

Hmong Mental Health and Alcohol and Other Drug Abuse: An Analysis of Focus Group Findings

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November 30, 2016

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Suggested citation:

Xiong, Yang Sao and Wisconsin United Coalition of Mutual Assistance Association.
2016. *Hmong Mental Health and Alcohol and Other Drug Abuse: An Analysis of Focus
Group Findings*. Onalaska, WI: Wisconsin United Coalition of Mutual Assistance
Association, Inc.

Table of Contents

Acknowledgments.....	1
About WUCMAA.....	2
Executive Summary	4
Background of the Wisconsin Hmong Mental Health and AODA Community Dialogue.	6
Method and Data Sources	7
Findings.....	8
Demographic Background of Focus Group Participants	8
Hmong Concepts of Mental Health and Mental Illness.....	9
Recognition of Mental Illness and AODA as Social Problems	9
Perceived Causes of Mental Illness and Factors that Lead to AODA	10
Perceived Effects of Mental Illness and AODA.....	13
Challenges to Seeking Help/Services for Mental Illness and AODA.....	13
Community Assets	15
Conclusion and Recommendations.....	16
Limitations	18
References.....	19
Focus Group Protocol and Questionnaire.....	21
Hmong Mental Health, Alcohols, and Substance Abuse Dialogue Participants	28
2014 Suicide and Homicide Key Informants Data	30
The Recovery Framework: Behavioral Health Factors and State Funded Services	31

Acknowledgments

The Wisconsin United Coalition of Mutual Assistance Association, Inc. would like to thank the following people who contributed their time and expertise to make possible the Wisconsin Hmong Mental Health and Alcohol and Other Drug Abuse (AODA) Community Dialogue and Report.

We are grateful to the Wisconsin Department of Health Services, Division of Care and Treatment Services which funded this project. We wish to especially thank Dr. Anthony Ernst, Section Chief and Mrs. Mai Zong Vue, InterCultural Program Coordinator for their support and guidance throughout this project. We are also grateful to Mr. Patrick Cork, Division Administrator, Division of Care and Treatment Services, for spending his weekend with us and for his valuable remarks on mental health and AODA issues.

We also wish to thank Dr. Xa Xiong and Dr. Alyssa Vang for sharing their expertise with our leaders and community members at this meeting. The education they provided was invaluable to everyone in attendance and helped facilitate the dialogue among participants. We are also grateful to Mr. Za Blong Vang for his keynote address.

Thank you to the panel presenters, Dr. Sebastian Ssempijja, Mr. Leng Lee, Ms. Mai Kue Lee, Mrs. Ka Ying Vue and Mrs. Mai Zong Vue, for sharing their insights, experiences and perspectives. Also, many thanks to our four volunteer facilitators: Dr. WahCher Vang, Mr. Thai Yang, Mrs. Mayyer Thao, and Mrs. Dawn Yang for their time and support. We would like to thank Ms. Tammie Xiong, Executive Director of Hmong Women Advancement Association, Inc. for her work in gathering and transcribing the focus groups and Dr. Yang Sao Xiong for his help in designing the focus groups, analyzing the data, and producing this final report. Mr. Thai Vue, Mr. Peter Yang, and Mrs. Mai Zong Vue read and provided invaluable comments on earlier versions of the report.

Finally, we are extremely grateful to the many Hmong women and men who participated in the community dialogue and the focus groups. This report would not have been possible without their insights and perspectives about the issues of mental health and alcohol and other drug abuse.

About WUCMAA

The Wisconsin United Coalition of Mutual Assistance Association, Inc. (WUCMAA) was founded in the state of Wisconsin under chapter 181 of the Wisconsin Statutes- a non-stock corporation-on June 19th, 1986. WUCMAA is a coalition of the Mutual Assistance Associations and plays major roles in assisting its members to gain leadership skills and work with other organizations at the state level to improve the quality of life for the Southeast Asian population in Wisconsin. The Board of Directors is composed of executive directors and presidents from each local member Mutual Assistance Association.

The purpose of WUCMAA is to:

- advocate for and represent the statewide interests of the mutual assistance associations* and their constituencies;
- promote central programs to improve the quality of life for South East Asians;
- share information and concerns;
- identify state-wide opportunities;
- preserve cultures and customs;
- promote economic self-sufficiency; and
- promote or provide leadership development among its member organizations and constituencies in the state of Wisconsin

The following are current members of WUCMAA:

- Hmong American Friendship Association, Inc.
- Hmong American Partnership Association, Inc.
- Hmong American Association of Portage County, Inc.
- Sheboygan Hmong Mutual Assistance Association, Inc.
- Shee Yee Community of Milwaukee, Inc.
- United Asian Services of Wisconsin
- Hmong American Center, Inc.
- Wisconsin Lao Veterans of America, Inc.
- Hmong Wisconsin Chamber of Commerce, Inc.

To learn more about WUCMAA's current members and activities, visit:

<http://www.wucmaa.org/>

*A Mutual Assistance Association - usually referred to as MAA - is established by the Southeast Asians to serve the Southeast Asians and refugees. Each MAA may be named differently by its founders. MAAs are private non-profit organizations that are formed

and governed by a majority of the Hmong and Southeast Asians; at least 51% of the board members must come from the Southeast Asian community.

The following description provides an overview of where MAAs are located and a summary of their services. MAAs exist in most large refugee communities throughout the United States. In Wisconsin, the following cities have MAA services for the refugee population: Milwaukee, Appleton, Sheboygan, La Crosse, Eau Claire, Madison, Oshkosh, Green Bay, Manitowoc, Wausau, Wisconsin Rapids, and Stevens Point.

The services that MAAs provide may vary from one organization to another. The following are some of the basic services that are provided to the Southeast Asian and other refugee communities: Employment services, case management, driver's education, support services, translation and interpretation, cross-culture counseling, peer counseling, advocacy, family strengthening, emergency hotline, domestic abuse prevention and intervention, English as a Second Language (ESOL), youth services, parenting education, elderly services, health screening, sexual assault and abuse prevention, speakers bureau, motivational training, housing and home safety education, Hmong literacy, cultural programs, business development and etc.

