



Hmong mental health

An assessment of mental health needs and services for the Hmong community in Ramsey County

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Summary

The Children and Family Services (CFS) division of the Amherst H. Wilder Foundation and Ramsey County's Children's Mental Health Services (CMHS) contracted with Wilder Research to evaluate the mental health needs of the Hmong community, and the availability and accessibility of mental health services for Hmong youth and adults in Ramsey County.

Research questions include:

- What is the scope of mental health issues within the Hmong community? Is there a need for Western mental health services in Ramsey County? What disparities exist? How can the mental health system reduce disparities for Hmong children, youth and adults?
- What barriers does the Hmong community face in accessing mental health services? What barriers prevent Hmong children, youth, and adults from being identified and referred for mental health services? Where and how do Hmong families access mental health services?
- What is the availability of mental health services within Ramsey County for the Hmong community? What mental health services are effective? How can those services be improved? What mental health services are most needed?
- How can social and health systems within Ramsey County be more responsive to the mental health needs of the Hmong community?

Data collection methods

For this assessment, Wilder Research conducted a comprehensive literature review and gathered the thoughts and perspectives of 172 individuals through multiple data collection methods, including 35 key informant interviews, 11 focus groups, 7 in-depth interviews, and 7 telephone surveys. Key informants were from diverse professional backgrounds; including public health and mental health professionals, community-based service providers, community leaders, school personnel (principals, social workers, and counselors), probation officers, child and adult case managers, child welfare and protections workers, and administration staff from Wilder's CFS and Ramsey County. Community members who participated in the assessment included parents/adults, young adults ages 18 to 30 years old, and youth ages 13 to 18 years old. Most key informants and all community members were Hmong. Thirty-nine community members were either

currently or previously receiving formal mental health services for themselves or their child from the Wilder Foundation or Ramsey County.

Key findings

An assessment of mental health issues and needs in the Hmong community

What is the scope of mental health issues within the Hmong community?

- While research on the Hmong community and mental health is limited and outdated, available literature suggests that the Hmong community is at least twice as likely as the total United States population to experience any kind of mental health issue, particularly major depression, post-traumatic stress disorder, and other anxiety disorders.
- Mental health issues are difficult to identify within the Hmong community because symptoms are often manifested through somatic complaints and stress and emotions are often internalized.
- Given the traumatic migration history of the Hmong, pre- and post-migration factors likely contribute to mental health issues within the community. Pre- and post-migration factors include war trauma, violence, poverty, loss, culture shock, acculturation, race and discrimination, lack of English proficiency, lack of education, unemployment, family role reversals, and intergenerational conflicts.
- Key informants and community members identified a variety of stressors and social issues within the community related to the family and adapting to life in the United States, including socio-economic issues, intergenerational conflict, family instability and infidelity, and changing gender roles and expectations. Youth, in particular, reported experiencing stress related to conflicts with their parents, acculturation, and cultural identity issues.

Where does the Hmong community receive support for mental health issues?

- The family and/or clan is the primary source of support within the Hmong community. Community members reported trusting family and clan members to support and guide them. Women were more likely than men to talk to family members about their problems. Men often felt seeking help and admitting to emotional issues was a sign of weakness. Youth generally felt comfortable talking to family members about their problems, such as siblings, cousins, aunts, and uncles;

however, they felt uncomfortable talking to their parents. They didn't feel their parents would understand them or believe that they had reasons to be stressed.

- While the family and clan are influential sources of support, mental health professionals felt clans often lack the capacity to appropriately recognize issues and provide mental health support. Several key informants also felt Hmong families and clans were unaware of available services to refer families to when the clan and family are unable to adequately meet the needs of an individual.
- The Hmong community will often use traditional healing methods before seeking formal Western health care services. Traditional healing methods are also commonly used in combination with Western services. Spiritual ceremonies, such as a “*hu plig*” or “*ua neeb*” ceremony, were most often identified by community members as a way to heal mental health issues so that mind, body, and soul are intact. Spiritual ceremonies are usually only practiced by those who follow Shamanism. Christian community members cited attending church and seeking guidance from a pastor or priest as ways to cope with mental health issues. Other traditional healing methods include herbal medicine and dermal abrasion techniques; which are most often used to heal physical ailments.
- Older adults or parents and more recent Hmong arrivals were more likely to prefer the use of traditional healing practices than Western services. While most youth prefer Western services, they reported that they would first try traditional healing practices to respect their parents' preferences.
- Western mental health services are commonly the last resort when seeking mental health support. Mental health services are typically used only when resources have been exhausted and/or symptoms are severe and unmanageable. Overall, the Hmong community is unlikely to use Western mental health care. However, key informants and community members felt that more acculturated and educated individuals, as well as Christian Hmong, would be more likely to seek Western mental health services than others within the community.

What barriers exist for the Hmong community in accessing Western mental health services?

- The Hmong community experience cultural and community barriers that impact seeking support for mental health issues, including varying mental health conceptions within the community, difficulty in defining mental health, shame and stigma surrounding seeking help for and admitting to mental health issues, concerns with

maintaining confidentiality, and lack of knowledge of Western mental health and how to access mental health services.

- Barriers for the Hmong community in accessing mental health services also exist at the system level, such as complicated referral processes and long wait times to see a mental health professional, cumbersome intake processes that do not allow time to build trust and relationships, and lack of culturally appropriate mental health screening and assessment tools.
- As in many other communities, the Hmong community experiences practical barriers that inhibit access to Western mental health services, such as language barriers, lack of transportation, and lack of health insurance. Youth particularly felt restricted by these practical barriers, in addition to the dependence on their parents to seek professional help and their parents' acceptance of Western services.

Part II: An assessment of mental health services for the Hmong community

What types of Western mental health services are appropriate for the Hmong community?

- Some types of Western mental health services or components of services are effective for the Hmong community, such as: the flexibility of coordinated and individualized case management services; group and family talk therapies that align with collectivistic values of the Hmong culture; alternative therapies that align with holistic views of health within the community; and psychosocial activities and social adjustment services that the community is familiar with and can help reduce adaptation stressors. Medication is a familiar form of treatment for relieving physical ailments, such as somatic symptoms, however psychotropic medication is stigmatized and viewed negatively within the community.
- Co-locating primary care and mental health care services is an effective service delivery strategy to reduce access barriers to mental health care. Co-locating services can increase client follow through with referrals, decrease wait times between referrals and appointments, and mitigate stigma in using mental health services.
- Several programs have been recognized as particularly successful for Hmong families, including Hmong Working Together (*Hmoob Koom Siab*) and Functional Family Therapy.

What mental health services are available in Ramsey County for the Hmong community?

- Ramsey County is a major funder and provider of mental health services for youth and adults. The County works with community-based organizations and programs to deliver services as well. Services available through the County include: Children’s Mental Health Case Management, Children’s Crisis Response, Project Assist, and Adult Mental Health Services.
- Wilder’s Children and Family Services (CFS) is also a main provider of mental health services for the Hmong community. Half of CFS’s Southeast Asian (SEA) Services clients are Hmong (49%). Adult services include: Assertive Community Treatment (ACT), Mental Health Targeted Case Management (TCM), Adult Rehabilitative Mental Health Services (ARMHS), Hmong Men’s Domestic Abuse Program, Social Adjustment Services, and a variety of other outpatient services. Services for youth include: Children’s Mental Health Case Management, Project Assist, and in-home, and school- and community-based outpatient services.
- There are many Hmong-serving agencies within Ramsey County, including the Lao Family Community of Minnesota and Hmong American Partnership. These culturally-specific agencies provide a variety of services for the Hmong community, but often lack the capacity to provide mental health services and support.

What are the gaps in mental health services for the Hmong community?

- There is a lack of early intervention and prevention mental health services for the Hmong community. Hmong families often access the mental health care system when crisis support or intensive services are needed. Key informants identified several types of early intervention and prevention programming that would be helpful, including parenting skills and school-based mental health programming. Parenting skills programming would help Hmong parents learn to identify and address behaviors that can become problematic; while school-based mental health programming can serve as a non-stigmatizing access point for engaging Hmong families into formal services.
- The lack of culturally competent mental health services was also identified as a gap in available services. Some key informants did not feel that mainstream providers had the cultural knowledge to effectively engage, understand, and serve the Hmong community. Service providers should have a good grasp on Hmong cultural values, cultural expressions of psychological distress, and family issues and needs to understand Hmong families. They should also be aware of family and clan structures and work within those structures or in partnership with community leaders to provide services.

- Within the mental health care workforce, there are not enough bilingual and bicultural Hmong mental health providers to meet the demand for services. Community members were unaware of Hmong mental health professionals, while key informants were able to identify a few Hmong providers. With the lack of Hmong providers, many service providers rely on paraprofessionals and interpreters to meet the linguistic and cultural needs of the community. However, it is important for paraprofessionals and interpreters to receive appropriate mental health training and support to be an effective part of service delivery.

Conclusions and recommendations

The Hmong community has had traumatic migration experiences and have faced adaptation challenges in the United States that impact their mental well-being. While many Hmong are resilient, mental health issues within the Hmong community often go unidentified and untreated. Furthermore, there are barriers, disparities, and gaps within the Western mental health system that inhibit access to services.

Three main themes emerge from this assessment:

- A lack of culturally specific services, bilingual and bicultural providers, and focused prevention and intervention services demonstrate gaps in services needed by the Hmong community.
- Western mental health systems do not provide services congruent with cultural conceptions of mental health expression and treatment within the Hmong community.
- The Hmong community experience prominent access barriers and disparities in receiving mental health services.

Recommendations

Recommendation #1: Increase school-based mental health programming

- Mental health providers and schools should collaborate in providing school-based mental health programming specifically for Hmong youth.
- School-based mental health programs should create a welcoming environment for Hmong families.

Recommendation #2: Increase access to case management services

- Provide outreach and education to referral partners.

- Revise current eligibility and screening criteria.
- Allow for flexibility in service delivery.

Recommendation #3: Consider alternative funding streams to meet the needs of Hmong families

- Develop alternative billing rates for families with specific cultural needs.
- Restructure program funding support.
- Seek and use grant subsidies.

Recommendation #4: Develop mental health services in partnership with the Hmong community

- Institute an advisory council of Hmong community members.
- Include family and/or clan members in services and treatment when appropriate.
- Build relationships with community, clan, and religious leaders.
- Build relationships with culturally-specific Hmong agencies.
- Work with community members, service providers, and funders to develop practice-based mental health programming.

Recommendation #5: Increase the availability and use of group and/or family therapies

- Incorporate group and/or family therapies when appropriate.
- Mental health programming for youth should incorporate a parent or family involvement component.

Recommendation #6: Increase the availability of alternative therapies and culturally relevant activities within the Western mental health system

- Incorporate alternative therapies to address somatic symptoms.
- Incorporate culturally relevant psychosocial activities and social adjustment services.

Recommendation #7: Increase the number of bilingual and bicultural Hmong professionals within the mental health workforce

- Promote the mental health field in local high schools and colleges.
- Partner with local colleges and universities to offer internships and mentorship opportunities.
- Provide incentives and support for obtaining licensure.

Recommendation #8: Provide mental health training and support to Hmong paraprofessionals and interpreters

- Provide training opportunities for paraprofessionals and interpreters to learn about the mental health field.
- Provide training opportunities for paraprofessionals and interpreters to understand their role within services and/or treatment.
- Provide training and/or professional development opportunities for paraprofessionals and interpreters to develop and build on interpretation and translation skills
- Provide paraprofessionals and interpreters with mental health support as needed.

Recommendation #9: Provide mental health outreach and education to the Hmong community and those serving the Hmong community

- Conduct outreach and education within the Hmong community.
- Conduct outreach to professionals working in the Hmong community.
- Develop and disseminate materials to agencies and professionals working with the Hmong community.

Limitations of this assessment

- The community members who participated in this assessment are not a representative sample of the Hmong community.
- Available research on mental health issues and the Hmong is limited.

Introduction

The Children and Family Services (CFS) division of the Amherst H. Wilder Foundation and Ramsey County's Children's Mental Health Services (CMHS) have collaborated for many years to provide mental health services in Saint Paul, Minnesota, and the surrounding East Metro. As partners, they strive to provide culturally competent services that meet the emerging mental health needs of the community.

Wilder's CFS division provides a wide range of direct services to children, youth, adults, and families in Saint Paul, including outpatient mental health services and school achievement services. Ramsey County's CMHS serves the East Metro providing direct mental health services to children, youth, and families, including crisis intervention, early intervention, and case management services.

Purpose of the assessment

In the spring of 2009, Wilder's CFS division and Ramsey County's CMHS came together with a common interest in exploring the mental health needs of the Hmong community, and the availability and accessibility of mental health services for Hmong youth and adults in the East Metro. Their shared knowledge about health disparities among minority and immigrant populations is a constant motivator to find ways to increase access to services and meet the needs of the community driven by demographic changes.

Overall, Wilder CFS and Ramsey County program staff have experienced low mental health service use rates among the Hmong community. It is unclear whether this low service use reflects a lack of need for mental health services, or if there are significant barriers to accessing services within the community. Thus, this assessment was commissioned to explore mental health issues and the need for mental health services within the Hmong community in Ramsey County.

About the research

Wilder’s CFS and Ramsey County’s CMHS contracted with Wilder Research to conduct this assessment. A largely qualitative methodology was used to conduct this assessment. Wilder Research collected data from a variety of sources to inform the assessment, including community members, professionals and service providers, Wilder CFS and Ramsey County staff, and available research literature.

For this assessment, the following research questions were developed in consultation with Wilder CFS and Ramsey County staff. They include:

- What is the scope of mental health issues within the Hmong community? Is there a need for Western mental health services in Ramsey County? What disparities exist? How can the mental health system reduce disparities for Hmong children, youth and adults?
- What barriers does the Hmong community face in accessing mental health services? What barriers prevent Hmong children, youth, and adults from being identified and referred for mental health services? Where and how do Hmong families access mental health services?
- What is the availability of mental health services within Ramsey County for the Hmong community? What mental health services are effective? How can those services be improved? What mental health services are most needed?
- How can social and health systems within Ramsey County be more responsive to the mental health needs of the Hmong community?

For the purposes of this report, the term “mental health” is defined using the Substance Abuse and Mental Health Services Administration’s definition (SAMHSA, 2009):

“How a person thinks, feels, and acts when faced with life’s situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explores choices. This includes handling stress, relating to other people, and making decisions.”

Data collection methods

Wilder Research conducted a comprehensive literature review of attitudes, perceptions, and use of mental health services within Hmong communities, both locally and nationally. The literature review helped to inform the qualitative data collection strategies as well as the assessment findings.

Between August 2009 and February 2010, Wilder Research conducted key informant interviews with professionals and focus groups, family interviews, and telephone interviews with Hmong community members to gather information about the following topics:

- Knowledge and conceptions of Western mental health in the Hmong community
- Knowledge and use of mental health services (both traditional Hmong healing practices and Western mental health services)
- Access and barriers to Western mental health services
- Cultural competency and the effectiveness of available Western mental health services
- Satisfaction with Western mental health services (Wilder and Ramsey County clients only)
- Thoughts and recommendations for increasing knowledge of mental health, eliminating barriers to accessing mental health services, and improving mental health services for the Hmong community

All data collection materials were written in Hmong and translated into English, with the exception of the youth and young adult focus group protocols and additional follow-up interview protocols, which were written in English only. A summary of the data collection efforts is provided in Figure 1.

Key informant interviews

Key informant interviews were conducted to gather the perspectives of those who work closely with, and are knowledgeable about, the needs of the Hmong community. Interviews were conducted with 35 individuals from diverse backgrounds, including public health and mental health professionals, community-based service providers, community leaders, school personnel (principals, social workers, and counselors), probation officers,

child and adult case managers, child welfare and protections workers, and administration staff from Wilder's CFS and Ramsey County (Figure 1).

