The California Reducing Disparities Project 2017-2021

The Hmong Helping Hands Intervention-IPP Final Evaluation Report

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The Fresno Center

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Executive Summary

The Hmong Helping Hands (HHH) Intervention was 1 of 35 Implementation Pilot Projects (IPPs) funded under Phase II of the California Reducing Disparities Project (CRDP) through California's Mental Health Services Act (MHSA). A collaborative of The Fresno Center in Fresno; Merced Lao Family Community, Inc., in Merced; and Lao Family Community Empowerment, Inc., in Stockton administered and supported the evaluation of the program. The goals of the Hmong Helping Hands Intervention were to help reduce depression, anxiety, and acculturation issues in Hmong adults and elders by improving their physical, psychological, social, and spiritual well-being and increasing their knowledge and awareness of mental health issues. The intervention was a community-defined evidence practice (CDEP) under the CRDP Phase II and served as a direct Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) program that was developed to prevent or reduce negative outcomes that may result from untreated illness or individuals with risk or early onset of mental illness.

There were five components to the HHH Intervention, with each component based on cultural practices and relevance in the Hmong community. These cultural practices have historically been instrumental in the Hmong community's resilience and perseverance as a minority group of people who have gone through wars, trauma, poverty, and persecution. These components included the following: Hmong Talk; Ncig Teb Chaws (Exploring); Cultural Therapeutic Arts, Crafts, and Activities; Maij-Maij (Beautiful); and Hmong Spiritual Healing. The HHH Intervention had three cycles, each was 6 months in length, and administered in three different locations in the San Joaquin Valley of California: Fresno, Merced, and Stockton. During the three cycles of the HHH Intervention, there were eight groups, with a total of 104 participants who successfully completed the intervention from August 2018 to March 2020, when it was discontinued due to the COVID-19 shutdown.

In this evaluation report, both quantitative and qualitative data were used to show whether our CDEP project was effective in improving the Hmong adults' and elders' physical, psychological, spiritual well-being, and reducing their psychological distress. There were six research questions: three were quantitative and three were qualitative; one research question coould not be answered with a test of significance. Two of the three quantitative research questions were significant, while the qualitative data showed that the participants had a high participation rate, and nearly all of them reported being satisfied with all of the weekly activities from each of the five components.

The Hmong Helping Hands Intervention provided a strong and positive program in the San Joaquin Valley both in terms of implementation and participant outcomes. HHH recruited a strong, capable, and hard-working, bilingual, bicultural staff with appropriate skills, especially in terms of speaking Hmong, familiarity with the Hmong culture, and respect for elderly clients. It also offered one of the most promising, compelling, helpful, and successful services available in the San Joaquin Valley for the older Hmong population.

Introduction/Literature Review

At the conclusion of the Vietnam War in 1975, many of the Hmong who fought alongside the Americans had escaped to Thailand and began living in refugee camps there. Some came to the United States shortly after resettling into the refugee camps, while others stayed in these camps for more than 15 years before finally deciding to resettle in the United States.

Upon their arrival, they were placed in several different states, with some living with their American sponsors, but most living with their family members in large cities like St. Paul and Minneapolis, Minnesota, and Sacramento and Fresno, California. This transition was an extreme culture shock after having come from living in small villages of families and now being resettled into much larger cities (Hendricks, 1986).

According to the 2020 United States Census, there were 308,803 Hmong in the U.S., with the vast majority living in California and Minnesota. In California's Central San Joaquin Valley, which stretches as far north as Butte County and south to Kern County, there were 96,255 Hmong, who represented the highest concentration anywhere in the United States. This accounted for 91% of all of the Hmong living in California, with Fresno County having the highest percentage of Hmong, which was the second largest in the nation.