Executive Summary

This report analyzes focus group data from the Wisconsin Hmong Mental Health and Alcohol and Other Drug Abuse (AODA) Community Dialogue in order to describe 1) the demographic background of Hmong focus group participants, 2) Hmong informants' perceptions about mental health and mental illness, 3) Hmong informants' perceptions about AODA, and 4) Hmong informants' perspectives about the types of community assets available to address mental illness and AODA issues in the Hmong American community. The major findings of this report are as follows:

1. Hmong informants recognized that mental illness, physical illness and alcohol and other drug abuse are real, serious, interconnected problems in Hmong American communities and believe that people with mental illness and/or AODA problems should seek professional help and services (in addition to traditional helpers such as lineage or clan leaders). Professionals are expected to be trained experts who are also culturally competent and there is some preference that professionals ought to be Hmong, bilingual and bicultural.
2. Hmong informants identified a number of challenges that could prevent persons with mental illness and/or AODA problems from seeking professional help and services. These challenges include the stigma attached to mental illness and AODA; the lack of peer support in the help seeking process; and the lack of bilingual and bicultural mental health professionals in the communities in which Hmong Americans live.
3. Hmong informants identified a number of social stressors that could lead to mental illness. These stressors include the breakdown in the communication between spouses and between parents and children; extra-marital affairs; abusive relationships/domestic violence; social isolation; social stigma; internalization; and poverty.
4. Hmong informants identified a number of factors that could lead to alcohol and drug abuse. These include strong pressure from peers; spousal conflicts; poverty; unemployment; and people's existing health/physical conditions.
5. Hmong informants are especially concerned about the frequency of suicide among Hmong young adults and young unmarried people.
6. Hmong informants are especially concerned about the abuse of alcohol among men, women, and younger adults and the use of marijuana and crystal meth among adults under 40 years old.

7. Hmong informants are concerned with the lack of local, state and national data on current problems Hmong are facing on a day to day basis.
8. Hmong informants identified a number of community assets that could be called upon to address mental illness and AODA problems in Hmong American communities. These assets include women and men leaders in the community, traditional healers, Hmong cultural specialists (wedding mediators, funeral directors, clan leaders), mutual assistance organizations, health professionals of Hmong background, and researchers of Hmong background.

Background of the Wisconsin Hmong Mental Health and Alcohol and Other Drug Abuse (AODA) Community Dialogue

Mental and physical illnesses are serious crises in Hmong American communities. As political refugees from the war-torn country of Laos, Hmong have had to endure decades of war and the physical and psychological traumas of war and forced displacement. While some of their physical scars may have healed, Hmong men and women's psychological scars are long lasting and oftentimes permanent. As they resettled in the United States, Hmong men and women came into contact with new sets of physical and social environments and contingencies, health attitudes and behaviors, and health institutions. Existing research shows that since Hmong's arrival to the U.S. in the mid-1970s, they have experienced a wide range of physical and mental illnesses (Cha, 2003; Culhane-Pera, Her, & Her, 2007; Culhane-Pera, Moua, DeFor, & Desai, 2009; Gjerdingen & Lor, 1997; Himes, Story, Czaplinski, & Dahlberg-Luby, 1992; Hu, 2001; Lee & Chang, 2012; Perez & Cha, 2007; Reder, Cohn, Vangyi, Vang, & Vang, 1984; Tanjasiri et al., 2001; Thalacker, 2011; Voorhees, Goto, & Wolff, 2012; Wahedduddin, Singh, Culhane-Pera, & Gertner, 2010; Wong, Mouanoutoua, Chen, Gray, & Tseng, 2005; A. Yang, Xiong, Vang, & Pharris, 2009; R. C. Yang, Mills, & Nasserri, 2010; R. C. Yang, Mills, & Riordan, 2004, 2005; Young, Xiong, Finn, & Young, 2012). Today, mental and physical illnesses continue to confront and affect Hmong individuals, families, and communities in far-reaching ways.

The U.S. Department of Health and Human Services (1999) defines mental illness as "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning." As a health condition, mental illness probably affects a significant number of Hmong in the United States. Although data on the prevalence of mental illness among this population are not readily available and some are quite outdated, past studies have estimated the prevalence of diagnosable mental health disorders among Hmong adults and adolescents to be quite high compared to those of the general U.S. population. Some of the major mental disorders that Hmong adults and adolescents experience include major depression (15% to 75%), general anxiety disorder (35% to 45%), and post-traumatic stress disorder (15% to 35%) (Thao, Leite, & Atella, 2010).

Since the mid-1980s, Wisconsin has been home to the third largest population of Hmong in the United States. According to the 2010 U.S. Census, 49,240 Hmong lived in Wisconsin, making Hmong the largest Asian American group in the state. As a racially and economically vulnerable population, Hmong former refugees and, to some extent, their U.S.-born children, continue to experience significant challenges in terms of health access, health service quality, and health outcomes.

In Wisconsin, there were 84 Hmong deaths due to suicide and/or homicide, including murder-suicide, in 2014 alone. Fifty-five percent of these suicides and homicides occurred in three cities: Milwaukee (19), La Crosse (14), and Wausau (13) (see Vue 2014 in appendix). Hmong's mental disorders may be intertwined with the issues of alcohol and other drug abuse/addiction (AODA), which have emerged in Hmong's new contexts of resettlement.¹

In recognition of the serious problems of mental health and AODA in Hmong American communities and the urgent need to identify strategies for addressing existing problems and preventing future ones, on July 30, 2016, the Wisconsin United Coalition of Mutual Assistance Association, Inc. (WUCMAA) organized a two-day community dialogue on Hmong mental health and alcohol and drug abuse in Reedsburg, Wisconsin. About 40 Hmong informants from Wisconsin were asked to participate in the community dialogue. The two-day event also included educational presentations about mental health and AODA by two health professionals, Alyssa Kaying Vang, Psy.D., LP of AKV Psychological and Consulting Services, LLC, and Xa Xiong, M.D. of Holy Family Memorial (HFM) Family Medicine. On the second day of the event, the WUCMAA organized focus groups with 40 Hmong informants on the topics of mental health, AODA, and community assets.

Method and Data Sources

Study Design and Data Analysis

Two consecutive sessions of focus group interviews were carried out on July 31, 2016. During the first 90-minute (morning) session, forty Hmong informants participated in four separate focus groups. Focus groups were comprised as follows: (1) One female facilitator and 10 female informants were assigned to discuss mental health issues; (2) One male facilitator and 10 male informants were assigned to discuss mental health issues; (3) One female facilitator and 10 female informants were assigned to discuss AODA issues; (4) One male facilitator and 10 male informants were assigned to discuss AODA issues. An effort was made to vary the age of informants in each of the focus groups, mixing younger adults with older adults. During the second 90-minute (afternoon) session, members of each of the four focus groups discussed community assets relating to their previously assigned topic.

¹ Since the 1970s, Hmong refugees underwent stringent medical examinations as a condition of being admitted to the United States. Refugees found to be drug abusers or addicts were usually not admitted to the United States.

Yang Sao Xiong, Ph.D., Assistant Professor of Social Work and Asian American Studies at the University of Wisconsin-Madison helped to design the focus group protocol and questionnaire provided to the facilitators. A copy of the focus group protocol and questionnaire can be found in the Appendix. Some parts of the focus group protocol and questionnaire were adapted from the Substance Abuse and Mental Health Services Administration's (2013) "Discussion Guide: Community Conversations About Mental Health."