Most key informants were identified by Wilder's CFS and Ramsey County staff. In-depth interviews were conducted with 14 male and 21 female informants. Most key informants (N=29) were Hmong. Interviews lasted about an hour and were conducted in Hmong or English, or both. Most key informants and interviewers were matched by gender. Some key informants who were Hmong mental health professionals completed a brief second follow-up interview.

Key informants were asked about their experiences working with the Hmong community and their thoughts on mental health needs and services within the community. Main questions focused on common mental health issues, the availability of mental health services, access points into the mental health care system, cultural appropriateness and effectiveness of Western mental health services, and strategies to improve access to mental health services within the Hmong community.

Focus groups with Hmong community members

To gather the perspective of Hmong community members who may or may not be linked into Western mental health services, Wilder Research worked with Saint Paul Public School (SPPS) staff and Hmong American Family to recruit Hmong youth and parent/adult focus group participants. Wilder Research conducted six focus groups with a total of 58 Hmong youth and parents/adults. Two focus groups were conducted with Hmong youth between 13 and 18 years old (N=27) and four focus groups were conducted with Hmong parents/adults, including two groups with women (N=19) and two groups with men (N=12). An additional youth focus group was conducted with adolescents in juvenile detention (N=8) (Figure 1).

Wilder Research also contacted a Hmong student association at a local community college with an opportunity for the student group to participate in two focus groups. As requested, some student group members also brought a friend who was not currently attending college. A total of 32 young adults participated in these focus groups.

The Hmong youth and young adult focus groups were primarily conducted in English; all Hmong parent/adult focus groups were conducted in Hmong. Almost all focus group facilitators and note-takers were Hmong. A non-Hmong facilitator and two non-Hmong note-takers helped with the youth or young adult focus groups, but they were paired with a Hmong native speaker. All focus groups lasted an hour to an hour and a half.

Hmong youth, young adults, and parents/adults were asked about their knowledge of mental health, the mental health perceptions of the Hmong community, issues that cause stress and stress coping strategies, knowledge of mental health services (both traditional and western practices), use of traditional Hmong healing practices and Western mental health services and the process of choosing which services to use, ability to seek help or find mental health services, and barriers to accessing mental health services.

Focus groups, in-depth interviews, and telephone surveys with Wilder and Ramsey County Hmong clients

To gather the perspective of Hmong community members who are familiar with and have used Western mental health services, Wilder Research conducted focus groups, in-depth interviews, and telephone interviews with Wilder's Southeast Asian Services and Ramsey County clients. Wilder Research conducted two focus groups with a total of 21 Hmong adult clients from Wilder's SEA Services, including 15 women and 6 men. Seven in-depth interviews were completed with Wilder's SEA services and Ramsey County child and adult case management clients and their families. Telephone interviews were also completed with seven of Wilder's SEA services clients who were non-compliant with services; however, two respondents did not complete the entire interview (Figure 1).

All focus groups, interviews, and telephone interviews were conducted in Hmong by Hmong facilitators, note-takers, and interviewers. The focus groups and in-depth interviews lasted about an hour, while the telephone interviews were brief, lasting only 10-15 minutes.

Overall, focus group and in-depth interview participants were asked about their personal experiences with accessing and using Western mental health services. They were asked about the referral process and whether they experienced any barriers in accessing services, in addition to their satisfaction with services and recommendations for improvement.

Participants who completed the telephone interview were only asked about their referral to Wilder's SEA services, barriers to receiving Western mental health services, and satisfaction with their experience at SEA services.

1. Overview of data collection

Participants/Respondents	Collection strategy	N
Key Informants (male/female)	35 Interviews	35
Community male adults or fathers	2 Focus Groups	12
Community female adults or mothers	2 Focus Groups	19
Community youth, ages 13 to 18 years old (male/female)	3 Focus Groups	35
Community young adults, ages 18 to 30 years old (male/female)	2 Focus Groups	32
Wilder-affiliated male adult clients	1 Focus Group	6
Wilder-affiliated female adult clients	1 Focus Group	15
Wilder- and Ramsey County-affiliated youth clients and families	3 In-depth Interviews	6
Wilder-affiliated adult clients (male/female)	4 In-depth Interviews	5
Wilder-affiliated adults clients who have discontinued services (male/female)	7 telephone interviews	7
TOTAL		172

A brief history of the Hmong

Today, an estimated 171,316 Hmong live in the United States.¹ The Hmong have a long history of war, bereavement, and displacement. During the Vietnam War, the Hmong were recruited by the United States' Central Intelligence Agency (CIA) to fight as allies against the Pathet Lao communists in Laos, known as "The Secret War" (Cerhan, 1990; Harvey, 2009; Hillmar, 2010; Vang, 2008). Once the United States pulled out of the Vietnam War in 1975, the Hmong were persecuted for aiding the United States. They fled Laos to refugee camps in Thailand; accounts of their journey through the jungle and across the Mekong River are traumatic and violent. They continued to experience trauma in refugee camps while waiting to be accepted as refugees and resettle in other countries, primarily the United States.

Hmong refugees began arriving to the United States in the mid 1970s; this wave of refugees primarily consisted of Hmong soldiers and highly educated individuals along with their families (Vang, 2008). The next large wave of Hmong refugees occurred throughout the 1980s, and a more recent wave of Hmong refugees, about 15,000, resettled in United States around the mid 2000s due to the closing of the Wat Tham Krabok Refugee Camp in Thailand (Hang et al., 2004; Harvey, 2009).

The Twin Cities in Minnesota has been termed the "Hmong capital," as it is home to the largest metropolitan Hmong community in the nation. Its Hmong community is vibrant with busy flea markets, Hmong-owned restaurants and businesses, and popular annual Hmong celebrations and events that attract the broader Hmong community from all parts of the world.

A demographic profile of the Hmong for Ramsey County and the city of Saint Paul, Minnesota

U.S. Census data indicate that the Hmong community in Ramsey County and Saint Paul tend to be relatively young, have low education and English proficiency levels, and are generally low-income. However, it is important to recognize that the Hmong community is rich with diversity within itself, as with any cultural community group. The following identifies a sample of key characteristics of the Hmong community in Ramsey County and Saint Paul:

¹ U.S. Census Bureau. B02006: Asian alone by selected groups. *2008 American Community Survey 1-year Estimates*. Retrieved from <http://factfinder.census.gov>

Ramsey County²

- About 26,700 Hmong live in Ramsey County, accounting for 5 percent of Ramsey County's total population. Half of the Hmong population (50%) is foreign born.
- Half of the Hmong population (50%) is under 18 years old. Not surprisingly, the Hmong are likely to live in family households with children under 18 years old, about three times as likely compared to the total population (79% compared to 27% respectively).
- Among those ages 25 and older, nearly half (48%) have less than a high school diploma; among those 5 years old and older, slightly more than half (52%) speak English less than "very well."
- About two in five individuals, age 16 years and older, are unemployed (40%).

Saint Paul³

- An estimated 18,500 Hmong live in Saint Paul, Minnesota. Nearly half of the Hmong population (48%) is under 18 years old.
- Ten percent of the Hmong population, 5 years old and older, does not speak English, while almost half (46%) speak English less than "very well."
- Within the Hmong population, the average family income is about \$40,000, while the average household income is about \$45,300. Over one-third of Hmong families (41%) are below the poverty threshold, and 11 percent of individuals, ages 15 years and older, receive public assistance.
- In the 2009-10 school year, about one-quarter of the total student population (24%) enrolled in the Saint Paul Public School district reported Hmong as their home language.⁴

² U.S. Census Bureau. S0201. Selected Population Profile in the United States, Hmong alone, Ramsey County, MN. *2006-2008 American Community Survey 3-year Estimates*. Retrieved from <http://factfinder.census.gov>

³ Tabulated by Wilder Research from Steve Ruggles, J. Trent Alexander, Katie Genadel, Ronald Goeken, Matthew B. Schroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* [Machine readable database]. Minneapolis: University of Minnesota, 2010

⁴ Saint Paul Public Schools: Department of Research, Evaluation, and Assessment. *District level enrollment data as of October 1, 2009*. Retrieved from: http://datacenter.spps.org/Student_Enrollment. Note: Primary home language counts are a reliable estimate of identifying the number of Hmong students within the Saint Paul Public Schools, despite that some Hmong students report English as their primary home language.

Part I: An assessment of mental health issues and needs in the Hmong community

To explore the mental health needs within the Hmong community, Wilder Research conducted an extensive literature review, in addition to soliciting the thoughts and opinions of community members, professionals, and leaders within the Hmong community. This section of the assessment summarizes findings regarding mental health issues and available supports for the Hmong community.

What is the scope of mental health issues within the Hmong community?

There is a gap in current available literature, especially epidemiological research, regarding mental health issues in the Hmong community. Despite this limitation, available studies that have included the Hmong population, or have focused on the mental health needs of immigrant and refugee populations, suggest that the traumatic war and migration experiences of the Hmong community are likely to be linked to increased rates of mental health issues.

Prevalence of mental health issues

Mental health prevalence data are not widely available on the Hmong. With the exception of a few health assessments of the new wave of Hmong refugees from the Wat Tham Krabok refugee camp, mental health research studies that have either focused on or included the Hmong community are quite outdated (Hang et al., 2004; Kroll et al., 1989; Nicholson, 1997; Westermeyer, 1988; Williams & Westermeyer, 1983; Xiong et al., 2004). However, these studies, which include adults and adolescents, indicate that the prevalence of any diagnosable mental health disorder is quite high (40% to 85%) and that major depression (15% to 75%), general anxiety disorder (35% to 45%), and post-traumatic stress disorder (PTSD) (15% to 35%) are common within the Hmong community. These mental health issues, in addition to schizophrenia, delusional disorder, acculturation issues, defiant issues among youth, and suicidal thoughts, were also identified by key informants as common mental health issues within the Hmong community.

Nationally, about 20 to 26 percent of the U.S. population has a diagnosable mental disorder in any given year, while the national prevalence of major depression is about 7 percent, PTSD is about 4 percent, and general anxiety disorder is at about 3 percent (Kessler et al., 2006; National Institute of Mental Health, 2008; U.S. Department of Health and Human Services, 1999). Thus, compared to the total U.S. population, the

Hmong community is at least twice as likely to experience some kind of mental health issue; particularly major depression, PTSD, and other anxiety disorders.

Mental health symptom expression

Several key informants emphasized that mental health symptoms are manifested and expressed differently within the Hmong community. Mental health symptoms are commonly exhibited through somatic symptoms and additionally, emotions and psychological distress are often internalized which make it difficult to identify mental health issues.

Somatic symptoms. Somatic symptoms are physical symptoms of psychological distress, such as headaches, body aches, stomachaches, and loss of appetite. Several studies have found somatic symptoms to be prominent in the Hmong community, primarily due to mental health perceptions (i.e., emotional symptoms are not identified as a health concern), suppression and internalization of emotions, and shame and stigma surrounding mental health (Cha, 2003; Kroll et al. 1989; Lie, Yang, Rai, & Vang, 2004; Moore & Boehnlein, 1991; Tatman, 2004; Westermeyer, Bouafuely, Neider, & Callies, 1989). Somatic symptoms are most common among older adults and those who are more traditional. Key informants, mostly school personnel and community-based service providers, commonly reported that somatic symptoms are often the first signs that prompt referrals for further mental health screening and assessment.

Internalized behaviors. Due to stigma surrounding mental health issues, emotions and stress are internalized to save face and protect the reputation of one's family and clan. Several key informants were most concerned with internalized behaviors among youth. They reported that most Hmong youth do not display disruptive behaviors that would typically cause concern among teachers, school staff, and parents; particularly at the elementary school level. Hmong children tend to be shy, quiet, and obedient; especially girls. Thus, mental health issues are likely to go unnoticed among Hmong children and youth until behaviors or symptoms become severe; such as excessive truancy, failing grades, running away from home, or suicide attempts.

Pre- and post-migration factors and mental health

Pre- and post-migration factors are linked to psychological distress and contribute to the high prevalence of mental health issues (Chung & Bemak, 2006; Hsu, Davies, & Hansen, 2004; Lie et al., 2004; Pumariega, Rothe, & Pumariega, 2005; Westermeyer, Vang, & Neider, 1983). Migration factors include war trauma, violence, poverty, loss, grief, culture shock, acculturation, race and discrimination, lack of English proficiency/

language barriers, lack of education, lack of job skills/unemployment, financial hardships, role reversal within the family, and intergenerational conflicts.

While many Hmong are resilient and successfully adapt to life in the U.S., some Hmong mental health professionals felt the experiences of war were still traumatizing for some individuals in the community. Hmong mental health professionals reported that many of their clients continued to have flashbacks and nightmares of either fighting in the war or escaping Laos. Furthermore, many key informants felt that traditional family life has been impacted by acculturation and migration to the U.S. They cited intergenerational conflict as a prominent issue between youth and parents, as did many youth and adult community members. The acculturation gap between youth and parents often stressed family relationships, as youth acculturate to mainstream U.S. values and norms and parents continue to hold on to the traditional Hmong culture.

Wat Tham Krabok Hmong refugees

Several informants noted their observations of social and behavioral differences in the adaptation of the recent wave of Hmong refugees in Minnesota. They felt that newly arrived Hmong children and youth from the Wat Tham Krabok refugee camp were very open to the Western culture, more so than previous waves of Hmong refugee youth. They also felt youth were more willing to try risky experiences, such as experimenting with alcohol and drugs. Several other informants felt that youth from the Wat Tham Krabok refugee camp were commonly untrusting of people as a result of the trauma and experience of growing up in the refugee camp. They felt the newcomer youth were typically very shy and unwilling to share a lot of information.

A few informants felt parents and adults from the Wat Tham Krabok refugee camp put a lot of pressure on themselves to be as successful as the Hmong who have been in the United States longer. Parents and adults often experienced stress related to housing, employment, and culture shock. However, several informants felt the new wave of Hmong refugees had access to more resources than previous waves, especially because they resettled in an area with an established Hmong community.

Stressors and social issues

A number of issues within the Hmong community were identified by key informants and community members as prominent stressors that impact one's mental well-being. Concerns and stressors varied across age and gender.

Social stressors

Community members identified issues and areas in their lives that were stressful, including poverty and economic issues (unemployment, low paying jobs, home foreclosures), intergenerational conflict, family instability and infidelity (spousal conflict, marital affairs, and polygamy), and changing gender roles and expectations. Additionally, issues such as youth truancy and delinquency, gang involvement, and chemical abuse were sources of stress for many families.

Family stressors

Hmong men are traditionally the breadwinners of the family and are expected to work and provide for their families; adequately fulfilling this role was a concern for many male community members. Female community members, who are typically responsible for child rearing and taking care of the family, commonly had concerns about raising children and meeting the needs of their husbands. A number of parents discussed concerns related to raising and disciplining children. One mother stated, “As a mother, you are uneducated, and not smart thus you do not know anything, therefore you cannot teach and discipline them [children] so you become worried.”

Additionally, several key informants felt divorce, infidelity, and polygamy were major issues that impacted the mental well-being of Hmong families, especially Hmong women. Polygamy is a culturally and socially accepted practice within the Hmong community; however, it may not be as highly accepted as it once was due to the influence of mainstream U.S. social norms and values that disapprove of polygamy. Several key informants reported that Hmong wives/mothers and children become depressed and hopeless from experiences of divorce, marital problems, and polygamous marriages or relationships. They also felt Hmong women are often unable to financially support themselves and their children after a divorce, as they are more likely to lack English proficiency and have lower income levels than their ex-husbands. Furthermore, they mentioned that divorced women are also commonly ostracized in the community and may lack the support of their family and/or clan. Anecdotal accounts of suicide and homicide incidents within the community are believed to have resulted from family instability and mental health issues.