The journey to America provided many new opportunities for the Hmong, especially for the younger generation. It allowed them to go to school and become educated in many new careers very different from living in Vietnam where only the males in wealthier families were allowed to go to school. The 2020 Census indicated that 24% of the Hmong who were over the age of 25 had completed bachelor's degrees, with many working in professional fields as doctors, dentists, surgeons, nurses, teachers, university and college faculty, including some who had even become city, county, and state officials.

However, for many of the Hmong adults and elders it has been a different story. The majority of them arrived in the United States with little to no employable skills or formal education. They often spoke no English; so in spite of their hardworking efforts, they continued to struggle to support their families. After having lived for more than four decades in the United States, this group of adults and elders were still facing many barriers and have struggled economically, needing to rely on various governmental assistance programs in order to survive (Hendricks, 1986).

These Hmong adults and elders have also experienced some of the highest rates of psychological distress and mental illness. Since their mass arrival to the United States in 1975, there has been very limited research addressing the specific mental health issues that have affected this collective community. Westermeyer (1988) conducted one of the first studies of the DSM-III psychiatric disorders in Hmong refugees, followed by a longitudinal study of the

refugees in 1989, with Westermeyer et al. (1989), to assess the refugees' psychosocial adjustment during their first decade in the United States. Fang (1998) was one of the first to do dissertation research on how acculturation was being used as a predictor of Hmong attitudes toward seeking professional, psychological help in the Hmong community. A team of nurse practitioners, Parker et al. (1999), made an example of the Hmong internationally with their approach for providing more appropriate culturally responsive health care, understanding and integrating the Hmong's unique health-related customs and beliefs in providing services to them.

Years later, Lee and Chang (2012) compared Hmong mental health issues to other Southeast Asian groups, finding they still had higher rates of being diagnosed with depression and had the lowest help-seeking behaviors in utilizing Western medicine, along with the lowest average of happiness scaled on an assessment they used. Collier et al. (2011) followed with an assessment to verify the mental health needs of Hmong living in the Midwest. Their focus groups found that the participants were confused and uncertain by what mental health meant, and the most common problems were consistent with depression, PTSD, anxiety, social stress, and acculturation difficulties.

Within the last 2 years, Vang et al. (2020) conducted a review of the cultural and social factors in Hmong mental health, noting that the Hmong adults and elders had experienced some of the highest rates of psychological distress and mental illnesses. Yang and Mutchler (2020) studied the depressive symptoms of older Hmong refugees in both Minnesota and California, with results showing that more than 72% of the participants indicated they had symptoms of depression, suggesting that depression may be a lifelong experience for this high-risk population.

While the earlier studies (Fang, 1998; Westermeyer. 1988; Xiong, 2002) reported high rates of anxiety, depression, and PTSD soon after the Hmong had arrived in the U.S., a more recent study from Vang (2015) compared two generations of Hmong and found more positive signs of acclimation to the home country. This suggested that as the refugees had adjusted to their homeland, the postmigration issues may have ceased and interest in mental health issues had increased as they became accustomed to the host culture. The Hmong believed that they had been able to maintain their traditional culture while also participating in the dominant culture through their work and access to education. It was suggested that there would be a need for a balance between the two cultures, and as the Hmong became more acculturated to Western society, they would also need to continue to preserve the strong elements of their original culture in identity and lifestyle.

In 1991, Dr. Tony Vang founded the Fresno Center for New Americans (now The Fresno Center-TFC) in response to the growing number of Southeast Asian refugees, primarily Hmong refugees, along with Cambodian, Lao, Thai, and Vietnamese, who had relocated to Fresno County. The refugees needed wide-ranging support to make the difficult transition from living in their home country to living in a new country where everything was foreign. At that time, the

Center worked closely with the United States Office of Refugee Resettlement to help the refugees successfully transition to living in America. The services included support with housing, health care, English language training, job retraining, health education, and employment. These services continued under Lue Vang, who became the second Executive Director in 1992 and remained with the organization for over 25 years. In 2017, Pao Yang became the organization's third Executive Director and first President & CEO. For the last three decades, TFC was known in the community as the place that helped Southeast Asian refugees.