Each focus group interview session was audio recorded and the audio recordings were transcribed by bilingual Hmong persons. Transcription work was done between early August and mid-September 2016. Content analysis of the focus group interviews was performed using NVivo (QSR, Australia) and completed in September 2016.

Findings

Demographic Background of Focus Group Participants

A total of 40 Hmong (55% female) informants participated in the focus groups. Participants came from various cities throughout Wisconsin, including La Crosse, Milwaukee, Holmen, Manitowoc, Onalaska, Sheboygan, Green Bay, and Stevens Point.

Of the 40 informants, 38 were 18 years old or older and two were under 18. The average age of the informants was 43 years. (33% of the participants were under age 40; 45% were between 40 and 55 years old; and 23% were 56 years or older).

Eighty percent of the participants were married; 10% were non-married; and 10% were separated.

Seventy-eight percent of the participants were born in Laos; 15% were born in Thailand; 5% were born in the United States; and 2% were born elsewhere. Of those born outside of the United States, 20 percent arrived in the U.S. in 1979.

The participants varied in terms of their religious affiliation. Fifty-five percent of the participants were affiliated with ancestor worship/shamanism; 38% were affiliated with Christianity; 5% were not affiliated with any religion.

Focus group participants were of various occupational backgrounds. These included teachers/educators, public administrators, social service workers, psychotherapists, interpreters, non-profit staff, machine operators, assembly line workers, attorneys, and bilingual educational assistants.

Hmong Concepts of Mental Health and Mental Illness

Hmong informants use a few specific phrases to refer to mental illness and mental health. For instance, informants often use *kev kaj siab* (literally a peaceful liver), to refer to mental health. Indeed, Hmong use the concept of *siab* (liver) to describe various feelings and emotions.

Conversely, participants frequently use, *kev mob siab mob ntsws* (literally, traumatized liver and lung), to refer to mental illness. Mental illness is regarded as an unbearable and difficult to relieve burden. As one participant explains,

Kev mob siab mob ntsws mas zoo li lub nra ua ris tsis tau li. Nce toj los rub tsis tau li, nqis hav los yeej txo tsis laib. (Mental illness is like a burden that is unbearable. It cannot be pulled uphill, it cannot be released downhill).

Recognition of Mental Illness and AODA as Social Problems

Hmong informants recognize that mental illness, physical illness and alcohol and other drug abuse are real, serious and interconnected problems in Hmong American communities. Responding to the question, “Why is mental illness an important or not so important problem in your community?,” one participant states,

Nws tseem ceeb rau peb txhua tus. Vim nws yog ib qhov kab mob ua koj tsis feel tias koj muaj. Txhua leej txhua tus yeej muaj. Yog tsis nrhiav kev pab, nrhiav treatment ces ua rau nws tag txoj sia. Los mus tua lwm tus. (It is important to all of us. Because it is [not necessarily] an illness that you feel you have. [However], anyone can have it. If help and treatment are not sought, the person could lose their life. Or kill others).

Although some participants regard mental illness as qualitatively different from physical illness, many agree that mental illness and physical illness as intertwined in important and sometimes even causal ways. For instance, one participant describes how being depressed led him to have diabetes.

Tau 5-6 lub xyoo no, kuv muaj kev nyuaj siab, ces kuv muaj ntshav qab zib. Kuv noj tshuaj ntshav qab zib lawm. (For 5-6 years now, I had depression and it led to my diabetes. I am now taking diabetes medication).

Perceived Causes of Mental Illness and Factors that Lead to AODA

Mental Illness

Hmong informants identified a number of social stressors that could lead to mental illness. These stressors include the breakdown in the communication between spouses and between parents and children; extra-marital affairs; abusive relationships; social isolation; social stigma; and poverty.

Female and male participants emphasize different causes of mental illness. Many women believe that women's and children's mental illness has a lot to do with the conflicts between spouses, extra-marital affairs, and abusive relationships in general. As a female participant recounts,

Kuv paub tej tug neeg ua nws tus txiv tham hluas nkauj es nws nyuaj siab, ntshav nce taub hau 172. Hos muaj tej tug, tus txiv ho yuav niam yau ces tshuav tuag xwb thaum lawv hu Nplog teb tuaj rau nws tias nws tus txiv yuav niam yau, nws yuav dhia qhov rooj. Ua rau kuv ntshai tag li. (I know of a person whose husband was having an affair and she became very fraught, [her] blood pressure climbed to 172. And then another whose husband married a second wife and [she] almost died when they called from Laos to tell her that the husband had married a second wife; she was going to jump out of the door. I was so scared).

Similarly, another female informant describes,

[M]uaj os, thaum ntej ces twb yog kev nkauj kev nraug ntawm niam txiv los mus, ces sib tshom, sib ceg los mus. Menyuam nyuaj siab ces cia li ua li ntawv lawm, tsis nyob normal. (It happened; in the beginning it was an affair, [which led to] disagreements and arguments. The children became distraught and became abnormal).

Moreover, some women believe that mental illness is associated with the process of aging and the stresses of parenting.

Kuv xav hais tias nws muaj ob yam. Yam ib yog cov laus, yam ob yog cov hluas. Cov laus kev nyuaj siab nyuaj ntsws, zoo li kuv no laus lawm. Muab xav thaum kuv tseem 15 -16 xyoo rau 20 xyoo ntawd mas, tam sis no yus txoj kev nyuaj siab thiab yus pom cov teeb meem ntau tshaj lawm. Ua rau yus nyuab siab nyuab ntsws ntau tshaj. Li hais, yog koj muaj ib tug menyuam, koj muaj ib txoj kev txhawj xeeb, yog koj muaj ob tug menyuam koj muaj ob txoj kev txhawj xeeb. Kuv pom tam sim no mas, cov laus qhov mas nws muaj menyuam, kev noj, kev haus. Yog koj tus menyuam tsis mloog lus, koj txhawj ib zaug. Koj muaj ib tug ntshais, muaj hnuab nyug tsis tau txiv los koj txhawj ib zaug. Koj muaj tub, muaj hnuab nyug tsis tau pojniam los koj txhawj ib zaug. Tagrho cov no ua rau koj kev nyuaj siab

tib si.(I think that there are two kinds. The first involves adults, the second involves minors. Mental illness among adults such as myself. Compared to my life when I was 15-16 years to 20 years old, my worries and my recognition of the problems have increased a great deal. It makes me a lot more mentally unstable. As we might say, when you have one child, you have one set of concerns; when you have two children, you have two sets of concerns. I see that nowadays, among the adults, it has to do with having children and trying to make a living. If your child does not listen, you worry. If you have a daughter of marriage age who can't find a husband, you worry. If you have a son of marriage age who can't find a wife, you worry. All of this becomes your mental illness).