Youth stressors

“Loss of identity is an issue for a lot of youth. Part of me is Hmong and part of me is Christian – I didn’t really know what I should be – discovering yourself and your identity is stressful.” – *Young adult community member*

“Parents grew up in a different world – they don’t know the experiences that you are going through. We have big cultural differences – parents don’t see that you are still Hmong.” – *Young adult community member*

Hmong youth commonly experience issues related to family stress. Youth community members reported stress related to parents not understanding their needs, peer pressure to fit in, and maintaining their Hmong culture within the U.S. given the pressures to acculturate. Several youth discussed the generational and cultural gaps between themselves and their parents. Some youth also discussed the pressures they face to be successful in school, maintain traditional family and gender roles, and act as a cultural bridge for their family.

Within the Hmong culture, youth and young adults are often deemed incapable of experiencing stress. Many youth and young adult community members felt that their parents did not recognize that they experience stress. One youth noted “[My parents] give me what I want so they think I don’t have stress.” In addition, a few key informants also felt that it was difficult for Hmong parents to recognize and understand the stressors and pressure that their children experience in the U.S., primarily because it is different from their own experiences of growing up in Laos or Thailand. Informants felt that parents often believe that their children have no worries because their children do not have responsibilities of maintaining living necessities, such as housing or food.

Where does the Hmong community receive support for mental health issues?

The Hmong community often turns to what is familiar to them when seeking support. The Hmong culture is very collectivistic, where life and decisions revolve around the family and clan (i.e., extended family members). Despite acculturation and adaptation pressures and challenges, Hmong families and clans continue to be close-knit. Hmong clans or clan leaders serve as a guiding and protective source of support for coping and dealing with issues and problems. In addition, cultural practices in health and healing are prominent and are often used in combination with available Western health services. The Hmong community will also turn to Western mental health services when all other resources have been exhausted.

Support from one's family and clan

“Among families help each other a lot, but we don't know our limitations. When we can't help someone, we are not able to refer them to others who can help them. You help as much as you can, but when you can't help anymore – you just let it go instead of referring them to agencies or other individuals who have special skills to deal with mental health issues.” – *Service provider*

Overwhelmingly, the majority of key informants, community members, and Wilder clients felt that their family clan, inclusive of immediate and extended family members, was their first source of support and help. Community members reported seeking help from elders or grandparents, clan leaders, parents, siblings, cousins, aunts and uncles, and other extended family members. They reported feeling comfortable confiding in family members and trusting family members to listen and help them. Confiding in family and clan members was seen as a way to relieve stress and seek guidance or advice.

Among the community members, there were gender differences in the preference for seeking support from family and clan members. Women were more likely to feel comfortable seeking help and comfort from family and friends. As one woman stated, “If there is stress, then you have to tell your friends, those who you trust the most.” Men, especially older men, were generally resistant to discussing personal problems with anyone, even their wives and family members. They reported that they may be seen as weak if they talked about their problems or sought help. It was more favorable to work through their problems on their own, to avoid the shame of admitting emotional issues and seeking help.

While youth community members reported that they would seek help from family and friends first, many were reluctant to seek help from their parents. They felt that their parents would not understand their problems or believe that they had any reason to feel stress. Youth reported seeking help from other family members who they felt might better understand their needs, such as a cousin or aunt/uncle. Other students sought help from teachers and counselors at school; however, students noted that they needed to trust a teacher or counselor before they approached him or her for help. A few youth were resistant to reach out to school staff; they felt teachers who were not Hmong would not relate to their situation and would be unable to help.

Many community members and key informants felt the Hmong community is unfamiliar and uncomfortable with talking to someone outside of their clan about their problems, much less paying someone outside of their clan for therapy or services. However, many community members, mostly women, young adults, and youth said they often seek help from unrelated peers and friends. Some community members also mentioned that there

are times when one must keep things to oneself so that they are not burdening others or sharing too much information.

The family clan and mental health support

“The majority of Hmong families are still very traditional – not a lot of them recognize mental illness – they don’t talk about mental health.” – *Mental health professional*

“In Laos, clans were effective because the culture really emphasized respect to the leaders – people respected leaders and authority was given to them – the community upheld this and it was very powerful. In the U.S., clan leaders use the same manner of addressing conflict, but they send families to live in the privacy of their own homes and no one hears about their day to day functioning. In Laos, families go home and home was where everyone was at.” – *Mental health professional*

While the family clan serves as the primary source of support, they may be unable to provide support for mental health issues. Mental health professionals were asked whether Hmong family clans had the capacity to provide mental health support to families. Most felt that while clans are supportive and influential in the community, they were unable to recognize mental health issues and were unaware of what supports would help families. Overall, they felt Hmong clans were more successful in providing support for marital and family issues than mental health issues.

Several key informants also felt Hmong family clans were generally unaware of available formal services and how to refer families to services. They felt the mental health system could build partnerships and work more effectively with Hmong clans to increase awareness of services and referrals.

Traditional health and healing

“For the older people in the Hmong community they lean more towards the Hmong traditional beliefs, they feel that the Hmong traditional methods are the way to go when it comes to healing spiritually.” – *Young adult community member*

“I want to believe what my parents or the older Hmong people believe in but then again I also believe what the American people believe in. Being raised here in the U.S. and having my parents who still believe in the Hmong traditional ways makes it hard for me.” – *Youth community member*

“If you are hurt/ill for a long time and if you lose your soul or if your soul wanders off somewhere – you can do a ‘hu plig’ ceremony to feed your soul and get your soul back. It’ll help you eat better and feel better because you have your soul with you.”– *Youth community member*

Traditional practices in health and healing continue to be well practiced within the Hmong community. Traditional and/or alternative medicine is likely used before seeking formal Western care, as well as, in conjunction with Western services.

Spiritual ceremonies were most commonly identified by community members as a traditional health practice when faced with mental health issues; such as a “*hu plig*” (soul calling) ceremony and other spiritual ceremonies like “*ua neeb*” (soul healing) ceremonies. Within traditional Hmong spiritual beliefs, an individual can become ill if their soul wanders off from their body or they lose their soul. Families typically pay a stipend to a shaman (i.e., spiritual healer) for performing spiritual ceremonies, even when the shaman is a close family member. Shamans have the ability to enter the spirit world to retrieve or heal an individual’s soul. Once body and soul are united, the afflicted will be healed. However, these ceremonies are usually only practiced by those who follow Shamanism. Christian community members talked about attending church and seeking help and advice from their priest and/or pastor to relieve their stress and cope with their problems.

Other traditional Hmong health and healing practices include herbal medicine and dermal abrasion treatments (Buchwald, Panwala, & Hooton, 1992; Cha, 2003). Herbal medicines are often made from animal parts, roots, and plants by herbalists (Cha, 2003). Hmong herbalists have a prominent healer role in the community, similar to shamans. They have often inherited and learned how to prepare herbal medicine from their elders. Herbal medicine is primarily used to heal physical ailments, but some are used to heal mental ailments as well. Spring (1989) found that 92 percent of 37 plants used as herbal medicine by the Hmong community in Minnesota had medicinal properties according to “Western biomedical criteria of efficacy” (as cited in Cha, 2003, p. 30).

Dermal abrasion techniques are also commonly practiced within the Hmong community (Buchwald et al., 1992; Cha, 2003). Dermal abrasion techniques include cupping, pinching, coining, and spooning. They are often used to treat physical pain, such as joint pain, headaches, and body aches. Unlike herbal medicine or spiritual ceremonies, dermal abrasion techniques do not need to be performed by a specialist.

Preference in using traditional practices

The preference to use traditional Hmong support services versus seeking Western services comes down to personal preference, religious belief, and understanding of what services are available. Older adults or parents and those who have recently arrived in the United States are more likely to rely on traditional healing. Community members cited increased trust and confidence in treatments that lie within their cultural beliefs. Working through traditional methods also eliminates concerns about language and cultural competency of providers.

Most youth who were born in the United States reported a preference for Western methods, but felt that their parents would expect them to try traditional Hmong methods first. They attributed this preference to their parents' lack of understanding and mistrust of Western methods. Several newcomer youth expressed that although they would like to try Western methods, they would seek traditional Hmong methods first because they had limited English language skills and were unsure of where to find services and how services would help. They felt mainstream doctors and professionals would not be able to communicate with them or their family.

Western mental health services

Western mental health services are commonly the last resort in seeking mental health support. Many key informants felt that mental health services were used only when mandated by some type of social services or in reaction to a crisis or family disruption.

Studies have documented reasons and barriers for not seeking formal Western health care among the Asian and Southeast Asian populations, many of which can be applied to the Hmong community (Chung & Lin, 1994; Leong & Lau, 2001). Overall, the Hmong community is unlikely to seek formal mental health care for a number of reasons, including reliance on family and clan support, shame and stigma, cultural beliefs and practices about symptoms and treatment, and limited awareness of available Western mental health services and how to access services.

Community members reported that they would delay seeking professional help. They reported that they would seek services first through their medical doctors, and that they were unaware of when and where to seek mental health services. Research supports that immigrants and refugees, as well as racial and ethnic minorities, are more likely to seek help from primary care doctors than mental health professionals due to stigma issues and the prevalence of somatic symptoms (Cerhan, 1990; Gensheimer, 2006; Hsu et al., 2004; Marshall, Schell, Elliott, Berthold, & Chun, 2005; Wang & Freeland, 2004; U.S. Department of Health and Human Services, 2001).

Use of Western mental health services

“We [the Hmong community] don’t want to be embarrassed or be labeled as “*xiam hlwb*” (insane). We have a perception that you are worthless when you have mental health issues.” – *Mental health professional*

“I use the traditional ways first. If the Hmong traditional ways don’t help – then I go see my American doctor.” – *Adult community member*

Most key informants felt mental health services were not widely used, although a few informants felt use had increased over the last 20 to 30 years. Research estimates that 15 percent of adults and 21 percent of children and adolescents in the general population across the U.S. use mental health services in any given year; while only around 9 percent of Asian adults report accessing services (Abe-Kim et al., 2007; U.S. Department of Health and Human Services, 1999). Another study found that Asian Americans were three times less likely than their European American counterparts to use mental health services (Matsuoka, Breaux, & Ryujiin, 1997).

Informants and community members felt that Hmong adults and youth who were more acculturated and educated would be more likely to seek help from mental health professionals and use mental health services than other subgroups within the community. There was a sense that less educated community members fear appearing ignorant of both the need for services as well as when to seek services.

Additionally, informants and community members felt that Hmong adults and youth who followed Christian traditions might be more accustomed to seeking assistance from someone outside their family or clan. There was a sense that Hmong Christians may be more informed about mental health issues through their church, and that those who did not participate in Christian beliefs may be less inclined to seek help from outside their family. Many key informants also felt Hmong women were more willing to seek and use mental health services than Hmong men because talking about problems was a norm for women within the culture.

What barriers exist for the Hmong community in accessing Western mental health services?

Many different access barriers were identified in the literature review, as well as by community members and key informants, including barriers influenced by cultural and community beliefs, systematic barriers that impact eligibility for services, and practical barriers that inhibit access to services.

Cultural and community barriers

Mental health conceptions

“I think that [mental health] is when one’s mind, soul, and heart are unhealthy.” –
Adult community member

”The Hmong community does not have a word for mental health. We use a lot of words to describe mental health. In the Hmong community, the understanding of mental health is like you’re crazy – there’s something wrong with you – you’re not normal.” – *Health service provider*

The concept of mental health within the Hmong community varies greatly, based on the length of time in the United States, age, religion, and gender. Many community members who have used mental health services seemed to have a clear understanding of mental health, but there was still some confusion. They had a better sense of mental illness than concepts related to mental health; however, youth and young adults were familiar with mental health and reported learning about mental health in school.

Most key informants felt that mental health conceptions varied within the Hmong community in that more traditional individuals, the older generation, and the more recent Hmong refugee arrivals did not have a good understanding of Western mental health. Many informants felt more acculturated individuals were more likely to understand and know more about mental health. Many informants felt that the Hmong viewed mental health holistically – that mental health was part of one’s overall well-being. One informant pointed out that a literal translation of a common Hmong greeting, “Koj puas noj qab nyob zoo?” meant “Are you eating and feeling well?”

Defining mental health. Community members were asked what “mental health” means to them. They defined “mental health” as:

- Being “crazy” (*vwm*), ill, “psycho,” insane (*xiam hlwb*), or disturbed; not behaving “normally”
- Feeling very sad or depressed; being “emo”
- Having excessive worry or thinking too much about one’s life
- Feeling stressed out about problems in one’s life
- Feeling alone, isolating oneself from family
- Being able to relate to other people and express emotions

- Having problems with one’s well-being, i.e., when one’s mind, body, soul, and heart are unhealthy

Adult community members, particularly men and older adults, often defined mental health as “crazy.” Youth, young adults, and women community members were somewhat more likely to define mental health in terms of emotions, stress, and relationships. Several youth used the term “emo” to describe mental health. When asked what “emo” meant, youth said “emo” referred to being depressed, having suicidal thoughts and thinking a lot about death, inflicting harm on oneself through cutting, and having low-self esteem.

Shame and stigma

Mental health stigma is prominent within the Hmong community and it is shameful to admit to mental health issues; which pose barriers to seeking and receiving support. Informants felt that the Hmong community was very private about their family matters because they wanted to protect their family’s reputation. In addition, informants felt that the Hmong community was afraid of being labeled. Many individuals with mental health issues are labeled as “vwm” (crazy), “xiam hlwb” (insane), and “ruam” (dumb/stupid). Several key informants also talked about the concept of “saving face” within the Hmong community. They reported that Hmong families often will not directly say they do not want to use mental health services, but continue to miss and reschedule appointments until they become unreachable. They felt reminders about appointments were helpful to some extent.

Confidentiality

“In the Hmong community, confidentiality is very important because when Hmong people seek help from you as a doctor and you are not careful and happen to say things about them and others find out – they will no longer trust you.” – *Adult community member*

“Adults don’t go to others for help because the Hmong community gossips a lot. Parents care a lot about their name – they don’t want to have a bad family name.” – *Young adult community member*

Adults and youth alike shared concerns about maintaining confidentiality through services. There were concerns that confidentiality may be compromised by seeking services from Hmong providers, exposing that person to shame and stigma within the community and being labeled as “crazy” for using services. However, most adults and youth were hesitant to see providers who were not Hmong, for a number of reasons. Adults with limited English were concerned about language barriers and indicated a lack of trust with

translators; adults and youth both expressed a preference for Hmong providers due to their increased understanding of the cultural sensitivity and other cultural aspects.

Lack of knowledge and awareness of Western mental health

“We don’t believe worries can cause someone to commit suicide until someone has committed suicide – then we acknowledge that he or she committed suicide because he or she had issues in their lives.” – *Community leader/service provider*

“The barriers are the lack of understanding on their part as to how [mental health services] can help, understanding what mental health is, and understanding how the services are delivered – how talking to someone can help them.” – *Community leader*

“It’s going to take a lot more man power to raise awareness and to really get people to understand the different services. It’s not like you can just put it on a website or you could just do one handout and pass it out to people or do a mailing. It’s more about the one-on-one in our community.” – *Community leader/service provider*

There is little understanding about Western mental health, mental health symptoms, and the spectrum of mental health issues within the Hmong community. This lack of knowledge may explain why community members were more familiar with mental illness, i.e., diagnosable, severe mental health disorders, than the broad spectrum mental well-being. Several community members shared stories of family members and others in the community they had known who had been hospitalized or died by suicide; they noted that it was only after those individuals had been hospitalized or died that anyone realized or acknowledged that there had been problems in that person’s life.