According to Fresno County's 2019-20 Mental Health Cultural Competency Plan, the refugees from Southeast Asia, like the Hmong, were heavily impacted by the physical and emotional stresses of war and relocation and were challenged in assimilating to Western culture and lifestyles and were experiencing untreated chronic medical conditions. Beyond these problems, the Hmong further struggled with accessing and receiving appropriate mental health services, some of which can be attributed to their strict cultural beliefs, customs, and the many practices that were utilized in Western therapies, including cognitive behavior therapy (Cerhan, 1990; Xiong et al., 2018).

When also taking into account the County's mental health system, Tatman (2011) found that there was also a lack of bilingual and bicultural Hmong licensed clinicians and culturally appropriate mental health services for the Hmong community. In the Central San Joaquin Valley where over 90% of the Hmong population lived, there were only two contract providers to supply culturally and linguistically appropriate mental health services for the Hmong community.

There were also considerable gaps in providing mental health services to the Hmong population, and the Fresno County Cultural Competence Plan (2018 to 2019) indicated that the Hmong had one of the lowest mental health service penetration rates of any ethnic group. There were 20,918 people who received one or more mental health services in 2018-2019. Of these individuals, there were 25.0% who were Caucasian, 50.4% Hispanic/Latino, 11.0% Black, 5.8% Asian/Pacific Islander, and 1.0% Alaska Native/American Indian. The majority of the individuals receiving mental health services had a primary language of English (82.5%), with 12.0% Spanish, and 2.4% Hmong/Lao. For race/ethnicity, the persons who were Caucasian had a penetration rate of 1.7%, Hispanic/Latino 2.3%, Black 5.2%, and 1.4% for Asian/Pacific Islander.

For these reasons and with consideration of the more recent mental health research related to the Hmong, The Fresno Center and their Hmong Mental Health Collaborative Partners, Lao Family of Merced and Stockton (HMHCP) in the Central San Joaquin Valley proposed a culturally and linguistically based mental health services project called the Hmong Helping Hands to meet the increasing mental health needs of the Hmong communities in Fresno, Merced, and San Joaquin Counties who were at a high risk for mental health problems or had mild-to-moderate mental health difficulties. At the same time, this program would create training

opportunities for bilingual and bicultural Hmong students to gain mental health work experiences and become licensed mental health providers.

CDEP Purpose and Description

CDEP Purpose

The Hmong Helping Hands Intervention is a direct prevention and early intervention program that aims to reduce depression, anxiety, and acculturation issues in Hmong adults and elders by improving their physical, psychological, social, and spiritual well-being and increasing their knowledge/awareness of mental health issues. It was designed to increase access to services by supporting culturally competent outreach, engagement, and education to (a) reduce the stigma related to mental illness and to raise awareness of mental health issues, (b) increase availability and quality of care by supporting services that meet the core competencies and program criteria as defined by the Asian Pacific Islander Strategic Planning /Workgroup (API-SPW), and (c) reduce disparities by collecting disaggregated data to accurately capture the needs of various AANHPI communities by supporting culturally appropriate outcome measurements, and providing continuous resources to validate culturally appropriate programs.

CDEP Description and Implementation Process

The Hmong Helping Hands Intervention is a community-defined evidence practice (CDEP) that under CRDP Phase II served as a direct Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) program developed to prevent or reduce negative outcomes that may result from untreated illness or individuals with risk or early onset of mental illness (Abe et al., 2018).

The HHH Intervention was specifically aimed to reduce mental health disparities at the individual-focused practice level. This means the project focuses on helping participants to change their knowledge, attitudes, beliefs, practices, and behaviors. This practice level is directed at individuals, alone or as part of a family, class, or group.

The HHH Intervention had multiple cycles, where each cycle or cohort was 6 months in length, and it was operated in three different locations in California: Fresno, Merced, and Stockton. The number of participants in each cohort at each of the three locations varied, from 5 participants to 23 participants.