Some male participants, on the other hand, emphasize social isolation and the social stigmas attached to mental health as causes of mental illness. From some participants' point of view, mental illness and the stigmas attached to them go hand in hand and are potentially reinforcing. One participant points out that being labeled "mental" could lead to a self-fulfilling prophecy:

Lo lus 'mental' health² no ces, kuv twb nyob normal los yog nws hais li rau kuv no ces kuv cia li mental health tam sis ntawv li. (Laughter) Nej puas xav li kuv, kuv ces chim kiag li lawm os. Kuv cia li tau kiag tus kab mob ntawv li lawm. Piv txwv tias, yog kuv tus pojniam hais lus ntau tshaj kuv, ces kuv cia li mob mental health lawm. Kuv muaj depression, kev nyuaj siab ntau yam. Txog thaum kawg ces, kuv muaj mental health.(Regarding the word 'mental' (illness), even if I were normal, if somebody were to call me by that label, I would become 'mental' right away. (laughter) Are you thinking what I'm thinking? I would be upset. I would immediately have that disorder. For example, if my wife were to speak more than I do, I could also contract mental (illness). I would have depression, anxieties of various sorts. In the end, I would have mental illness).

Social isolation is also seen as a possible contributor to mental illness. As one informant describes,

Ib co [neeg] mas kaw qhov rooj nti, tsis tawm qhov twg, tsis muaj phooj ywg, mus hauj lwm los tsev ces nyuaj nyuaj siab.(Some people live their lives at home, don't go out much, don't have many friends; they return home from work and simply worry).

Alcohol and Other Drug Abuse

Hmong informants identified a number of factors that could lead to alcohol and drug abuse. These factors include people's existing mental and physical conditions; strong pressure from peers; cultural norms; poverty; and unemployment.

² Given the context, this participant most likely meant to say "mental illness" instead of "mental health."

Some participants believe that some people sometimes use alcohol and drug as a way to cope with mental and physical illnesses. The following statement by a participant reflects this view,

Qhov kuv ntxiv, ces kuv hais yooj yim xwb. Li kuv pom mas, cov pheej haus ntawv mas, haus daws lawv txoj kev nyuaj siab. Yus tsis paub tias txojkev nyuaj siab yog dabtsi. Lawv haus kom mus loog lawv, kom lawv txhob hnov, txhob nco qab lawv tej kev nyuaj siab. Tej zaum lawv mob cancer, mob dabtsi, mob loj loj lawm, tsis xav hnov lawv kev mob, kev nyuaj siab ntawd ces lawv haus dej cawv, haus yeeb haus tshuaj mus kom loog lawv lub hlwb, es txhob xav txog. (I'd like to add something, and it is simple. As I see it, those who drink do so to reduce their anxieties/worries. We don't know what those anxieties/worries are. They drink in order to numb themselves, so that they won't feel, won't remember their worries. Perhaps they have cancer, or some other serious illness, and don't want to feel their pain or worries; they may drink or do drugs to numb their mind, to forget).

Some participants believe that financial stress can also lead people to abuse alcohol and other drugs.

Kuv xav mas, ib txhia neeg poob hauj lwm. Thaum koj poob hauj lwm, koj nrhiav tsis tau hauj lwm. Koj nyuaj siab, nqi bill los tuaj ntau them. Nws nyuaj siab ces, haus beer kom qaug es daws kev nyuaj siab. Nws tsis paub tias muaj kev pab qhov twg. Haus ntau ces muaj teeb meem rau nws tus kheej. Nws xiam hlwb, nws tuag thiab. (I think some people lost their jobs. When you become unemployed and are unable to find work, you stress and bills start to pile up. The person worries and then gets drunk on beer in order to ease their worries. He/she doesn't know where help is. As they drink more, problems affect them personally. They can lose their mind or stroke and die).

Most participants, including men and women, believe that strong peer pressure and expectations during Hmong festivities contribute to alcohol abuse/addiction among people within Hmong communities. As one participant put it,

Lub hauv paus, puag ta kuv twb touch on me me lawm thiab. Kuv rov muab reverbalize. Nej yeej paub tias tim peb coj noj coj ua. (The root of it, which I already touched on previously but will say again: You know that it has to do with our leaders).

In the context above, “our leaders” refer to a range of persons in informal positions of influence. While participants did not identify any particular class of leaders, participants implied that these are persons who are frequent or regular participants at public gatherings, events and/or parties.

Some female participants believe that alcohol abuse is a serious social problem among many Hmong women. They attribute some of women's drinking behavior to spouses'/men's drinking behavior.

Perceived Effects of Mental Illness and AODA

Two of the most common effects of mental illness identified by Hmong informants are social isolation and suicides. Informants are especially concerned about the frequency of suicide among Hmong young adults and young unmarried people.

Kuv txhawj xeeb tshaj plaws yog peb nyob twj ywm tsis saib dab tsi no ces, zoo li peb cov neeg thaum ub uas commit suicide los [yog] dai tuag coob. Tam sim no peb tig los ntsia 2-3 xyoo no, cov hluas tuag coob tshaj plaws[yog cov] under 30 xyoo. (I am extremely concerned; if we weren't paying too much attention, it would appear that most of the past suicides or hangings occurred among the older generation. However, if we paid attention to the most recent 2-3 years, those who committed suicide are those under 30 years old).

Challenges to Seeking Help/Services for Mental Illness and AODA

Hmong informants identify a number of challenges that could prevent persons with mental illness and/or AODA problems from talking about and seeking professional help and services. These challenges include the stigmas attached to mental illness and AODA; the lack of peer support in the help seeking process; and the lack of bilingual and bicultural mental health professionals in the communities in which Hmong Americans live.

Stigmas Associated with Help Seeking

Many informants recognize the strong stigmas attached to mental illness in their communities. As one participant describes,

Kuv hnov lo lus tias mental health mas kuv hnov tias, "Koj puas yog poj ntxoog? Koj puas yog cov txiv tsov tom tom neeg?" Hais txog mental health mas yog lo lus phem phem. Zoo li hais tias, koj puas mob uav, mob ruas? Thaum hnov lo lus ntawv, ces tsis xav hais tawm. (When I hear the word mental health, I hear the question, "Are you a ghost? Are you a human eating tiger?" Mental health is a bad word. It sounds like asking, do you have leprosy? When that word is heard, it makes it undesirable to speak about it openly).

According to informants, this stigma is related to the fact that people who seek mental health services are often prescribed drugs. As one participant explains,

Li kuv pom mas, Meskas muaj tshuaj rau cov menyuam Meskas noj. Qhov ntawv mas tsis muaj leejtwg pom zoo li. You don't want to be known as a 'crazy.' (As I

see it, Americans give drugs to American minors. Nobody agrees with that. You don't want to be known as a 'crazy').

