-ended)

_____
_____
_____
_____

20) Family and Domestic Violence are concerns that should be addressed by this program.

( ) Strongly Disagree
( ) Disagree
( ) Neutral
( ) Agree
( ) Strongly Agree
( ) Not applicable

21) Please include any additional comments on the above item here:

_____
_____
_____
_____

Potential Programmatic Improvements

22) What aspects of the project do you believe are working particularly well for the client population?

_____
_____
_____
_____

23) What specific changes or additions to the project do you think would improve its effectiveness in meeting the needs of the Afghan community?

_____
_____
_____
_____

24) Are there any barriers you have observed that hinder clients from fully engaging with or benefiting from the project services?

_____
_____
_____
_____

Impact and Future Needs

25) What adjustments do you think should be made for future programming for Afghan clients?

_____
_____
_____
_____

Thank You!

Annex 11. Client Satisfaction Survey

1. Had you heard anything about the Raahat program provided by CVT and the Afghan Cultural Society (ACS) before today?
2. After hearing about the Raahat program, what is your first impression? Do you think programs or services like this are needed in your community? Why or why not?
3. What would you like to add, change, or improve in this program?
4. How can this program better support families still adapting to life in the U.S.?
5. Can you share reasons why you have not participated in this program until now? Are there reasons you have only recently become aware of it, or other reasons?
6. Are there groups within the Afghan community (for example women, elders, youth) whose needs are ignored?
7. Do you think there is stigma around mental health in the Afghan community? If yes, what could help reduce this stigma?
8. One challenge this program has faced is that men's participation is less than women's. What do you think could be the reasons?
9. Have you heard of therapy before? Do you think it is an effective way to deal with daily problems or challenges resulting from past violence?
10. How should organizations talk about mental health in a way that is comfortable and respectful to people?
11. What is your opinion about translation services, for example when a client may not want to share their problems with a translator or the translator may not accurately translate conversations? What solutions could improve the effectiveness of these services?
12. Do you feel Afghan culture and traditions are respected by service providers?
13. How can organizations build more trust?
14. What advice do you have for service providers working with Afghans?
15. Are there barriers such as transportation, language, or childcare that make it difficult to use these services?
16. In your opinion, what type of support will be most important for Afghan families in the coming years, especially considering ongoing changes in immigration policies?