Some informants felt that the challenges in defining mental health and translating mental health concepts contributed to the community’s lack of knowledge of mental health and reception of inaccurate mental health information. Overall, translating Western mental health terms and concepts into the Hmong language is difficult and challenging. Many key informants felt the Hmong language lacked words to adequately explain and define mental health; thus, translation and interpretation of mental health is often long, confusing, and inconsistent.

Lack of knowledge and awareness of available Western mental health services and how to access them

“I think that Hmong people don’t tap into services until they are in a crisis and that’s always the mode that we operate under.” – *Community leader*

There is a lack of knowledge about available mental health services in the Hmong community. While some informants felt many mental health services were available, others, especially those who do not work in the mental health field or make mental health service referrals, were unaware of services. Community members, young and old, were generally unaware of any available services as well, in addition to what services may entail. Some youth mentioned services available at their schools and said they would seek those if it were necessary. A few youth were also able to identify types of mental health professionals, such as therapists, psychologists, and social workers; however, many youth said they would not seek services from these professionals because they were unaware of where to find them.

In addition to the lack of awareness among themselves, key informants and community members did not feel that the wider Hmong community knew about services or where to find them. Many informants and community members felt there needed to be more mental health outreach and education in the Hmong community. They felt the community needed more information about available services, the effectiveness of services, and when to seek help or use services.

Several members of the community and key informants felt it was important to educate Hmong clan leaders about mental health so the information can trickle down the clan systems. Key informants felt building relationships within the Hmong community – with Hmong leaders, culturally specific agencies, and Hmong families – is key to increasing mental health service use. Informants felt that once relationships have been established, the Hmong community would be more trusting of mental health information and services. These insights point to the strong and influential internal networks within the Hmong community, as well as how internal networks can be used to inform and educate the community about resources and services outside of the community; such as Western mental health services. Other suggestions for disseminating mental health information included distributing fliers and posters, broadcasting information through radio and TV, advertising services and posting information in Hmong newspapers, and partnering with community education classes to provide information.

A few community members were familiar with services available through Wilder and mentioned that they knew someone who had received services from Wilder. Many key informants also knew about Wilder's Southeast Asian services, primarily because they have referred Hmong clients to Wilder in the past or they knew someone who worked at Wilder. While many key informants knew of Wilder services, they were unfamiliar with current available types of services; they did not feel confident about what services were still in operation. Those who knew of Wilder's SEA services felt that the program was doing a good job at serving the Hmong community.

System barriers

The referral process

“I refer kids out [to mental health services] and they are put on a waiting list for 1-2 months. If a Hmong family faces this – what sort of [message] is being sent to a parent? Are they going to come back? No. I face this a lot. Kids facing mental health issues cannot wait a month.” –*School counselor*

“The person making the referral needs to call the provider right there with the client. If they don’t have someone to walk them through it and make the call – they won’t know where to go for mental health services.” – *School social worker*

Primary care doctors are typically the primary referral source for Hmong adults, not surprisingly, given the high prevalence of somatic symptoms and stigma in seeking mental health care (Cerhan, 1990; Gensheimer, 2006). Youth are identified in school or by other professional staff as being in need of mental health services; some youth are not identified until their psychiatric conditions have reached the point of medical intervention through hospitalization.

Many key informants and community members received referrals from primary doctors, in addition to schools, juvenile corrections, and social service agencies that provide basic needs services, such as employment or public assistance services. These referral sources were also identified as primary places where the Hmong community learned about mental health services. Some informants felt that Hmong families were willing to use mental health services only when some sort of social service system was involved and mental health services were part of their service plan or mandated by the system.

Community members who were aware of available services reported that it can be difficult to access services. They expressed frustration with long wait times to access programs. As one man stated, “By the time they can see you, the stress is already done. It is too late.” Additionally, young adult community members stated that they may feel more comfortable being referred to an agency that one of their peers had been to, although they would need to be assured of confidentiality before disclosing any issues they were facing.

A couple of informants felt “active” referrals were most successful when referring Hmong families to mental health services. “Active” referrals involve walking families through the process to get mental health services, such as calling to make the first few appointments, driving clients to the appointments, and attending the first appointment with the client. This process allows the referral agency to build a trusting relationship with the client and provides the client with a continuum of care from a source they trust.

The intake process into services

“The Western medical model doesn’t work – it doesn’t have time to build trust and relationships with families. It would be nice to do some psycho-education before the diagnostic assessment or before families start services, but the relationship building and engagement pieces are not billable component.”–

Mental health professional

The intake process into services can be stressful and cumbersome for Hmong families. Several case managers and other mental health professionals felt Hmong families were overwhelmed with the needed paperwork and assessments at intake, sometimes resulting in families refusing services before the process is complete. This was an added stressor for families facing many additional challenges. Lack of English proficiency also impacted parents’ ability to understand, read, and complete the intake paperwork; thus, families often required assistance from case managers or therapists that made intake appointments much longer than usual. Informants reported having to explain what mental health is and how mental health services would be beneficial to families during intake.

The intake process also inhibits building relationships and trust with Hmong families. Many key informants stressed the importance of establishing and building trust with families and clients in order to make any progress with mental health services. They noted the limited opportunity to build trust and rapport with a family, as intake processes are long, time-consuming, and usually completed before there is an opportunity for providers and families to get to know each other. Informants felt the lack of opportunity to build rapport and trust ultimately impacted families’ willingness to share their true challenges.

Mental health screening and assessment

Few screening tools and assessments have been developed specifically for the Hmong, and the available screening tools often do not accurately identify mental health concerns or issues. Several key informants in the mental health field felt screening tools used to determine eligibility for county-reimbursed mental health services were not culturally appropriate; thus, they did not accurately screen for mental health issues among Hmong clients and prevented a number of Hmong adults and youth from being eligible for services. They felt some available screening tools, such as the Global Assessment of Functioning (GAF), did not include symptoms that were commonly displayed by the Hmong, such as somatic symptoms and undisruptive behaviors. Several key informants felt that Hmong youth often do not score high enough on screenings to warrant further assessment or follow up because they do not display disruptive or defiant behaviors. They felt that criteria and scoring should be tailored to be more culturally appropriate for the Hmong community.

Furthermore, tools and assessments often do not consider the impact of spirituality and religious beliefs which have a prominent role in the Hmong culture. For example, a Hmong adult may report talking to spirits, hearing voices, or seeing deceased relatives. These behaviors can be misinterpreted as hallucinations, delusions, or other symptoms of psychotic disorders in Western mental health. However, these symptoms are interpreted differently in the Hmong culture and have significant meaning as they are beginning signs of those who will become a shaman or spiritual healer. When assessing for mental health issues, it is important to review the findings from the screening tools with Hmong clients after they are completed to accurately interpret and assess symptoms while considering cultural and spiritual beliefs.

Few culturally specific and relevant mental health screening tools exist for the Hmong. Screening tools and assessments have been translated into the Hmong language; however, simply translating tools and assessments does not guarantee cultural relevance or appropriateness. In addition to accurately translating tools and assessments, it is equally important to ensure that the content and items in the screening tools fit within a Hmong cultural context. Some mental health screening tools have been culturally adapted for the Hmong, including:

- *The Hmong Adaptation of the Beck Depression Inventory* (Mouanoutoua, Brown, Cappelletty, & Levine, 1991). The Hmong Adaptation of the Beck Depression Inventory (HABDI) is a 21-item, self-administered screening tool that assesses the presence of depression symptoms. The HABDI was tested using a sample of Hmong refugees, ages 18 to 66 years old, in Fresno County, California. It was found to be useful in identifying depression symptoms in both clinical and non-clinical samples. Items were translated in Hmong and back translated in English for accuracy. Items and terms were also modified to be culturally relevant. In addition, the response scale was changed from a 6-point severity rating scale to a 3-point frequency of occurrence scale, due to confusion and frustration among Hmong participants in interpreting the differences among the original six rating options.
- *Hopkins Symptoms Checklist – 25, Hmong Version* (Mouanoutoua & Brown, 1995). The Hopkins Symptoms Checklist – 25, Hmong Version (HSCL – 25, Hmong Version) was adapted and tested with a sample of clinical and non-clinical Hmong adults, ages 18 to 67 years old, in California’s Central Valley region. It is a 25-item, self-administered screening tool that assesses psychological distress, including anxiety, depression, and somatic items and was found to be successful in identifying them. Items were translated into Hmong and back translated with discrepancies being modified to be culturally relevant. The Hopkins Symptoms Checklist – 25 has also been culturally adapted for Laotian, Cambodian, and Vietnamese populations.

In administering translated or culturally adapted screening tools and assessments, it is important to be aware of the literacy level of the respondent. Many Hmong youth and adults are not literate in the Hmong language. Thus, assistance may be required to complete screening tools and assessments, such as explaining how to complete the tool, explaining the rating scale, reading the items out loud in Hmong, and/or providing further explanation of items and symptoms.

Practical barriers

Language

“There is help, but are you willing to seek help if you are unable to speak English and talk to the doctor about your problems? It won’t be effective.” – *Adult community member*

The lack of English language proficiency is a common barrier and impacts access to mental health information and services, as well as communication with service providers. Many adult community members felt that they would not seek Western mental health services because they were unable to communicate with service providers in English. With such language barriers, they felt services would ultimately be ineffective because service providers would not understand their problems and be unable to help. Hmong youth who have been in the U.S. for less than five years also cited their limited English language skills as a prominent reason for not seeking Western mental health services and a fear that service providers would not be able to help them.

While interpreter services are often available and there are bilingual Hmong service providers in the community, some adult community members who have used mental health services had concerns with the accuracy of translations, in addition to how fluently Hmong interpreters and providers were able to speak Hmong. They felt that the interpreters sometimes did not translate information accurately to and from service providers; thus, their problems were not fully explained to service providers and they did not understand the information that service providers gave them through the interpreters.

Transportation

The lack of transportation continues to be a barrier to accessing mental health services. Most community members and key informants cited transportation as one of the most prominent barriers for the Hmong community in accessing any kind of service. Some community members felt service providers and programs should provide transportation because some Hmong families either did not own a car or did not know how to drive. Several service providers who were interviewed said that their agency offered

transportation services, including parking vouchers, or that they personally provided their clients with transportation when needed.

Several community members who have used mental health services complained that arranged rides would sometimes fail to arrive on time or at all to transport them to appointments, resulting in missed appointments or group sessions. A few participants also requested that service providers or some other type of agency should provide clients with driving lessons to alleviate transportation barriers.

Health insurance and cost of services

“If you have insurance then the doctors are willing to help you, no matter which doctor you go to. If you do not have insurance, doctors are not willing to help you and you will be worried.” – *Adult community member*

The lack of health insurance and the cost of services, including co-pays, is a common barrier for the Hmong community. Many adult community members identified insurance and cost barriers to accessing services. A couple youth community members said the cost of services was a barrier for them because they did not have the means to pay for services themselves, and they did not want to burden their parents with the cost. Many adults also reported not having health insurance. Among those with insurance, most did not know whether mental health services were covered. Adult community members felt it was important to offer free services and advertise the services in the community.

Practical barriers specific to youth

“Parents – they may not believe in that therapy stuff. They might not approve of going through the American way.” – *Youth community member*

“Teachers can’t understand what we’re going through – there’s such a big difference between us and our teachers – we live in different worlds.” – *Youth community member*

Due to the dependence on their parents, youth experience barriers that prevent them from being identified for services and accessing services. Youth community members felt they were unable to access mental health services because they had to depend on their parents to give permission, provide transportation, and pay for services. Many youth were not comfortable talking to their parents and did not want their parents to know about their problems, so they felt uncomfortable approaching their parents about seeking help or services. A few youth also felt that their parents would not accept or allow them to receive Western mental health services, such as therapy.

Several youth felt that free mental health services in school or in their neighborhood would be helpful. Youth mentioned having suicide prevention programs available in their schools and identified school counselors and teachers as people students can go to for help. However, some youth did not feel comfortable talking to their counselor or teachers because they didn't think counselors and teachers would understand their problems due to differences in American and Hmong cultural norms and values.

Part II: An assessment of mental health services for the Hmong community

To assess the appropriateness and availability of mental health services for the Hmong community in Ramsey County, Wilder Research reviewed available literature and community resources or directories. Key informants were also asked to provide their expert opinion and advice about mental health services for the Hmong community.

What types of Western mental health services are appropriate for the Hmong community?

Western mental health services offer effective approaches; however, thoughtful consideration must be given to the cultural appropriateness of services as well as how well services align with Hmong values and address the mental health needs and issues of the Hmong community. While there is a lack of culturally competent mental health services, some types of services or service components are effective for Hmong clients, but they must be done in specific ways in order to be effective.

Components of Western mental health services suitable for the Hmong community

Case management services

The flexibility to tailor services to clients' needs was seen as an effective component of case management services. Mental health professionals felt that because Hmong clients experienced a variety of issues and needs, the ability to individualize and provide coordinated services was useful. In addition, they felt it was helpful for Hmong clients to have a case manager to connect and help them access services and resources that they otherwise would not have known about or would have had difficulty accessing on their own. Yet, informants felt that providing case management services to Hmong clients differed from serving other clients. Hmong clients require more intensive support compared to other clients, and informants felt it was easy for Hmong clients to become dependent on case managers. Thus, case managers needed to help clients build their capacity to access services on their own, while at the same time, be available to meet clients' needs and expectations.

In addition, while coordinated and individualized services are an effective way to serve Hmong clients, key informants felt state and federal regulations, and the intake process into case management, was restricting for case managers to serve Hmong families in an

effective way. State and federal regulations restrict the billable services and supports case managers can directly provide for families, such as transportation. This limited the types of services available, such as alternative therapies, and the ways in which case managers could meet the needs of Hmong clients. Furthermore, key informants felt that the intake process into case management was not welcoming for Hmong families. When enrolling into case management services, families are given a substantial amount of paperwork to complete before they even build a relationship with their case manager. Time to engage and build relationships with families is crucial to building trust and buy-in with families.

Talk therapy

Talk therapy can be effective for the Hmong community when done appropriately. Key informants generally felt the Hmong are familiar with the concept of talking about one's issues; however, they are not comfortable disclosing issues to someone outside of their family or clan and furthermore, they are less familiar with paying a professional to talk and listen to them. The critical factor in determining the effectiveness of talk therapy is the ability of professionals to build rapport and trust with clients (Gensheimer, 2006; Tatman, 2004).

Unlike individual therapy, group and/or family therapy are effective treatments for the Hmong, as these types of services align with their cultural values. Research supports group and family therapy for group-oriented and collectivistic cultures, like the Hmong (Chung, 2001; Jaranson, Forbes, & Ekblad, 2000; Weisman et al., 2005; Wong et al., 2006). Many informants supported group therapy, but felt that women and youth would be most receptive to group services. Overall, it is very difficult to engage Hmong men in support groups or any type of mental health services.

Alternative therapies, psychosocial activities, and social adjustment services

“Treating a Hmong person is different from treating an American person. In a Hmong person, there is a spiritual and physical imbalance – you have to work on both. The Western mental health system doesn't include spiritual health.” –
Mental health professional

“Doctors fix your sickness and the Hmong way helps your soul.” – *Adult community member*

Mental health professionals felt that the Western mental health system does not successfully address both physical and spiritual health. They overwhelmingly stressed the disparity between the focus on cognitive process in Western mental health to the holistic health views within the Hmong community that is inclusive of mind, body, and

spirit. Because of this disconnect, the Western mental health system fails to provide the Hmong community with services to meet all their mental health needs. The system is especially lacking in available alternative therapies and services to address the ways in which the Hmong manifest psychological distress, i.e., somatic symptoms, as well as adaptation and acculturation stressors.