Lack of Peer Support and Traditional Helpers are Sometimes Not Helpful

Hmong informants believe that people with mental illness and/or AODA problems should seek professional help and services as opposed to traditional helpers such as lineage or clan leaders. A male participant describes how a person could face a dead-end when going to traditional helpers for help:

Tsis xav noj mov, ibleeg pw ib ces kaum txaj. Mus tham qhia cov laus, lawv tias 'koj ua tsis tau txiv,' ces txaj muag thiab. Yus muab npog ob peb vas thiv, tsheej hli ces nyuaj siab. Pojnim muaj pojnim nyiaj, lawv hais tias lawv muaj lawv nyiaj tsis txhob thab thab lawv. Yus hais [kom] mus ntsib txiv hlob, txiv ntxawm los lawv hais tias tsis ntse li lawv, lawv tsis mus. Lawv hais tias, mus tham los tsis pab thiab muab lawv lub qe tham xwb. Zoo li no ces, peb ob peb txoj kev kaw tas.(Not wanting to eat; each [person] on their own corner of the bed. When one tells this to one's adults/parents, they say, 'you are not man enough,' and one becomes embarrassed. One may hide it for several weeks, perhaps months, worrying alone. The wife has her own money; they say they have their own money, don't bother them. One encourages them to go to an uncle [for advice], but they say the uncles aren't as smart as them. They say that it won't help the matter; it would just produce gossip about them. In this way, we find ourselves in dead-ends).

Lack of Bilingual, Bicultural Hmong Professionals

To many informants, it is obvious that there is a serious lack of bilingual and bicultural mental health professionals of Hmong background. Informants are concerned that existing mental health professionals, despite their training, are not necessarily culturally competent. From the view of many informants, the lack of bilingual, bicultural Hmong professionals combined with the lack of culturally competent non-Hmong professionals discourage Hmong who want or need mental health services from seeking or being able to easily access services.

Community Assets

Hmong informants identify a number of community assets that could be called upon to address mental illness and AODA problems in Hmong American communities. These assets include families, leaders in the community, traditional healers, mutual assistance organizations, health professionals of Hmong background, and researchers of Hmong background. But they also identified as community assets several facilities and events which Hmong Americans have access to.

Many informants believe that strong families and strong homes are essential to good mental and physical health for individuals, families, and communities in general. A loving relationship, two-way communication and regular bonding between spouses and between parents and children are identified as being especially crucial to a healthy family. From the point of many informants, healthy adult relationships, including healthy marriages, could contribute to healthy parenting, which could reduce stress on adults, children, and other dependents.

Beyond families, leaders who lead by examples are highly regarded. For instance, leaders who set and follow clear rules about drinking alcohol in private as well as public spaces could help to reduce alcohol abuse. These include Hmong former leaders, community-based organization leaders, and traditional leaders.

Besides leaders, Hmong informants also identified professionals, social workers, educators and researchers of Hmong background as important community assets. Informants believe that these professionals would be more informed, more sensitive and potentially more effective in terms of helping to uncover the causes and effects of health conditions in Hmong American communities, helping to educate others about health issues, and potentially helping to address negative health issues. Hmong informants of one focus group identified, for instance, at least 8 Hmong medical doctors, 6 Hmong chiropractors, 4 Hmong dentists, 11 Hmong pharmacists, 4 Hmong holders of PhDs, 4 Hmong holders of EdDs, and 4 Hmong jurist doctors within Wisconsin.

Besides professionals with formal educational credentials, Hmong informants also identified trained Hmong cultural specialists as important assets to the Hmong community. These trained cultural specialists include Hmong shamans, other spiritual healers (*niam/txiv hu plig*), herbalists, priests, wedding ceremony mediators (*mej koob*), and funeral ceremony specialists (*kav xwm, taw kev, txiv qeej, cov ua mov, thiab lwm tus neeg*). It is the set of specialists who can attend to individuals' spiritual needs and who can help them develop strong inner strength.

Beyond individuals, informants also identified Hmong community organizations, including churches and associations, as comprising important community assets.

Informants identified, for example, 8 Hmong association centers, 6 Hmong churches, several Hmong businesses, and 3 Hmong shopping malls. Mutual assistance organizations are regarded as important community assets in the sense that these organizations could provide spaces/facilities for persons who struggle with social isolation, economic deprivation, language difficulties, stress, intra-family conflicts, etc.

Finally, Hmong informants identified regular and major Hmong events that could enable Hmong people to socialize with one another and to support each other during times of need. Some of the events they identified included the WUCMAA Hmong conference, the Hmong New Year, Hmong summer and fall events, clan events such as conferences picnics, and sub-clan events and picnics. Wedding and funeral events also recognized as events that could benefit from social support and as spaces that could help to sustain communities and people's kinship and friendship ties to one another.

In sum, Hmong informants recognize that these multidimensional community assets can play crucial roles in terms of preventing and intervening in mental health and AODA issues. The different community assets that Hmong informants identified could possibly address different levels and sources of mental illness and AODA issues in the Hmong American community. These community assets could potentially help to improve individuals' bodies, minds, spirit, and world. There is strong recognition that Hmong people already are engaged and will be engaged in new social problems and concerns including but not limited to mental health and AODA in the future at every level. Additionally, there is strong recognition that community members—leaders and ordinary persons alike—and their communities need current and accurate information about mental health, AODA, and the prevention and intervention programs available to address these social problems.

Conclusion and Recommendations

The informants of the focus groups make the following recommendations in hopes of building effective partnerships between state agencies and communities, increasing access to mental health, alcohols, and substance abuse services, improving service delivery, and increasing our understanding of these complex dynamic social problems in Hmong American communities:

1. Develop preventive mental health and alcohol and other drug abuse services in close partnership with the Wisconsin Hmong community especially through the Wisconsin United Coalition of Mutual Assistance Association. A partnership with WUCMAA is vital because its bilingual and bicultural staff has an established track record of being involved in Hmong communities throughout Wisconsin, coordinating communication and cooperation among various Mutual Assistance Associations and other community-based organizations who serve

Hmong communities, and carrying out research projects relating to Hmong health and other issues.