There were five components to the HHH Intervention, with each component based on cultural practices and relevance in the Hmong community. These cultural practices have historically been instrumental in the Hmong community's resilience and perseverance as a minority group of people who have gone through wars, trauma, poverty, and persecution. These components included the following: Hmong Talk; Ncig Teb Chaws (Exploring); Cultural Therapeutic Arts, and Crafts Activities; Maij-Maij (Beautiful); and Hmong Spiritual Healing. A further description of these components is described below.

Component No. 1: Hmong Talk

Hmong Talk was based on the Hmong cultural practice of "*Qhuab Ntuas*" (Khua-Thua). When a person or family is at a loss in their life or does something negative and needs new directions or guidance, the family usually will seek the help of a wise person to come and "lecture" the person or family. Although it might be seen as a "lecture" to the individual and family from an outside perspective, to the family, the lecture is more of a spiritually blessing talk. Therefore, the hope of Hmong Talk was for the person or family to gain new insights, meaning, and draw strength from someone whom they or the community highly respect, and it delivers the message that if someone of this status still cares and comes to talk to you, you should and must care about yourself.

Hmong Talk was held once each month, during the HHH 6-month cycle, and was a 30- to 45-minute inspirational, spiritual, and motivational live psychoeducation talk by prominent and respected Hmong figures from the community to one or two group(s) in a warm and welcoming living-room-like setting.

Component No. 2: Maij-Maij (Beautiful)

When a person feels physically beautiful, they would also feel emotionally happy. This was the idea behind this component. It was focused on implementing those past or present activities that would create and foster a beautiful image of oneself and an appreciation of oneself. The hope was through helping and making participants see themselves in beautiful ways through improving looks like grooming, hygiene, and positive thinking, they would experience the energy to have self-confidence, self-esteem, and feel happier about themselves. Maij-Maij (or Mai-Mai) was a 1- to 1.5-hour sequential for participants to focus on improving self-image, personal grooming, and hygiene.

Component No. 3: Ncig Teb Chaws (Exploring)

Ncig Teb Chaws was a way for Hmong people to become familiar with the environment and its natural resources. In the traditional old days when Hmong families moved from one village to another village, they needed to know the surrounding hills, mountains, and valleys. So, they would go out and explore each of these and see what kinds of resource were available, because their decision to stay or move to another village depended on whether or not they could farm, find foods, shelter, and water.

In America, where a Hmong family lived, due to barriers, they might have had no way of exploring and becoming familiar with their environment and finding out what resources were there that could help them. After arriving to America, many adults and elder Hmong felt imprisoned in their house (Faderman & Xiong, 1998). They felt isolated and disconnected from

their environment. Therefore, the goal of this component was to address acculturation issues by introducing participants to their environment and people. They would learn and become familiar with different kinds of services, resources, culture, and people. The component included language interpretation, where necessary, to allow participants to simultaneously engage in dialogue.

Ncig Teb Chaw was a 3- to 4-hour cross-cultural learning of the people and environment around where the participants live. The activities under this component required traveling to various locations and/or places.

Component No. 4: Cultural Therapeutic Arts and Crafts Activities (C-TACA)

Arts and crafts activities have been employed therapeutically to help all people better cope with depression and anxiety. Also, arts and crafts can be therapeutic and help people to find new meaning and purpose. This component blended past and present therapeutic activities to help participants engage in meaningful daily activities. C-TACA was a 1- to 1.5-hour long activity that was focused on conducting cultural therapeutic acts and activities that would help participants to learn more about themselves. +

Component No. 5: Spiritual Healing

The Hmong believe spirituality plays a significant role in illnesses, especially those unexplainable forces that lack physical symptoms but exhibit more psychological and emotional disturbances (Cha, 2003; Fadiman, 1997; Hu, 2000). Traditional Hmong believe that the body is full of souls and spirits, and when these souls and spirits are not in harmony with the body, they are believed to cause illnesses. For example, isolation, lack of friendship, and love, all can contribute to the souls leaving the body.