Many mental health professionals felt non-traditional services such as alternative therapies, psychosocial activities, and social adjustment services would benefit the Hmong community and compliment Western mental health services. Key informants recommended the following types of therapies and activities:

- Alternative therapies: acupuncture, tai chi, yoga
- Psychosocial activities: farming/gardening, fishing, paj ntaub (Hmong cross stitching), cooking
- Social adjustment services: English language classes, citizenship classes, job skills training

These types of therapies and services address somatic symptoms and mitigate post-migration and adaptation stressors for Hmong clients. Mental health professionals felt these activities provided a framework for holistic recovery. They felt clients had opportunities to heal by participating in familiar activities, incorporating meaningful activities and routines into their daily lives, and building life skills, such as socialization and citizenship skills, to become contributing members in family, clan, and the community.

Medication

“If you worry too much and you cannot sleep and your body aches – the doctor gives you medicine and you feel better because the pain subsides.” – *Adult community member*

“I don’t take medications because I see it as a way to only make your brain not think. If you take too much, it can become a problem for you in the future.” – *Adult community member*

There are competing thoughts about medication as a form of treatment. Some key informants felt that the Hmong community was familiar with medication and will look for medication as an instant “cure” to somatic complaints, but other informants felt that medication was viewed negatively as “*tshuaj vwm*” (crazy drugs). Among some parents and the older generation, the perception is that psychotropic medication only makes an individual worse. Key informants generally felt that the Hmong community lacks knowledge of how psychotropic medications work. An informant said that the Hmong

community did not understand the biology of mental health and thus, do not know how psychotropic medication works (for example, how medication can treat depression as a result of chemical imbalances in the brain).

Parents are especially skeptical of allowing their children to take psychotropic medication. Some key informants talked about parents taking their children off medication once symptoms improved or if symptoms did not improve immediately. Literature has also documented high non-compliance with psychotropic medication use among Southeast Asian immigrants and refugees due to discomfort with side effects, beliefs in the ineffectiveness of psychotropic medication, and language barriers related to accurately understanding dosage information (Kroll et al., 1990; Lee, Buchwald, & Hooton, 1993; Shimada, Jackson, Goldstein, & Buchwald, 1995). Overall, medication is more openly accepted for severe mental illness or symptoms, such as schizophrenia, delusions, hallucinations, and suicidal ideation.

Co-locating mental health services into primary care clinics

The World Health Organization (2008) has called integrating mental health services into primary care the most viable way of closing the treatment gap for untreated mental illnesses, characterizing primary care for mental health as affordable and an investment that can bring important benefits. Often the responsibility for detecting mental health issues falls increasingly to primary care providers. It is estimated that approximately 7 out of every 10 youth who are in need of mental health services or treatment do not receive them. Furthermore, "...approximately 75 percent to 85 percent fail to receive specialty services, and most of these children fail to receive any services at all" (American Academy of Pediatrics, 2009). As part of their focus on a person's overall health, primary care providers are playing an increasingly important role in identifying and treating mental disorders.

While many primary care physicians have been diagnosing mental health disorders in children for decades, the American Academy of Pediatrics found that physicians have inconsistent opinions about their role and accountability in providing mental health care. Some of the key issues for physicians treating families with mental health concerns, highlighted in the report from the American Academy of Pediatrics in 2009, include:

- **Inadequate range of diagnostic codes** which prevents primary care clinicians from being paid for developmental and behavioral issues that are not considered a "disorder" according to the Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition (DSM-IV) and the Internal Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM).

- **Mental health carve-outs** that prohibit some physicians from being able to bill for their mental health care services because they are not considered a contracted behavior health specialist by the insurance companies.
- **Inadequate benefit packages** that limit access to mental health services by many insurance plans because of high co pays, annual spending limits, and separate deductibles for mental health services.
- **Incentives to support collocation of care** for psychiatric services are not the same as with medical services. For instance, Medicare pays for services provided by a physician assistant who is providing a medical procedure, but will not pay for services that are provided by a psychiatric nurse practitioner.
- **Lack of payment for non face-to-face aspects of care** creates an issue for providers who work as a team because many insurance companies will not pay for this effort. This means that a lot of the ongoing monitoring, collaboration, and communication with others involved with a patient are not billable and therefore, hard to justify.

Having co-located services, where a mental health clinician can be housed with a physician or pediatrician, has been found to resolve some of the barriers to access. Reasons for providing mental health services in primary care clinics include:

- **Increased follow through with referrals:** Both in the mainstream and Hmong cultures, it is common for families to either not follow through with mental health referrals or terminate treatment too early. Community members mentioned that Hmong families did not follow through with referrals and commonly stopped treatment when the immediate problem or issue subsided. If primary care and mental health services were co-located, families may be more trusting of providers to follow through with referrals and complete treatment. Providers may also work together to engage and re-engage families in treatment and services.
- **Decreased wait time between referral and appointment:** Offering services within the primary care clinic may minimize the length of time between receiving a referral and getting into an appointment. Many co-located mental health services offer same day appointments, rather than having the patient responsible for calling for an appointment at a later time.
- **Reduced stigma:** Providing mental health services within a primary care clinic offers more discretion about why a patient is being seen. Community members noted that they would feel more comfortable seeking mental health services at their primary care

clinic because they would not worry about being seen there, since there can be stigma associated with being seen at a mental health clinic.

An example of a successful co-located program is the Bridge Project in Boston, which enhanced their program by providing training seminars for primary care physicians regarding common mental health issues and disorders. In addition to the seminars, the program utilizes a primary care nurse to assist with the referrals made by the physicians. Yeung et al. (2004) studied this project and found that integrating mental health care with primary care was successful in improving access to low-income immigrant Chinese Americans.

From the literature, it is evident that families go to their physicians for mental health issues, but there are barriers in place preventing physicians from providing effective mental health services. In particular, there is a need to tailor mental health services to one's culture. Programs that incorporate mental health services within primary care attempt to reduce barriers to services, and when coupled with the integration of culturally sensitive programming, working with the Hmong community may be more seamless.

Spotlight on effective programming

While there are some program components that seem to benefit the Hmong community, no evidence-based mental health programs exist for this community. In a literature search of mental health service models, few services and programs were found to be culturally relevant and specific to the Hmong population. A review of national evidence-based program registries, including the National Registry for Evidence-based Programs and Practices (NREPP) and Blueprints for Violence Prevention, did not result in the identification of any mental health treatment programs specifically for the Hmong. However, Wilder's Social Adjustment Program for Southeast Asians was identified by two national organizations, the Association of Asian Pacific Community Health Organizations (AAPCHO) and Bridging Refugee Youth and Children's Services (BRYCS)⁵, as either a "best practice/service model" or "promising practice." The Community-University Health Care Center Mental Health Program in Minneapolis, Minnesota and Wilder's Hmong Working Together program (*Hmoob Koom Siab*) were listed as "best" or "promising" models by AAPCHO and BRYCS, respectively. Wilder's Hmong Working Together program, however, is currently not in operation.

Due to the lack of evidence-based programming for youth and adults in the Hmong community, an alternative strategy for developing and testing programs and services may be using practice-based approaches. Rather than developing programs and approaches in

⁵ Descriptions of NREPP, Blueprints for Violence Prevention, AAPCHO, and BRYCS are provided in the appendix.

an academic setting, practice-based interventions are developed within the community, reflecting the needs, priorities, and goals identified by a number of different stakeholders, including community members, practitioners, funders, and policymakers.

The following identifies some successful strategies or programming for addressing mental health issues in the Hmong community.

Working in collaboration

Collaboration may be a powerful tool in designing and implementing culturally-specific mental health programs. A 2003 report by Hosley, Gensheimer, and Yang identified a number of strategies for building effective collaborations in designing and implementing family-based programming. Strategies include:

- Ensuring that the collaborative recruits representatives of the cultural community.
- Working with bilingual and bicultural staff to bridge cultural gaps between members of the collaborative and the community.
- Engaging participants (youth and adults) in program planning, implementation, and other decision-making roles and duties.
- Using variable styles and practices in making decisions and hosting meetings.

These strategies may be helpful for service providers to build relationships and improve service delivery to the Hmong community.

Hmong Working Together

Hmong Working Together was a collaborative project involving Wilder's Southeast Asian Services and several middle schools in the Saint Paul Public School district. The purpose of the project was to implement the Families and Schools Together (FAST) program with Hmong families. The general goal of FAST, developed in 1987, is to help at-risk youth succeed in the community, at home, and in school and to avoid problems such as violence, addiction, and dropping out of school. The model serves children and youth aged 3 to 14 using a research- and family therapy-based, multifamily approach that emphasizes partnerships of families, schools, and communities. FAST has been widely implemented across the United States and in several other countries.

During the 2005-06 and 2006-07 fiscal years, Hmong Working Together served 266 clients (Holm-Hansen & Kelly, 2008). The following are key findings from a 2008 program evaluation of Hmong Working Together:

- Parent ratings of family functioning on 11 social relationship items increased significantly from pretest to posttest. The majority of youth reported having a good relationship with their family at pretest and posttest.
- Parents and youth tended to rate youth as exhibiting a range of strengths by the end of the program. For example, parents felt that youth were getting along with others, helpful, considerate, more interactive, and less fearful.
- After participating in the program, parents were more likely to say that they had clear and specific rules about their child's associations with peers who use alcohol or other drugs, they had explained their rules regarding substance abuse, and they had explained the consequences of not following their rules.
- Parents were more likely to talk to their children and include them in family discussions after participating in the program.
- Parent ratings of their relationships with their neighbors, community agencies, and the community in general, as well as their child's relationship with peers, improved significantly after participation in the program. Although youth ratings were somewhat lower, they also generally reported positive relationships with their peers, neighbors, community agencies, and the community.

Functional Family Therapy

Another mental health program that has demonstrated success with families from different backgrounds is Functional Family Therapy (FFT), a clinical approach to working with culturally diverse families with youth aged 10-18 that have conduct disorders, substance abuse, or other behavior problems. FFT has evolved over the last 30 years into a respected, grounded and highly successful family intervention. The FFT model has been successfully replicated across many different settings, including the child welfare system, juvenile justice, chemical dependency treatment, and school-based programs.

FFT often serves at-risk youth and families who have been underserved and have not found success in other programs. FFT has been successful in working with families who have limited resources and whose youth are experiencing a range of diagnoses. In order for the FFT model to work, a therapist works with the youth and family for at least 8 sessions and focuses largely on the interpersonal relationships that exist within a family system.

The framework of FFT focuses on building and enhancing the strengths within the family then incorporating other resources to foster the positive functioning of the family (Mease & Sexton, 2004). Because FFT's primary focus is on the family, this approach may be a good fit for Hmong families because it allows the family to be involved in the clinical process.

What mental health services are available in Ramsey County for the Hmong community?

While there are a number of available mental health services and programs in Ramsey County, there is a lack of culturally specific and culturally competent mental health services for the Hmong community. Mental health services need to be available, but more importantly, providers need to have the cultural and linguistic capacity to serve the Hmong community and reduce barriers and disparities that inhibit access to services. Many places rely upon interpretation services to serve non-English speaking clients, because mainstream providers may not have staff that fully understand important cultural nuances and family structure within the Hmong community, and therefore, may not deliver services in a culturally appropriate way.

Many Hmong-serving organizations have the cultural and linguistic capacity to serve the Hmong community, but few provide mental health support. In reviewing available services in the East Metro area, Ramsey County and Wilder's Southeast Asian Services were the largest mental health service providers for the Hmong community.

Ramsey County mental health services

“The leap from nothing [no service] to case management and all of the requirements is what keeps families from getting into the system.” – *Community service provider*

Ramsey County is a major funder and provider of many health services for youth and adults. The following identifies the types of mental health services available in Ramsey County. While these mental health services are provided directly by Ramsey County, the county also contracts and works with community-based organizations and programs to deliver services as well.

Children's Mental Health Case Management (CMHCM)

This program works to: 1) assess the needs of youth, 2) provide referrals to needed services, and 3) coordinate services for youth and families with an identified mental health need. CMHMC provides services to youth in Ramsey County, including Hmong youth who are referred to the Ramsey County program from a number of partners, including school social workers, therapists, hospitals, corrections, and Wilder Southeast Asian Services, among others.

CMHMC works with families to identify the appropriate types of services and provides a link to those services. Case managers meet with families at least monthly, although case managers report meeting with Hmong families more often.

In 2009, Ramsey County Children's Mental Health Case Management served 590 families; this includes 15 Asian families, 6 of whom were Hmong.

Children's Crisis Response

Ramsey County Children's Crisis Response is a voluntary crisis intervention program for youth and their families in Ramsey County. Families seek services on their own, often with the cooperation and support of school staff, Child Protection, and other professionals in contact with the family. A goal of Children's Crisis Response is to prevent youth with mental health needs from entering into the criminal justice system. Children's Crisis Response partners with the Juvenile Detention Center (JDC) when youth are involved in domestic violence or assault cases. The Juvenile Detention Alternative Initiative (JDAI) works to place youth somewhere other than the JDC, including shelters or other alternative placements if immediate return to their home situation is not possible. Additionally, the JDAI and Crisis Response works to engage parents during the assessment process to develop a safety plan, and ultimately, resolve the crisis event.

Crisis Response works with families in immediate need of de-escalation of crisis situations. Short-term intervention plans are aimed at getting families through the initial crisis; plans can include respite care, shelter for youth, and an assessment of the need for additional services. Staff provide services other than mental health support for families, including connection to food shelves, and facilitating communication with school staff.

In 2009, Children's Crisis Response served a total of 14 Hmong families, among more than 400 families served. In recent years, the program has had a Hmong specialist on staff, but as of March 2010, the program has instead relied upon three-way calling with interpreters to resolve family conflict.

Project Assist

Created in 2004, Ramsey County staff described Project Assist as a program focused on providing culturally competent, comprehensive mental health assessments that help parents and families access the correct interventions and supports needed to improve a young person's mental health functioning at home, school and in the community. Project Assist receives referrals for services from juvenile justice and Child Protection, but also from schools, shelters, physicians, and community providers. This voluntary program provides culturally specific case management-like services for families, including referral to community providers, connection to food shelves, stabilized housing, and communication with school staff. Project Assist does make referrals to CMHCM; however, there is no requirement that families complete a diagnostic assessment to

receive Project Assist services. Families generally participate in Project Assist for three months, although there are no time limits.

In 2009, Project Assist served 25 Hmong families out of 250 total families served. Community informants acknowledged a need for these types of case management-like services, recognizing the barriers and challenges Hmong families face in accessing traditional case management services.

Adult mental health services

Ramsey County provides a variety of adult mental health services. Adult case management services are provided for adults with a serious and persistent mental illness. Ramsey County provides both direct and contracted adult case management services. Based on the needs of the consumer, various types of case management services are available, including: Assertive Community Treatment (ACT), short-term intensive treatment, and long-term non-intensive treatment.