2. Provide mental health and AODA outreach and education to Hmong community members and those serving the Hmong community. Develop educational programs to educate the Hmong and Hmong leaders about mental health, alcohols, and substance abuse and consequences; educate them on the stigmas attached to mental health services and the benefit of seeking services.
3. Increase early intervention services across multiple domains, including schools and workplaces, especially intervention services to prevent suicides and the misuse or abuse of drugs among Hmong youth. Develop culturally appropriate strategies to reach persons who need the services and ensure that prevention programs are making a concerted effort to include and involve these persons and their advocates in all major decision making processes. Develop a 24-hour state-wide hotline staffed with trained Hmong-speaking personnel who can offer prompt and professional assistance, referral and intervention in crisis situations.
4. Require health care professionals to provide affordable, transparent and culturally competent services to Hmong patients.
5. Expand the Comprehensive Community Service (CCS) program to address Hmong needs including mental health needs. Establish and fund culturally and linguistically responsive programs and offices to address the current crises of mental illness and alcohol and drug abuse in Hmong American communities throughout Wisconsin.
6. Increase the number of bilingual and bicultural Hmong professionals within the Wisconsin mental health workforce by training and hiring these professionals in both private sectors and public sectors of the workforce. Develop Hmong peer specialists and peer support personnel and services.
7. Provide federal and state funding for translatable research studies focused on identifying health disparities in Hmong American communities, including disparities relating to Hmong mental health and alcohol and other drug abuse issues.
8. Invest financial resources and human capital in Hmong communities in order to reduce poverty and increase Hmong families' standards of living. A reduction in poverty and an increase in families' standards of living could help to improve families' access to health care services and improve overall wellbeing.

We believe that these recommendations are consistent with the ideas presented in the Wisconsin Department of Health Services' Recovery Framework for Behavioral Health Factors and State Funded Services (see Appendix). These recommendations offer a set of

possibilities for aligning state funded services with the needs of the Hmong American community.

Limitations

As is the case in all studies, there are limitations to this particular focus group study of Hmong's mental health and alcohol and other drug abuse issues. First, the Hmong American community is immensely heterogeneous, complex, and dynamic. The 40 Hmong persons who participated in the focus groups represent only a tiny segment of the Hmong community in Wisconsin. Their views and insights on mental health or AODA issues, while invaluable, are not necessarily representative of the spectrum of views present in the Hmong community. Despite this limitation, it is hoped that the themes that surfaced from the focus group interviews may help pave the way toward more in-depth and more sustained qualitative and quantitative studies on Hmong's mental health and AODA issues in the future.

References

- Cha, D. (2003). *Hmong American concepts of health, healing, and conventional medicine*. New York: Routledge.
- Culhane-Pera, K. A., Her, C., & Her, B. (2007). "We are out of balance here": A Hmong cultural model of diabetes. *Journal of Immigrant and Minority Health, 9*(3), 179-190. doi: 10.1007/s10903-006-9029-3
- Culhane-Pera, K. A., Moua, M., DeFor, T. A., & Desai, J. (2009). Cardiovascular disease risks in Hmong refugees from Wat Tham Krabok, Thailand. *Journal of Immigrant and Minority Health, 11*(5), 372-379. doi: 10.1007/s10903-008-9211-x
- Gjerdingen, D. K., & Lor, V. (1997). Hepatitis B status of Hmong patients. *Journal of the American Board of Family Medicine, 10*(5), 322-328.
- Himes, J. H., Story, M., Czaplinski, K., & Dahlberg-Luby, E. (1992). Indications of early obesity in low-income Hmong children. *American Journal of Diseases of Children 146*(1), 67-69.
- Hu, J. (2001). Increased incidence of perforated appendixes in Hmong children in California. *New England Journal of Medicine 344*(13), 1023-1024. doi: 10.1056/NEJM200103293441316
- Lee, S., & Chang, J. (2012). Mental health status of the Hmong Americans in 2011: Three decades revisited. *Journal of Social Work in Disability & Rehabilitation, 11*(1), 55-70. doi: 10.1080/1536710X.2012.648117
- Perez, M., & Cha, K. (2007). Diabetes knowledge, beliefs, and treatments in the Hmong population: An exploratory Study. *Hmong Studies Journal, 8*, 1.
- Reder, S., Cohn, M., Vangyi, S. V., Vang, D., & Vang, T. (1984). The Hmong resettlement study: Site Report: Fresno, California. Washington, D.C.: Office of Refugee Resettlement, U.S. Department of Health and Human Services.
- Substance Abuse and Mental Health Services Administration. (2013). *Community Conversations About Mental Health: Information Brief*. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://www.mentalhealth.gov/talk/community-conversation/discussion_guide_07-22-13.pdf.
- Tanjasiri, S. P., Kagawa-Singer, M., Foo, M. A., Chao, M., Linayao-Putman, I., Lor, Y. C., . . . Vang, X. (2001). Breast cancer screening among Hmong women in California. *Journal of Cancer Education, 16*(1), 50-54. doi: 10.1080/08858190109528725
- Thalacker, K. M. (2011). Hypertension and the Hmong community: Using the health belief model for health promotion. *Health Promotion Practice, 12*(4), 538-543. doi: 10.1177/1524839909353735
- Thao, M., Leite, A., & Atella, J. (2010). Hmong mental health: An assessment of mental health needs and services for the Hmong community in Ramsey County. Saint Paul, MN: Wilder Research.
- U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. . Rockville, MD: U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration; Center for Mental Health Services; National Institutes of Health; National Institute of Mental Health.

- Voorhees, J., Goto, K., & Wolff, C. (2012). Overweight, Elevated Blood Pressure, Acanthosis Nigricans and Adherence to Recommended Dietary and Physical Activity Guidelines Among Hmong and White Middle School Students. *Journal of Immigrant Minority Health*. doi: 10.1007/s10903-012-9739-7
- Wahedduddin, S., Singh, J. A., Culhane-Pera, K. A., & Gertner, E. (2010). Gout in the Hmong in the United States. *Journal of Clinical Rheumatology*, 16(6), 262-266. doi: 10.1097/RHU.0b013e3181eeb487
- Wong, C. C., Mouanoutoua, V., Chen, M. J., Gray, K., & Tseng, W. (2005). Adherence with hypertension care among Hmong Americans. *Journal of Community Health Nursing*, 22(3), 143-156. doi: 10.1207/s15327655jchn2203_2
- Yang, A., Xiong, D., Vang, E., & Pharris, M. D. (2009). Hmong American women living with diabetes. [Research Support, Non-U.S. Gov't]. *Journal of Nursing Scholarship* 41(2), 139-148. doi: 10.1111/j.1547-5069.2009.01265.x
- Yang, R. C., Mills, P. K., & Nasser, K. (2010). Patterns of mortality in California Hmong, 1988-2002. *Journal of Immigrant Minority Health*, 12(5), 754-760. doi: 10.1007/s10903-009-9230-2
- Yang, R. C., Mills, P. K., & Riordan, D. G. (2004). Cervical cancer among Hmong women in California, 1988 to 2000. *American Journal of Preventive Medicine*, 27(2), 132-138. doi: 10.1016/j.amepre.2004.04.003
- Yang, R. C., Mills, P. K., & Riordan, D. G. (2005). Gastric adenocarcinoma among Hmong in California, USA, 1988-2000. *Gastric Cancer*, 8(2), 117-123. doi: 10.1007/s10120-005-0314-y
- Young, E., Xiong, S., Finn, L., & Young, T. (2012). Unique sleep disorders profile of a population-based sample of 747 Hmong immigrants in Wisconsin. *Social Science & Medicine*, 79, 57-65. doi: 10.1016/j.socscimed.2012.06.009

Appendix:

Focus Group Protocol and Questionnaire

Focus Group Discussions on Hmong Mental Health and AODA

Goal: The goal of this set of focus groups is to get the participants to discuss the mental health and alcohol and drug addiction issues that Hmong communities (individuals, families, and groups) have experienced or are experiencing and to consider how mental health and alcohol and other drug addiction may impact Hmong men, women, younger people and older adults differently or similarly.