In addition, adult mental health services are provide through the Ramsey County Mental Health Center, staffed by licensed independent clinical social workers, licensed psychologists, psychiatrists, nurse clinicians, physician assistants, occupational therapists, and mental health workers. The Center offers a variety of services to assist individuals in coping with mental illness. The comprehensive array of outpatient services includes:

- Diagnostic assessments
- Individual and group therapy
- Medication management
- Day treatment (short term services for stabilization of acute illness)
- Partial hospitalization (short term intensive services for people who would otherwise be hospitalized)
- Adult Rehabilitative Mental Health Services (ARMHS)
- Consultation and evaluations for the court system

Wilder's Children and Family Services – Southeast Asian Services

“Southeast Asian program is good at keeping us in touch with what’s going on with our child and follows up with us.” – *Parent of child receiving Wilder SEA services*

“Southeast Asian [Services] has helped me by talking to and giving me ideas and then I feel less stress.” – *Wilder SEA client*

Southeast Asian (SEA) Services within Wilder’s Children and Family Services (CFS) division has provided outpatient mental health services for the Hmong community, as well as other Southeast Asian communities, since 1984. In the 2008-09 fiscal year, half of the client population in SEA Services was Hmong (49%). Some of the adult services include:

- ACT- Assertive Community Treatment uses an intensive 24/7 multi-disciplinary team approach to prevent clients from returning to the hospital by reducing clients’ symptoms and preventing acute episodes through medication management, rehabilitative mental health interventions, supported employment services and persistent unconditional support. ACT helps participants progress toward recovery by utilizing evidenced based practices such as Supported Employment, Integrated Dual Disorder Treatment and Illness Management and Recovery to increase their ability to meet basic needs and enhance the quality of their lives.
- TCM – Mental Health Targeted Case Management helps adults with serious and persistent mental illnesses gain access to needed medical, housing, social, educational, financial, vocational and other services necessary to meet their complex mental health needs.
- ARMHS – Adult Rehabilitative Mental Health Services is a mental health skills service designed to help participants develop and enhance their psychiatric stability, social competencies, personal and emotional adjustment, independent living and community skills through medication education, mental illness symptom management, household management, employment issues, transition to community living, skills development including interpersonal communication, crisis assistance, relapse prevention, budgeting, cooking and nutrition skills, and transportation. Eligible clients must be at least 18 years old, have a serious mental illness, have substantial disability and functional impairment in three major areas of functioning, and be eligible for Medical Assistance.
- Adult Outpatient Mental Health Services – Wilder offer clients the opportunity to address significant personal concerns while identifying strengths, barriers, and new skills and insights leading to increased functioning, recovery and growth through outpatient individual and family therapy. These services are provided by well trained and licensed mental health professionals and are offered to Hmong, Cambodian, Vietnamese and Karen community members. Whenever possible, therapy services are offered in clients’ preferred language. Outpatient services for adults include:

- Hmong Men’s Domestic Violence Program – a 22 session domestic violence program offered in a group format for Hmong speaking men. Clients are referred by Ramsey County Probation and Parole.
- Social Adjustment Services – includes psycho-educational groups, support groups, gardening groups, field trips, guest speakers and enrichment programs.

In addition, SEA’s youth services include:

- Children’s Mental Health Case Management Services (in partnership with Ramsey County) – assesses the needs of youth with a diagnosed severe and persistent mental illness, provides referrals to needed services, and coordinates services for youth and families with an identified mental health need.
- Project Assist – offers mental health outreach, early identification, assessment and referrals for youth who are under 18 years old. Referrals typically come from Child Protection, Juvenile Justice/Detention and schools; however, anyone can make a referral.
- Youth Outpatient Mental Health Services – including a variety of in-home, school, and community based services.

Key programming to reduce access barriers and disparities within Wilder’s Children and Family Services

In addition to the aforementioned services and in an effort to reduce barriers and disparities, Wilder’s CFS has undertaken a couple of unique efforts to address access barriers for Hmong girls and racial and ethnic disparities in children’s mental health.

- **Hlub Zoo.** Hlub Zoo, meaning “Grow well, love well” in Hmong, is a culturally specific program that provides support services and resources for Hmong girls. Hlub Zoo is a collaborative effort between Wilder Kofi Services and Jackson Elementary School; it was launched in February of 2010. The program was developed using a framework that merges the Hmong culture with a Western mental health approach to provide a broader access point to services for families. The main goals of Hlub Zoo are to support Hmong girls in building a strong cultural identity, developing positive self-esteem, improving behaviors and leadership skills, and strengthening peer and family relationships. The program serves Hmong girls in grades Kindergarten through 6th grade, who are referred to the program by teachers and other school staff. Program participants who present a need for formal mental health services are referred to Wilder’s Southeast Asian Services for screening and assessment.

- ***The Clinical Training Institute.*** The Clinical Training Institute is an effort to increase the community's capacity to serve children from diverse cultural and ethnic backgrounds by training bicultural and/or bilingual practitioners to develop clinical skills and obtain their clinical licensure. The Institute provides consultation and training on specific topics that relate to delivering culturally competent clinical services. In addition, the Institute provides practitioners with supervision towards licensure, mentorship opportunities, and preparation and support for passing licensure exams.

Hmong serving organizations

While there are many Hmong-serving agencies in Ramsey County, the following Hmong-serving organizations are prominent within the community and operate some programs that support mental health issues.

Lao Family Community of Minnesota

Lao Family's bilingual and bicultural programs strive to empower the Hmong community to meet the many challenges of modern American life within a context that honors and preserves their traditions, values, and heritage. Lao Family's Youth and Family Programs offer culturally-specific education, support, guidance and assistance to youth and their families to help them cope with social and cultural issues.

Hmong American Partnership

Hmong American Partnership works to provide programs and services designed to empower Hmong families to acculturate to life in America, as well as to build the knowledge and skills needed to become successfully educated and employed, while retaining their cultural heritage and identity. The Youth and Family programs offer a wide variety of culturally-specific programs to serve the needs of the families and youth in the Hmong community. While not focused specifically on mental health, programs are designed to support academic achievement, help prevent youth from engaging in negative behaviors, provide leadership and career development opportunities, connect youth to media outlets through which they can voice their perspectives, and provide direct support services to promote healthy and stable families.

Other available services

In an effort to reduce systemic barriers to accessing mental health services for Hmong families as well as to build capacity within the community to serve Hmong families, Children's Hospital and Clinics, with funding from the F.R. Bigelow Foundation, developed the Hmong Community Resource Directory. The most recent version of the directory, updated in 2010, identifies mental health services, social services, healthcare,

and general community services for the Hmong community in the Greater Twin Cities Metro area. Figure 2 lists the available programs and service providers highlighted in the directory that provide mental health services in the East Metro. These services and descriptions are current as of March 2010.

2. Available mental health services in Ramsey County

Agency name	Description of services
<i>Mental health supports</i>	
Center for Victims of Torture	Provides supportive counseling, long term therapy, medical and psychiatric assessments, and services for social adjustment and support. Hmong speaking staff available for interpretation; no Hmong speaking clinical staff. <i>Services available for children and adults.</i>
Face to Face Health and Counseling	Provides one-on-one therapy and in-home therapy. Hmong-speaking interpreters available. <i>Services available for children and adults.</i>
Northwest Youth and Family Services	Provides diagnostic assessments, individual and family therapy. Will provide interpreter as needed. <i>Services available for children and adults.</i>
Nystrom & Associates, Ltd.	Provides individual, family, marriage, and play therapy, psychological testing, medication management, home based therapy for adults and adolescents. Will provide interpreter as needed. <i>Services available for children and adults.</i>
<i>Youth and family supports</i>	
Big Brothers Big Sisters of the Greater Twin Cities	Offers mentoring between adult volunteers and youth. Programs have Hmong speaking staff. <i>Services available for children.</i>
Health Start	Provides mental health care for students enrolled in school with Health Start Clinic. <i>Services available for children.</i>
Lao Assistance Center of Minnesota	Provides comprehensive social services for Lao families in need. Have Lao speaking staff. <i>Services available for children and adults.</i>
Pacer Center	Provides publications, workshops, and other resources for families with children with disabilities. Pacer Center has one Hmong speaking staff. <i>Services available for children and adults.</i>

2. Available mental health services in Ramsey County (continued)

Agency name	Description of services
Primary care/Home health care services	
ACEA Home Health Care, LLC	Provides home care services for children, adults, and elderly patients with complex medical needs and mental health diagnoses. ACEA Home Health Care has Hmong speaking staff available. <i>Services available for children and adults.</i>
Bethesda Clinic (University of Minnesota Physicians)	Family practice residency clinic with a clinical psychologist. Bethesda Clinic has a full time Hmong speaking interpreter on staff. Services are available for children, adolescents, and adults, and include diagnostic assessments, medication management, individual or family psychotherapy, and group therapy for Hmong women. <i>Services available for children and adults.</i>
Center for International Health	Provides mental health and social work in a primary care setting. Hmong speaking interpreters available. <i>Services available for children and adults.</i>
Hmong Elder Connections/ Volunteers of America	Provides access to mainstream services, adult day services, home visits. All staff speak Hmong. <i>Services available for adults.</i>
People Incorporated Home Health Agency	Provides assessment of client's physical and mental health status, medication management, and daily living support. Program has one Hmong speaking staff. <i>Services available for children and adults.</i>
Phalen Village Clinic	Provides mental health services, including support groups, individual counseling and psychiatric services in a primary care setting. Interpreters are available on site. <i>Services available for children and adults.</i>
Quality Plus Home Healthcare Services	Provides PCA, in home support, and respite care. Have Hmong speaking staff available, and provide interpreters on request. <i>Services available for children and adults.</i>
Southeast Asian Health Services, Inc.	Provides PCA services. Have Hmong speaking staff available. <i>Services available for children and adults.</i>
West Side Community Health Services	Provide individual and group therapy and social work services. Have Hmong speaking staff and provide interpreters upon request. <i>Services available for children and adults.</i>

What are the gaps in mental health services for the Hmong community?

“There is a need for families to receive services earlier – by the time they meet eligibility criteria for services – they are in need of deep end services.” – *Child case manager*

“It’s hard to provide services that fall in line with the Hmong culture completely – it’s hard to provide mental health services for a culture that has no concept of mental health services.” – *Mental health professional*

“Mental health treatments in the Hmong culture involve getting help from their families, or maybe a shaman or church. Western mental health services have constraints – funding constraints and HIPAA. The family usually isn’t involved unless the client gives consent.” – *Mental health professional*

Key informants in the mental health field identified several gaps in existing Western mental health services, including a lack of mental health early intervention and prevention services for Hmong families, a lack of culturally competent services, a lack of bilingual and bicultural Hmong mental health service providers in the community, and lack of systems that are not culturally responsive even when they exist.

Lack of early intervention and prevention services

The lack of mental health early intervention and prevention services for Hmong families were identified as gaps in the types of available services. Many key informants felt that Hmong families delayed seeking services and by the time services were sought, individuals were in need of intensive treatments. Thus, several informants felt early intervention and prevention services were needed to intervene earlier. These types of services would connect and engage families in services, identify mental health issues, and provide support services before issues became severe.

Informants reported that Hmong youth and adults are often not identified as needing mental health services, often because symptoms present differently among Hmong compared to other mainstream youth and adults. Hmong youth instead are identified as being in need of services further along the continuum, when externalizing behaviors have led them to the juvenile corrections system for issues related to truancy, gang involvement, runaway, or other socially disruptive behaviors.

Informants offered a few suggestions and thoughts on what kinds of early intervention and prevention services would be helpful for the Hmong community, including parenting skills programming and school-based programming. Parenting programs would be a way to

educate parents on enabling behaviors, identifying behaviors that could be problematic in the future, and teaching their children to follow through with expectations. It is unclear how receptive Hmong parents would be to participating in these types of programs, though.

Several other informants mentioned school-based mental health programming as a way to reach out to Hmong families, both in terms of providing prevention services and increasing accessibility to formal mental health services. Informants felt that Hmong families generally trusted schools and regarded school as a safe place. School-based mental health programs can build upon already established relationships and serve as a non-stigmatizing access point for families. As a prevention strategy, school-based programming would engage students and families regardless whether students present a need for services, and give program staff an opportunity to get to know students and their families. If additional services were needed, students and families could be referred for further assessment and screening.

Lack of culturally competent services

In addition to the lack of early intervention and prevention services, the lack of culturally competent services was also identified as a gap. Some informants did not feel that current mental health services were culturally appropriate, unless provided by a Hmong professional. They felt mainstream providers did not have the cultural knowledge necessary to understand Hmong clients and their issues. The lack of cultural knowledge also inhibits the ability of mainstream providers to engage Hmong clients in services through the use of cultural metaphors and idioms to explain service concepts and incorporating culturally specific components into services. Many informants also felt that language barriers continued to limit the availability of culturally competent services as well as the lack of bilingual and bicultural Hmong mental health professionals.

Cultural barriers exist in delivering Western mental health services to Hmong youth and adults. For example, members of the Hmong community may not make a distinction between physical and psychological problems. Additionally, Hmong youth and adults may be reluctant to seek help in times of need due to stigma, shame, and lack of awareness of the availability of Western services. Culturally competent services should therefore focus not only on the language needs of clients but also on cultural differences related to attitude, emotional expression, and help-seeking practices and behaviors. Culturally competent providers can acknowledge, accept, and value cultural differences between themselves and their clients, and can use an understanding of unique cultural differences to enhance service delivery.

A recent study (Zhou, Siu, and Xin, 2009) identifies five distinct cultural values that may impact the degree to which traditional Western services meet the needs of Asian-

American clients. Distinct cultural values include: 1) collectivity versus individualism; 2) duty and obligation versus personal rights and privileges; 3) hierarchy and status versus equality and egalitarianism; 4) deference and respect versus assertiveness; and 5) self-control and restraint versus emotional expressiveness. Family integration and interdependence valued in Asian-American families may be considered maladaptive from a Western mental health perspective that values individualism and boundaries with family and other social situations.

The following identifies strategies for delivering culturally competent mental health services (Zhou et al., 2009):

- Explore how and to what extent programs will use culture in their implementation, and define what is meant by culture.
- Gain competency in identifying unique cultural expressions of psychological distress, specifically somatic complaints.
- Explore difficulties with parent/child conflict related to acculturation and struggles for interdependence and independence.
- Employ directive, action and crisis-oriented counseling and concrete problem solving rather than more ambiguous approaches.
- Work within family structures to enhance rather than detract from service delivery.
- Help families gain an understanding of complex educational, political, social service, and other systems to more effectively use available resources to solve problems.
- Collaborate and form relationships with elders, religious leaders, and other representatives from the community as they may have strategies to make services more culturally appropriate and appealing.

Lack of bilingual and bicultural Hmong mental health service providers

“We need more (Hmong) mental health professionals – the capacity is increasing, but we still need many more. There are not enough (Hmong) providers – we only have one practicing psychologist.” – *Child case manager*

“We have family counseling, but we do not have a Hmong psychologist or psychiatrist who understands the difference between services and the Hmong culture.” – *Child case manager*

There is a lack of bilingual and bicultural Hmong mental health service providers in the community. Community members were unable to identify any Hmong mental health professionals, although many reported a preference for a Hmong provider. Community members overwhelmingly reported that there were not enough Hmong mental health professionals and were able to name only a handful of Hmong mental health professionals.

The shortage of Hmong providers does not meet the current demand for services. Many Hmong mental health professionals reported that they had high case loads and were over capacity. They often received a high volume of referrals and intake requests because they had the language capacity to serve Hmong families. A few providers were also commonly asked by clients and potential clients to hold private practice hours on the weekends. However, a couple of key informants felt Hmong private mental health practices were difficult to sustain due to mental health stigma, the lack of knowledge of services, and the preference for traditional healing practices within the Hmong community. Furthermore, other key informants from the juvenile justice and child welfare sectors reported that not only was it difficult to find a Hmong provider to refer families to, but that it was also difficult for families to schedule appointments because Hmong providers were at capacity. It often took months before families were able to meet with a Hmong provider to complete the intake process or diagnostic assessment for services.

Due to the lack of Hmong mental health providers, there is an over-reliance on paraprofessionals and interpreters, including interpreters working for clinic or service agencies as well as independent, contracted interpreters. Mental health training among paraprofessionals and interpreters may vary; thus, it is important for them to have the appropriate training and support to be effective in service delivery (Downing, 1992; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005; Musser-Granski & Carriollo, 1997). To ensure these individuals are sufficiently prepared to serve the Hmong community, they should receive training and support in:

- Engaging and building relationships with clients;
- Maintaining confidentiality;
- Learning mental health diagnoses, concepts, and the types of available services, treatments, or therapy, especially trauma focused services;
- Acquiring effective and culturally relevant interpretation skills, including effective strategies for interpreting to and from professionals and clients, as well as translating cultural meanings of mental health concepts, emotions, and behaviors;

- Understanding one's role and responsibilities as an interpreter or paraprofessional to effectively work with mental health professionals; and,
- Managing their own traumatic experiences, which may be triggered through shared or similar experiences with clients.