Logistics: Divide 40 persons into four groups. Designate two focus groups (Groups #1 & #2) to discuss the topic of mental health. Designate the other two focus groups (Groups #3 & #4) to discuss the topic of alcohol and other drug addiction (AODA).

How to go about comprising the groups: It is important that we provide a safe space for women to be among women and men to be among men. Each group should have 8-10 persons. So, for example, form the following groups: 8-10 women in Group #1; 8-10 men in Group #2; 8-10 women in Group #3; 8-10 men in Group #4). When assigning participants to groups, be sure that each group contains participants who vary in their ages and occupation. Each group will need to have one facilitator and one note-taker. Ideally, there should be female facilitators for the women's groups and male facilitators for the men's groups. The note-takers can be of either gender. Each group has 90 minutes total to complete four tasks (these tasks are explained in Parts 1 through 4 below). Please provide each focus group participant with a pencil or pen and a few sheets of note cards so that they can jot down ideas as they go along.

Directions for the facilitator: The very first thing to do is to administer the survey to all of the participants in your group. Once that is done, start by setting some guidelines or ground rules for the focus group discussions. After setting guidelines, ask members of the group to do brief introductions. Next, begin the discussion. Finally, wrap up the discussion. Keep track of the time to be sure that each part is done within the allotted time. Encourage all of the participants to participate—verbally as well as by writing notes/comments on their sheets of note cards. Collect the note cards after each focus group is completed.

Instructions for Focus Groups #1 and #2: Discuss mental health issues in the Hmong Community

Administer the Demographic Survey (10 minutes). Hand out the surveys to the participants. Tell the group that “we’ll be completing the survey one question at a time, together.” Then read each question on the survey and give each participant a moment to

write his or her answer. Once the last question is completed, collect the surveys and give them to the note taker.

Part 1: Setting guidelines (5 minutes)

What guidelines or ground rules do you and your participants want to set for your discussion? Here are some examples:

- Listen with respect.
- Each person gets a chance to talk.
- One person talks at a time. Don't cut people off.
- When sharing, speak about yourself and your personal experiences.
- It's OK to disagree with someone else—in fact, it can be helpful—but personal attacks are never appropriate.
- Help the facilitator keep things on track.
- After this event is over, it is OK to share the main ideas discussed in the small group but not OK to link specific comments to specific people (“He said ... and she answered...”)

Part 2: Introductions (20 minutes)

1. Each person takes one minute: Introduce yourself and say a little about why you wanted to be part of this discussion.

2. Next, each person takes one minute: Think of just one word, phrase, or image that relates to why you think it is difficult for us to talk about mental health issues in Hmong communities or in American society in general. Write it down if you wish, or draw a picture. Then we will go around the circle and share each person's effort.

Part 3: Starting the discussion (35 minutes)

Central Question: What does mental health mean to me/you? How are mental health issues intertwined with issues of alcohol and other drug addiction?

Probing Questions:

1. What does good mental health look like to you? What does mental illness look like to you?
2. Why is mental illness an important or not so important problem in your community?
3. In your experience, how are mental illnesses affecting people in the Hmong community? If you are a young adult or an older adult, how do mental illnesses affect you and your peers? If you are a man or a woman, how do mental illnesses affect you and your peers?

4. Do you think your cultural background or your religion influences how you think about mental health or mental illness? If so, how?
5. Do you think your gender (being a woman or a man) influences how you think about mental health or mental illness?
6. In your experience, how are mental health issues in the community intertwined with issues of alcohol and other drug addiction? How are they both intertwined with physical health or wellbeing on an individual or community level?

Part 4: Wrapping up (20 minutes)

In your social circle or in your community,

1. There are many opinions on mental illnesses, their causes, and how we identify and treat these conditions. What are your views? For example, what do you think causes people to become mentally ill, and what actions do you think can we take to prevent these kinds of addictions?
1. What are your views on how mental health services are being delivered—or how they should be delivered?
2. What new insights did you gain from this discussion?

Instructions for Focus Groups #3 and #4: Discuss alcohol and other drug addiction issues in the Hmong community

Administer the Demographic Survey (10 minutes). Hand out the surveys to the participants. Tell the group that “we’ll be completing the survey one question at a time, together.” Then read each question on the survey and give each participant a moment to write his or her answer. Once the last question is completed, collect the surveys and give them to the note taker.

Part 1: Setting guidelines (5 minutes)

What guidelines or ground rules do you and your participants want to set for your discussion? Here are some examples:

- Listen with respect.
- Each person gets a chance to talk.
- One person talks at a time. Don’t cut people off.
- When sharing, speak about yourself and your personal experiences.
- It’s OK to disagree with someone else—in fact, it can be helpful—but personal attacks are never appropriate.
- Help the facilitator keep things on track.

- After this event is over, it is OK to share the main ideas discussed in the small group but not OK to link specific comments to specific people (“He said ... and she answered....”)

Part 2: Introductions (20 minutes)

1. Each person: Introduce yourself and say a little about why you wanted to be part of this discussion.
2. Next, each person takes one minute: Think of just one word, phrase, or image that relates to why you think it is difficult for us to talk about alcohol and other drug issues in Hmong communities or in American society in general. Write it down if you wish, or draw a picture. Then we will go around the circle and share each person’s effort.

Part 3: Starting the discussion (35 minutes)

Central Question: What does alcohol and other drug addiction mean to me/you? How are substance abuse issues intertwined with mental health issues?

Probing Questions:

1. How does alcohol addiction look like in your community or the Hmong community in general? What are other kinds of drug addictions in your community or the Hmong community in general?
2. Why is alcohol and other drug addiction (AODA) an important or not so important problem in your community?
3. In your experience, how are alcohol and other drug addiction issues affecting people in the Hmong community? If you are a young adult or an older adult, how do alcohol and other drug addiction issues affect you and your peers? If you are a man or a woman, how do alcohol and other drug addiction affect you and your peers?
4. Do you think your cultural background or your religion influences how you think about alcohol and other drug addiction? If so, how?
5. Do you think your gender (being a woman or a man) influences how you think about alcohol and other drug addiction?
6. In your experience, how are alcohol and other drug addiction issues in the community intertwined with issues of mental health or mental illness? How are they both intertwined with physical health on an individual or community level?

Part 4: Wrapping up (20 minutes)

In your social circle or in your community,

2. There are many opinions on alcohol and other drug addiction, their causes, and how we identify and treat these conditions. What are your views? For example, what do you think causes people to become addicted to alcohol or other drugs, and what actions can we take to prevent these kinds of addictions?
3. What are your views on how alcohol and other drug addiction services are being delivered—or how they should be delivered?
4. What new insights did you gain from this discussion?

Focus Group Discussions on Hmong Community Assets

Goal: The goal of this set of focus groups is to get the participants to discuss the assets or resources that Hmong communities (individuals, families, and groups) have or perceive themselves having for addressing the issues of mental health and alcohol and other drug addiction.

Logistics: Keep the same four groups that have been formed during the morning sessions as they already are. Each group will keep its same topic but discuss community assets and strategies as they pertain to either mental health or AODA. This means that focus groups #1 and #2 will discuss community assets as they pertain to mental health issues. Focus groups #3 and #4 will discuss community assets and strategies as they pertain to AODA. Each group will have one facilitator and one note-taker. Each group will take 90 minutes to complete the activities in Parts 1 through 3 below.

Directions for the facilitator: Start by doing brief introductions as the groups probably consist of people new to each other. Next, begin the discussion. Finally, wrap up the discussion. Keep track of the time to be sure that each part is done within the allotted time. Encourage all of the participants to participate—verbally as well as by writing notes/comments on their sheets of paper. Collect the sheet of papers with written comments after the focus group is completed.

Instructions for Focus Groups #1 and #2: Discuss Hmong community assets as they pertain to mental health issues

Part 1: Introductions (25 minutes) and Proposed Solutions

1. Each person takes one minute: Think of just one word, phrase, or image that relates to how we can reduce mental illnesses among Hmong persons. Write it down if you wish, or draw a picture. Then we will go around the circle and share each person's effort.

Part 2: Beginning the discussion (35 minutes)

1. What kinds of resources (individuals, support groups, churches, organizations or agencies, leaders, role models, centers/places, rituals, moral education, counseling services, etc.) do you already have in your community for addressing mental health problems? Have each person think about and come up with a list of resources on their note cards if they can. Then engage in a group discussion.
2. What kinds of resources do you, as a Hmong woman/man, parent/child have access to that can help address mental illnesses in your family or community?

Part 3: Wrapping up (30 minutes)

1. What promising strategies are already in place to improve mental health among young Hmong people (boys and girls, youth under 18 years old)?
2. What promising strategies are already in place to improve mental health among *older Hmong adults* (adults 65 years and older)?
3. What promising strategies are already in place to improve mental health among *Hmong women*?
4. What promising strategies are already in place to improve mental health among *Hmong men*?
5. In what ways have your community worked with local, state and/or federal institutions to promote the mental health of everyone in your community?

Instructions for Focus Groups #3 and #4: Discuss Hmong community assets as they pertain to alcohol and other drug addiction issues

Part 1: Introductions (25 minutes) and Proposed Solutions

1. Each person takes two minutes: Think of just one word, phrase, or image that relates to how we can reduce alcohol and drug addiction among Hmong persons. Write it down if you wish, or draw a picture. Then we will go around the circle and share each person's effort.

Part 2: Beginning the discussion (35 minutes)

1. What kinds of resources (individuals, support groups, churches, organizations or agencies, leaders, role models, centers/places, rituals, moral education, counseling services, etc.) do you already have in your community for addressing alcohol and drug addiction? Have each person think about and come up with a list of resources on their note cards if they can. Then engage in a group discussion.

2. What kinds of resources do you, as a Hmong woman/man, parent/child have access to that can help address alcohol and other drug addiction in your family or community?

Part 3: Wrapping up (30 minutes)

1. What promising strategies are already in place to improve alcohol and other drug addiction among *young Hmong people* (boys and girls, youth under 18 years old)?
2. What promising strategies are already in place to improve alcohol and other drug addiction among *older Hmong adults* (adults 65 years and older)?
3. What promising strategies are already in place to improve alcohol and other drug addiction among *Hmong women*?
4. What promising strategies are already in place to improve alcohol and other drug addiction among *Hmong men*?
5. In what ways have your community worked with local, state and/or federal institutions to reduce alcohol use and/or other drug addiction within your community?

Hmong Mental Health, Alcohols, and Substance Abuse Dialogue Participants

Thank you to each participant for engaging and providing valuable input at this dialogue. WUCMAA wants to recognize the following informants, leaders, and professionals for your contributions to the findings and recommendations in this report.

Patrick Cork
Dr. Anthony Ernst
Dear Chang
Belinda Hang
Charles Hang
Mrs. Viluck Kue
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Nhia Khue Yang
Peter Yang
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Va Yang
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2014 Suicide and Homicide Key Informants Data

Released date: 8/15/2014

Summary:

WI Hmong Population (2010 Census)	49,240	Persons
WI Hmong Suicides/Homicides (2014)	84	Persons

City:

1 Menomonie:	7	8%
2 Eau Claire:	7	8%
3 La Crosse:	14	16%
4 Wausau:	13	16%
5 Appleton:	5	6%
6 Green Bay:	6	7%
7 Manitowoc:	4	5%
8 Madison:	2	2%
9 Sheboygan:	7	8%
10 Milwaukee:	19	23%
	<hr/>	
	84	100%

Gender:

Male	70%
Female	30%

Known method of death:

Drowning(jumped in water)	3	5%
Drug	4	7%
Gun	34	57%
Hanging	14	23%
Knife	5	8%
	<hr/>	
	60	100%

For more information about this key informant data, please contact:

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Key informants data over the years in each of the community listed; some communities may be under reported.

The Recovery Framework: Behavioral Health Factors and State Funded Services



Wisconsin
Department of Health Services
The Recovery Framework: Behavioral Health Factors

- Genetics
- Medication
- Eating
- Sleeping
- Nutrition
- Hygiene

- Knowledge
- Attitude
- Beliefs

- Religion
- Higher Power
- Inner Strength

- Home
- Work
- Friends
- Stigma
- Opportunity

• 5



Wisconsin
Department of Health Services
State Funded Services

- Prevention: Teen Intervene...
- Medication-Assisted Treatment (MAT)
- Comprehensive Community Services (CCS)
- Recovery-Oriented Systems of Care (ROSC)
- Peer Services

- Prevention
- MAT
- CCS
- ROSC
- Peer Services

- Faith-Based Services
- Peer Services

- Prevention: Environmental Strategies, Coalitions, DFC...
- CCS
- ROSC
- Residential
- Peer Services
- Recovery Rally 9/17/16