In addition to training and support, it is equally important to be aware of the service dynamics involved in using paraprofessionals and interpreters. It is recommended that paraprofessionals and interpreters be matched to the gender and background of clients, in addition to consistently using the same paraprofessional or interpreter for a client (Miller et al., 2005; Musser-Granski & Carriollo, 1997). Furthermore, appointments may need to be extended for clients to have enough time to receive services and build relationships with providers, as the interpretation process may take up a considerable amount of time and clients are likely to have more contact and communication with interpreters.

Part III: Conclusions and recommendations

The Hmong, as a community and ethnic group, have endured many challenging experiences over the last several decades which have a profound impact on their mental well-being, from traumatic war experiences to cultural clashes in adapting to Western societies. While many Hmong have showed resilience, mental health issues often go unrecognized and untreated within the community. Furthermore, barriers, disparities, and gaps within the Western mental health system inhibit access to services.

Commissioned by Wilder's Children and Family Services and Ramsey County, this assessment was conducted to explore the mental health needs within the Hmong community, as well as assess the availability and accessibility of mental health services. Three main themes emerge from this assessment:

- There is a lack of culturally specific services, bilingual and bicultural providers, and focused prevention and intervention services in the Hmong community.
- Western mental health systems do not provide services congruent with cultural conceptions of mental health expression and treatment within the Hmong community.
- The Hmong community experiences prominent access barriers and disparities in receiving mental health services.

Recommendations

Given the findings of this assessment, the following are recommendations to build partnerships, increase access to mental health services, improve mental health service delivery, and increase mental health awareness within the Hmong community.

Recommendation #1: Increase school-based mental health programming

Schools are becoming increasingly recognized as a promising way to make mental health services available to children who may not otherwise have access. School-based mental health programming would: 1) reduce practical access barriers for Hmong youth and parents, 2) address cultural barriers to accessing services, and 3) increase access to early intervention services for Hmong youth.

Eliminating barriers. Many different barriers inhibit access to services, including practical barriers, cultural and community beliefs, and systematic barriers that impact eligibility for services. School-based programming can be successful in increasing access

to and engaging Hmong families in mental health services. It eliminates transportation and cost barriers for families and reaches out to families within an environment that they are familiar with and trust – the school.

Increasing early intervention services. Hmong youth are often not identified in school or by other professional staff as being in need of mental health services. Instead, Hmong youth are often identified as needing mental health services further along the continuum of services, when externalizing behaviors have led them to the juvenile corrections system for issues related to truancy, gang involvement, runaway, or other socially disruptive behaviors. A few key informants felt school-based programming was an effective way to identify mental health issues early and refer families to formal mental health services before a crisis occurs. Additionally, schools are familiar to families and may be a safe place to build trust with Hmong families. Offering services at schools can help mental health professionals connect to families that may not have access to mental health professionals otherwise.

Action items

- **Mental health providers and schools should collaborate in providing school-based mental health programming specifically for Hmong youth.** Providing school-based mental health services helps to eliminate cultural and practical barriers for youth and families in need, by providing a safe and familiar forum to build rapport with families. Additionally, school-based mental health programs may work to identify children in need of services at an earlier stage than otherwise possible.
- **School-based mental health programs should create a welcoming environment for Hmong families.** Making families feel welcome in schools will make it more likely they will trust the schools with their child’s mental health issues. It is important that the school provides translators and translated materials to the families when they are attempting to engage them.

Recommendation #2: Increase access to case management services

Case management services are an appropriate and useful service for Hmong youth and adults for a number of reasons, including the ability to provide individualized services based on the needs of the client. However, there are challenges to engaging youth and adults in this type of programming, including: 1) identifying Hmong youth in need of case management services, 2) determining eligibility for services, 3) engaging families in services, and 4) providing services in a culturally appropriate way while maintaining program fidelity.

Identifying mental health issues. Some key informants have observed that Hmong youth typically do not present the same mental health symptoms as youth from other cultural groups. Common referral partners (school staff, community serving organizations, etc.) may not be able to identify Hmong youth with mental health needs as readily.

Screening and eligibility. Hmong youth in need of mental health services may be excluded based on required eligibility and screening processes. To be eligible for Children's Mental Health Case Management, youth and their family must complete an application process and a diagnostic assessment (DA). Several informants identified challenges with the DA process, reporting that the tool and process were not culturally sensitive, making it challenging to administer in the required timeline. Additionally, screening is often completed with a therapist of a different cultural background. These factors increase the likelihood that the process is not culturally appropriate.

Engaging families. Informants noted challenges in engaging Hmong families in services. Informants noted that Hmong families have different concepts of mental health as defined by the County and by available services. Staff work with families to explain Western mental health concepts, what services are available, and why services are offered in the way they are. Additionally, Hmong families often present with significant parent/child conflict, often tied to different degrees of acculturation within a family. Parent/child conflict is not an uncommon issue, but within Hmong families, this conflict can be complicated by role reversal, with parents relying upon children to act as cultural brokers for the family.

Providing culturally competent services. Delivery of services through CMHCM may not be culturally sensitive to Hmong families. Every six months, case managers are required to assess a child's current functioning and develop a case plan. All services and referrals must refer back to goals established in the current case plan, outlining a very linear service delivery model. Informants reported that the linear nature of services may not align with the needs and culture of Hmong families. Informants noted that many Hmong families have a number of issues that fall outside the scope of mental health services and feel that it is necessary to have flexibility to work toward those goals in order to successfully address mental health goals.

Informants note that children's mental health cannot be addressed effectively without also addressing issues within the family, such as language needs, parental employment, stabilized housing, and so on. Case managers working with Hmong families noted the challenges in only providing services that are billable under current funding streams; given families' needs, they routinely need to provide non-billable services as well, such as transportation. Staff also recognize a need for auxiliary services unique to Hmong

families, including additional ongoing education about mental health, facilitating communication with school staff, providing translation of County documents and other necessary paperwork due to language barriers, and generally acting a cultural liaison for Hmong parents.

Action items

- **Provide outreach and education to referral partners.** Partnering with those who interact with Hmong youth, including school staff, community-serving organizations, and other professionals who work with Hmong families, is necessary to increase the number of Hmong youth who can be identified as benefiting from case management services. Additionally, outreach and education of professionals may increase the number of youth who are identified earlier in the process, before their mental health needs require hospitalization or result in involvement of juvenile justice.
- **Revise current eligibility and screening criteria.** Current screening and eligibility criteria do not align with the Hmong culture. Access barriers could be reduced and the number of youth served could be increased by changing the screening and eligibility processes, including allowing more time to develop relationships and build trust with families, identifying/developing more culturally appropriate screening questions, changing the way in which Diagnostic Assessments are completed, and lessening the requirement of a ‘diagnosis’ for services.
- **Allow for flexibility in service delivery.** Case management staff must devote significant time to developing relationships and building trust with families once youth are engaged in services. Additionally, case managers must have the flexibility within their work with families to deliver services that are not always billable, such as transportation. Allowing auxiliary tasks to be billable under current funding structures would allow case managers to deliver services that are likely to include and serve the entire family more effectively.

Recommendation #3: Consider alternative funding streams to meet the needs of Hmong families

To support flexibility in service delivery, new and alternative program funding streams are necessary. The following are needed to support additional and alternative tasks and services for Hmong families:

- **Develop alternative billing rates for families with specific cultural needs.** County funding streams may be altered to allow for flexibility in payment and service delivery for families with unique needs, such as specific cultural needs. Through the

creation of new and blended funding streams through the County, programs and staff could offer services that are more culturally appropriate while maintaining sustainability of programming through adequate reimbursement.

- **Restructure program funding support.** Programs may consider other uses for existing program funds, such as alternative uses of endowment funds.
- **Seek and use grant subsidies.** In addition to restricting existing funding streams, service providers should seek subsidy from other sources, such as grant funding. Grants may be especially helpful as programs look to expand or alter programming to better meet the needs of clients.

Recommendation #4: Develop mental health services in partnership with the Hmong community

Building trust and rapport is crucial when working with Hmong families. Hmong families are close-knit and well-connected to each other and the community. They are often reluctant to seek help from outside their clan and community. Support and comfort in addressing issues and problems are first found within the family and clan. Thus, it is important for mental health services providers to have connections and relationships within the community by partnering with Hmong families/clans, community leaders, and Hmong-serving organizations. These partnerships are imperative in understanding the issues that Hmong families experience and serving the community to meet their needs.

Action items

- **Institute an advisory council of Hmong community members.** To learn about effective strategies for serving the Hmong community, it is important to reach out and listen to the community. Mental health service providers should institute an advisory council of community members, including Hmong leaders, parents, and youth, to advise the agency in culturally appropriate engagement and service delivery strategies.
- **Include family and/or clan members in services and treatment when appropriate.** The Hmong family and clan is a strength within the community upon which service providers can build. Service providers should have a good understanding of the family and clan structures within the Hmong culture to effectively work with them. Family and/or clan members can be influential partners in engagement and service delivery processes.
- **Build relationships with community, clan, and religious leaders.** Hmong leaders, such as community, clan, and religious leaders, are very well-respected and influential within the community. They may be able to serve as cultural and/or

religious consultants to providers, helping providers understand client's issues within a broader community context. Consultation and partnership with religious leaders in particular would also help providers align services and treatment with the holistic beliefs of well-being within the Hmong community.

- **Build relationships with culturally-specific Hmong agencies.** Culturally-specific Hmong agencies are well-connected to Hmong families and are a visible resource within the community. While they have the cultural and linguistic capacity to serve the community and provide many different kinds of services, they often lack the capacity to provide mental health services. Mental health service providers and culturally-specific Hmong agencies can work together in identifying community issues and needs, and sharing information and experiences in effectively serving the Hmong community. Culturally-specific Hmong agencies can also serve as a referral partner in increasing access to mental health services for the Hmong community.
- **Work with community members, service providers, and funders to develop practice-based mental health programming.** Practice-based interventions are developed considering the needs, priorities, and goals of a community. Working in collaboration with community members, service providers, and funders can help identify the needs within the community and the most appropriate services and strategies to meet those needs.

Recommendation #5: Increase the availability and use of group and/or family therapies

Group and family therapies are effective for the Hmong community because they align with the collectivistic values of the Hmong culture. The Hmong community is very group-oriented; they place high value on familial ties and the clan structure. The community has also shared experiences, and individuals may likely find support from one another within a group format. Furthermore, Western mental health services often serve individuals; however, within the Hmong cultural context, recovery and healing includes the Hmong family.

Group and family therapies are especially important for serving Hmong youth. Hmong youth commonly experience stressors related to the acculturation process, including identity issues and conflicts with parents. To effectively serve Hmong youth, it is important to help them build strong bicultural identities and family relationships. Youth commonly reported that they find support and understanding from their peers.

Action items

- **Incorporate group and/or family therapies when appropriate.** Group and family therapies should be incorporated into services when appropriate as they reflect the collectivistic values and traditions of the Hmong culture.
- **Mental health programming for youth should incorporate a parent or family involvement component.** Helping Hmong youth maintain and build strong relationships with their parents and family fosters communication, understanding, and interaction within the family.

Recommendation #6: Increase the availability of alternative therapies and culturally relevant activities within the Western mental health care system

A way to improve the current mental health system for Hmong clients is to ensure that there is a variety of treatments and services available that align with holistic healing conceptions and address adaptation and acculturation stressors. Key informants felt alternative therapies, psychosocial activities, and social adjustment services were needed in order to address the prevalence of somatic symptoms and acculturative stress within the Hmong community.

Addressing somatic symptoms. Mental health issues are commonly manifested through somatic symptoms within the Hmong community. While psychotropic medication is an option for treating and managing somatic symptoms, it is highly stigmatized within the Hmong community and only accepted when symptoms are severe or when an individual is diagnosed with a psychotic disorder. Thus, additional treatments and therapies are needed to provide Hmong clients with options in treating somatic symptoms.

Addressing acculturation and adaptation stressors. Stressors related to acculturating and adapting to life in the U.S. are common among Hmong youth and adults. Issues such as unemployment, lack of English proficiency skills, poverty, family instability, and changes within family roles and responsibilities were commonly identified as social stressors for the Hmong community. In serving the Hmong community, it is difficult to provide mental health services without acknowledging the presence of these issues. Key informants felt psychosocial and social adjustment services were needed to mitigate acculturation and adaptation stressors.

Action items

- **Incorporate alternative therapies to address somatic symptoms.** Mental health services should incorporate alternative therapies, such as acupuncture, tai chi, and

yoga. These therapies provide relief for somatic symptoms and they are congruent with holistic views of health.

- **Incorporate culturally relevant psychosocial activities and social adjustment services.** Mental health services should incorporate psychosocial activities and social adjustment services to mitigate common stressors of adaptation and acculturation in the U.S. Examples of psychosocial and social adjustment services include farming/gardening, fishing, *paj ntaub* (Hmong cross stitching), cooking, English language class, citizenship classes, and job skills training.

Recommendation #7: Increase the number of bilingual and bicultural Hmong professionals within the mental health workforce

There is a high need for bilingual and bicultural mental health professionals. Key informants had difficulty identifying Hmong mental health providers. Bilingual and bicultural Hmong mental health professionals help reduce access barriers to services, such as eliminating language barriers and engaging Hmong clients in a culturally sensitive manner. Furthermore, most Hmong adult community members prefer seeking help from a Hmong provider rather than a mainstream provider. However, there is a shortage of Hmong providers to meet the demand.

Action items

- **Promote the mental health field in local high schools and colleges.** Hmong youth and young adults reported learning about mental health through school in health and psychology classes. Collaborating with school staff to promote the mental health field and bring awareness to the need for Hmong providers is a way to disseminate information and possibly spark interest among Hmong youth in mental health careers.
- **Partner with local colleges and universities to offer internships and mentorship opportunities.** Mental health providers and local colleges and universities should partner and collaborate to provide internships and mentorships to Hmong students in the mental health field.
- **Provide incentives and support for obtaining licensure.** Given the lack of bilingual and bicultural Hmong mental health professionals in the community, mental health service providers and county sectors should consider providing incentives and other support for career development and licensing, including competitive wages and benefits, and highlight the benefits of being a licensed mental health professional, such as having opportunities to advance to managerial and administrative roles.

Recommendation #8: Provide mental health training and support to Hmong paraprofessionals and interpreters

Due to the shortage of bilingual and bicultural providers within the mental health care system, service providers employ paraprofessionals and interpreters to meet the language needs of their diverse clientele. However, mental health training among paraprofessionals and interpreters varies. Given the challenges in translating mental health concepts into Hmong and considering the stigma surrounding mental health within the community, it is essential that paraprofessionals and interpreters have the proper mental health training to be effective in engaging, educating, and serving Hmong families.

Action items

- **Provide training opportunities for paraprofessionals and interpreters to learn about the mental health field.** It is important for paraprofessionals and interpreters to understand mental health in order to effectively work in partnership with service providers in serving the Hmong community. Mental health training should include information on mental health conceptions, symptoms, diagnoses, and services or treatments.
- **Provide training opportunities for paraprofessionals and interpreters to understand their role within services and/or treatment.** Paraprofessionals and interpreters assist providers in meeting the cultural and language needs of diverse clientele. To effectively be part of service delivery and treatment, they need to understand their roles and responsibilities in working with service providers, such as engaging families, translating within services or treatment, and maintaining confidentiality.
- **Provide training and/or professional development opportunities for paraprofessionals and interpreters develop and build on their interpretation and translation skills.** The Hmong language has limited words that clearly define and interpret mental health and mental health concepts, making the translation process challenging. This difficult translation process may lead to misinformation and misinterpretation of mental health within the Hmong community. Paraprofessionals and interpreters need to have appropriate interpretation skills to accurately and consistently translate mental health information for providers and clients. They should also have enough knowledge and understanding of the Western and Hmong cultures to translate cultural meanings of idioms, emotions, and behaviors.
- **Provide paraprofessionals and interpreters with mental health support as needed.** Paraprofessionals and interpreters are likely to have shared experiences with clients and may need support in managing their own traumatic experiences. They

and/or their employer(s) should have resources and support in place so that their experiences do not interfere with service delivery.

Recommendation #9: Provide mental health outreach and education to the Hmong community and those serving the Hmong community

Many Hmong community members, including focus group participants and key informants, were unfamiliar with Western mental health concepts and unaware of available mental health services. The Hmong hold a holistic view of mental health that includes finding a balance between physical, mental, and spiritual well-being, one that is very different from the Western perspective.

Key informants felt that psycho-education was successful in helping Hmong clients learn about Western mental health concepts, services, and treatments. They felt Hmong clients were more willing to comply with services and treatments once they understood how they would help.

When providing mental health outreach and education to the Hmong community, it is important to consider and be sensitive to Hmong mental health beliefs and conceptions, as well as the stigma surrounding mental health. This recommendation is intended to increase awareness of Western mental health concepts and familiarity with formal Western mental health services that are available.

Action items

- **Conduct outreach and education within the community.** Mental health service agencies should conduct outreach to the general Hmong community, clan leaders, and religious leaders to inform them of mental health issues and available services. Mental health information should be disseminated through multiple Hmong media outlets, such as Hmong newspapers and radio talk shows.
- **Conduct outreach to professionals working in the Hmong community.** Mental health service agencies should have an outreach and marketing coordinator to make connections and market services to Hmong-serving organizations, schools, hospitals/primary care clinics, and other possible referral sources.
- **Develop and disseminate materials to agencies and professionals working with the Hmong community.** Mental health professionals and service providers should develop and disseminate mental health information such as tip sheets or toolkits on common mental health issues within the Hmong community and its symptoms, identifying mental health issues among Hmong youth and adults, how to talk to the

Hmong about mental health, how to refer the Hmong to mental health services, and available mental health services and/or programs for the Hmong.

Limitations to this assessment

The findings and results of this assessment should be interpreted with the following limitations in mind:

- The Hmong community is diverse and heterogeneous. The community members who participated in the focus groups and interviews are not representative of the Hmong community. For instance, the young adult community members were recruited through an Hmong student association at a local community college; these young adults may have differing opinions, thoughts, and experiences compared to other young adults who are not engaged in school associations or do not attend college. In addition, while there were some Wat Tham Krabok refugees and new arrivals who participated in the focus groups and interviews, data collection strategies did not attempt to specifically target this subgroup. It is likely that experiences and issues of this particular subgroup are different compared to the Hmong who have been in the U.S. for longer periods of time.
- While this assessment reviews mental health needs of the Hmong community, it draws from available literature on the Hmong, Southeast Asian, Asian, and immigrant and refugee populations. To the knowledge of the authors, current formal mental health screenings and epidemiological studies on the Hmong population are not available. Thus, it is difficult to assess or estimate the prevalence of mental health disorders within the community. However, despite the fact that some of the research is dated, mental health research studies on the Hmong are the best available resources in providing a context of how common experiences within the Hmong community have impacted their mental well-being.

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Appendix

U.S. Census Data: 2006-08 American Community Survey

Saint Paul Public School District Data

Telephone survey data

Overview of service model databases

U.S. Census Data: 2006-08 American Community Survey

1. Ramsey County: Hmong population characteristics

	Total population	Margin of error	Hmong alone	Margin of error
Population estimate	498,864	-	26,712	+/- 1,797
Place of birth				
Native	441,040	+/- 2,617	13,292	+/- 1,393
Foreign born	57,824	+/- 2,617	13,420	+/- 1,321
Age				
Under 5 years old	7.1%	+/- 0.1	12.7%	+/- 1.3%
5 to 17 years old	17.4%	+/- 0.1	36.9%	+/- 1.7%
18 to 24 years old	10.2%	+/- 0.1	10.8%	+/- 0.9%
25 to 34 years old	12.6%	+/- 0.1	11.9%	+/- 1.4%
35 to 44 years old	14.0%	+/- 0.1	11.7%	+/- 1.1%
45 to 54 years old	15.0%	+/- 0.1	7.3%	+/- 1.1%
55 to 64 years old	10.9%	+/- 0.1	4.4%	+/- 0.9%
65 to 74 years old	6.2%	+/- 0.1	2.8%	+/- 0.8%
75 years old and older	6.7%	+/- 0.1	1.5%	+/- 0.5%
Median Age	37	+/- 0.2	18.2	+/- 0.7
Family households with children under 18 years old	26.9%	+/- 0.7	78.5	+/- 4.7
Educational attainment (Population 25 years and older)				
Less than high school diploma	9.7%	+/- 0.4	47.6%	+/- 5.0
High school graduate (included equivalency)	24.2%	+/- 0.6	24.5%	+/- 4.2
Some college or associate's degree	27.4%	+/- 0.6	18.3%	+/- 3.2
Bachelor's degree	23.4%	+/- 0.6	8.4%	+/- 2.7
Graduate or professional degree	15.3%	+/- 0.5	1.2%	+/- 0.9

Source: U.S. Census Bureau, 2006-2008 American Community Survey 3-year estimates, S0201: Selected population profile in the United States, Hmong alone, Ramsey County, MN

A1. Ramsey County: Hmong population characteristics (continued)

	Total population	Margin of error	Hmong alone	Margin of error
Ability to speak English				
Population 5 years old and older	463,529	+/- 142	23,311	+/- 1,631
Speak English less than 'very well'	8.2%	+/- 0.5	52.1%	+/- 4.2
Employment status				
Population 16 years old and older	391,959	+/- 522	15,337	+/- 1,128
In labor force	64.7%	+/- 0.8	53%	+/- 5.1
Not in labor force	30.9%	+/- 0.7	39.8%	+/- 3.5

Source: U.S. Census Bureau, 2006-2008 American Community Survey 3-year estimates, S0201: Selected population profile in the United States, Hmong alone, Ramsey County, MN

A2. Saint Paul, Minnesota: Hmong population characteristics

	Total population	Margin of error	Hmong alone [†]	Margin of error
Population estimate	269,135	+/- 3,130	18,529	+/- 6,859
Age				
0 to 17 years old	25.5%	+/- 1.3	48%	+/- 5.3
18 to 30 years old	20.8%	+/- 1.1	19.8%	+/- 12.0
31 to 64 years old	43.2%	+/- 1.2	28.7%	+/- 8.5
65 years old and older	10.5%	+/- 0.7	3.5%	+/- 2.8
Speaks English				
N/A (Blank)	7.7%	+/- 0.8	9.6%	+/- 5.4
Does not speak English	2.2%	+/- 0.6	9.9%	+/- 5.3
Yes, speaks only English	70.5%	+/- 1.9	1.5%	+/- 1.3
Yes, speaks very well	10.5%	+/- 1.1	33.3%	+/- 13.0
Yes speaks well	4.8%	+/- 0.8	20.5%	+/- 5.7
Yes, but not well	4.2%	+/- 0.8	25.2%	+/- 9.4
Average income				
Family	\$53,726	+/- \$2,412	\$39,894	+/- \$8,249
Household	\$62,559	+/- \$2,737	\$45,288	+/- \$10,375
Poverty Status				
Income at or above poverty threshold	80.6%	+/- 2.4	59.1%	+/- 14.2
Income below poverty threshold	19.4%	+/- 2.4	40.9%	+/- 14.2
Public assistance				
Population 15 years old and older	211,811	+/- 3,839	11,200	+/- 2,388
Receives public assistance	4.9%	+/- 0.8	10.6%	+/- 4.6
Average welfare income	\$2,687	+/- \$460	\$3,485	+/- \$1,447
Homeownership				
Number of households	108,742	+/- 1,261	3,806	+/- 777
Owned or being bought	57.1%	+/- 2.0	42%	+/- 11.4
Rented	42.9%	+/- 2.3	58%	+/- 11.6

Source: U.S. Census Bureau, 2006-2008 American Community Survey 3-year Estimates; Tabulated by Wilder Research from the Integrated Public Use Microdata Series

¹ According to the 2000 census data, the Hmong population in Saint Paul was about 24,400; thus the available data may be underestimating the current Hmong population.

Saint Paul Public School District Data

A3. Saint Paul Public School district data on students with Hmong as their primary home language: 2009-10 school year

Students with “Hmong” as a primary language

Percent of total student population	25%
Free lunch	81%
Reduced lunch	9%
English Language Learners	80%
Receives Special Education	12%

Source: *Saint Paul Public Schools: Research, Evaluation, and Assessment Department*

Note: *District level data as of October 1, 2009.*

Telephone survey data

A4. Referral agency (N=6)

Who or what agency referred you to services at Wilder?	N
A primary care family doctor/physician	2
Someone else	2
Don't know	2

A5. Accessing Wilder services

	Total N	# of respondent saying "Yes"
Did anyone help you access services at Wilder?	5	3
Did anything make it difficult for you to access services at Wilder?	6	2

A6. Assistance in accessing Wilder services (N=4)

Did anyone help you access services at Wilder? If yes, who helped you access services?	N
A social worker	1
Someone else	2
Don't know	1

A7. Difficulties in accessing Wilder services

Did anyone help you access services at Wilder? If yes, who helped you access services? In what ways did they help you?

She calls to make the appointment and she comes to pick me up to go to the doctor – takes me to my appointments and brings me to Wilder.

Set appointment, call for a ride – pick and drop off.

She calls me and she comes to do home visits. She tells me to come to Wilder for treatments. She asks me if the medication works and if the services help me.

A8. Referral agency (N=4)

Did anything make it difficult for you to access services at Wilder? If yes, what made it difficult for you to access services?

Don't have medical insurance because I don't have a permanent residency where I can put my name. No address for them to send me paper or information.

I always forget to go to the sessions. It would be helpful if they made reminder calls and came to pick me up every time.

A9. Satisfaction with staff and services (N=6)

	Total N	Strongly agree	Agree	Disagree	Strongly disagree
Staff understood my problems or concerns.	6	4	2	0	0
Staff respected me.	5	3	2	0	0
Staff communicated with me in a way that I understood.	5	3	2	0	0
Staff were caring and warm.	5	3	2	0	0
Staff were knowledgeable and skilled.	5	3	2	0	0
It was easy for me to find out about the services.	5	3	2	0	0
It was easy for me to contact staff when I needed to.	4	3	1	0	0
Staff helped me to understand the services that I received.	4	2	2	0	0
The service times were convenient.	5	4	1	0	0
The location was convenient.	5	4	1	0	0
The cost of services was reasonable.	4	4	0	0	0
It was easy to schedule the first appointment.	5	5	0	0	0
I would recommend these services to others who need similar services.	4	4	0	0	0

A9. Satisfaction with staff and services (N=6) (continued)

	Total N	Not a problem	A slight problem	A moderate problem	A major problem
Difficulty obtaining transportation to services	5	4	0	1	0
Difficulty in finding child care for your children during appointments	5	5	0	0	0
The cost of services	4	4	0	0	0
Lack of insurance to help pay for services	5	5	0	0	0
Lack of food, clothing, or other necessities	5	2	1	0	2
Lack of knowledge of services	4	3	0	1	0
Stigma/shame in receiving mental health services	5	5	0	0	0
Lack of Hmong therapists/professionals or staff	5	4	0	0	1
Lack of staff with ability to speak Hmong	6	4	2	0	0
Other ¹	5	4	0	1	0

¹ A respondent reported lack of English language skills as a problem for receiving services.

A10. Completion of Wilder services (N=5)

	# of respondent saying "Yes"
Did you complete treatment or services at Wilder?	1

A11. Reasons for not completing Wilder services

Did you complete treatment or services at Wilder? If no, why not?

I am still receiving services

I am still coming to Wilder for treatment right now. I am not done with the program yet.

A12. Use of services outside of Wilder

	# of respondent saying “Yes”
Are you currently receiving mental health services at another agency?	0

Note: While no one reported receiving mental health services at another agency, one respondent commented that she received help in “carrying heavy things, cooking, and cleaning.” However, she couldn’t remember which agency was providing this service to her.

A13. Feedback about how to improve Wilder services**If you could change one thing about the services you received from Southeast Asian Services, what would that be?**

Everything is good – will tell them if things need to change.

I am not too sure because I only came to 2 sessions and I thought everything was great. Nothing.

I would like them to take me out to have fun. I would like to go out to eat at restaurants and eat Hmong food. I would like to have field trips.

I can’t think of anything.

A14. Feedback about positive aspects of services**What was the most positive aspect of the services you received at Southeast Asian Services?**

Staff speak nice to me – help me with my mail and fill out papers at the welfare place.

I think they do a really good job listening to us and helping us with our problems. They give us ideas on how to deal with it. They have Hmong staff there that help us.

They help me change myself, have patience, control my anger and become a better person.

Nothing to change. Everything is very good. They say nice things to me and they love me.

No, nothing. I can’t think of anything.

A15. Additional comments/feedback**Additional comments**

One thing I would like to change is to have Hmong workers who can really speak Hmong so that it is clear and elders can understand. Sometimes there is miscommunication because Hmong workers can't speak proper Hmong to explain what needs to be explained.

Overview of service model databases

The Association of Asian Pacific Community Health Organizations (AAPCHO)

The Association of Asian Pacific Community Health Organizations (AAPCHO) is a national association representing community health organizations dedicated to promoting advocacy, collaboration and leadership that improves the health status and access of Asian Americans & Native Hawaiians and other Pacific Islanders (AA & NHOPI) within the United States, its territories, and freely associated states, primarily through our member community health centers. (<http://www.aapcho.org/site/aapcho/>)

Blueprints for Violence Prevention

Blueprints for Violence Prevention, a project of the Center for the Study of Prevention of Violence at the University of Colorado, reviews and identifies promising and effective violence and drug prevention and intervention programs and models. It is a resource for those who are interested in implementing and investing in violence and drug prevention programs. Programs are reviewed through a selection process and must meet high standards and tests of effectiveness to be selected as a model program or promising practice, such as evidence of deterrent effect with a strong research design, sustained effort, and multiple site replication. (<http://www.colorado.edu/cspv/blueprints/index.html>)

Bridging Refugee Youth and Children's Services (BRYCS)

Bridging Refugee Youth and Children's Services (BRYCS) is the Office of Refugee Resettlement's national technical assistance provider on refugee child welfare. BRYCS assists service providers from refugee resettlement agencies, mainstream service agencies, such as child welfare and schools, and ethnic community based organizations. BRYCS provides individual consultations, trainings, and conference presentations on topics related to serving refugee children and families. In addition, BRYCS authors publications and maintains a Clearinghouse of thousands of resources. (<http://brycs.org/aboutBrycs/index.cfm>)

National Registry for Evidence-based Programs and Practices (NREPP)

The National Registry for Evidence-based Programs and Practices (NREPP), a program of the Substance Abuse & Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services, is an online database of mental health and substance abuse interventions. NREPP selects interventions for review and provides a summary of the intervention, including its outcomes, quality of research

methods, and readiness for dissemination, to help the community learn about and identify programs that prevent and treat mental health and substance abuse disorders.

<http://www.nrepp.samhsa.gov/index.asp>