This component explored Hmong spirituality and conducted cultural activities that would help to empower and restore one's own inner strength. Counselors and respected community elders collaborated together with the participants and/or group members on various cultural healing practices, usually lasting between 5 to 15 minutes. The cultural activities were conducted as needed and were available throughout the project.

Evaluation Questions

The focus of our evaluation looked at how successful the Hmong Helping Hands Intervention was in improving Hmong adults' and elders' physical, psychological, spiritual well-being and sense of belonging and in reducing their psychological distress. Also, we looked at how well each of the components at each of the locations was implemented and how satisfied the participants were with each of the five components.

In our CDEP, we had six evaluation questions; three evaluation questions were focused on outcome measures, and three were focused on the process of our CDEP. These research questions did not change from when our evaluation plan was finalized and adopted. However, the Hmong Adaptation of the Beck Depression Inventory (HABDI) tool was later taken out because it was contributing to lengthening the surveying process. At the same time, it was determined that the State Wide Evaluation (SWE) Core Survey was sufficient in capturing what we needed from the HABDI.

Our evaluation questions were as follows:

1. To what extent will the HHH Intervention participants show reductions in psychological distress? (Outcome)

2. To what extent will the Hmong Helping Hands Intervention strengthen participants physically, psychologically, and spiritually? (Outcome)

3. To what extent will the Hmong Helping Hands Intervention strengthen participants' sense of belonging? (Outcome)

4. How consistently will the participants participate in each of the components? (Process)

5. How satisfied will the participants be with each of the components? (Process)

6. To what extent will the partnership between The Fresno Center, Merced Lao Family, Community, Inc., and Stockton Lao Family Community Empowerment, Inc., be collaborative and successful? (Process)

These evaluation questions were utilized to see whether our HHH Intervention was improving the well-being and sense of belonging of our participants. We also wanted to see if it helped in reducing the psychological distress of our participants.

Evaluation Design and Methods

Design

The type of evaluation methods used in assessing our Hmong Helping Hands Intervention was a mixed methods of quantitative and qualitative designs. The quantitative design was a nonexperimental pre and post with single group where two translated surveys were administered. In addition, there were weekly self-satisfaction surveys for each of the cohorts.

The qualitative design utilized several qualitative research methods. The design included a focus group exit interview of the participants at each of the locations. The exit interview was important because many of the participants in the program did not speak or read English and were older, so understanding their situational constraints, the evaluator felt that it was important to also capture what the given meaning of this experience would be to these groups of people. Being able to observe and capture their perspectives might mean being able to be closer to them and their perceived perspectives and also having an individual's point of view, prioritizing perceptions, meaning, and emotions (Creswell & Creswell, 2018; Denzin & Lincoln, 2018; Silverman, 2018).

The postfocus group was conducted 1 week after exiting the HHH Intervention. The focus groups consisted of 5 to 15 participants, with a facilitator, note taker, and interpreter. All of the sessions were recorded. The facilitator followed a standard procedure and protocol for conducting the focus groups.

The research was exempt from IRB from the State of California Health and Human Service Agency Committee for the Protection of Human Subjects. However, we formed an advisory group of five to seven committee members from the Fresno, Merced, and Stockton locations. These committee members were people with a deep understanding and knowledge of Hmong issues, cultural practices, and arts. Also, they were people with extensive experiences in working with Hmong adults and elders in the Central Valley. The committee members served in an advisory capacity, where they assisted in identifying culturally appropriate activities and practices and reviewing of assessment tools.

Sampling Method/Sample Size

Since there is a definite cultural stigma related to mental illness and mental health in this population, the sampling methods needed to be adaptable, accessible, and open in order to encourage possible participants to feel safe and welcome to come into an environment that has been viewed in a negative manner. Being able to overcome the shame and this perceived cultural disgrace was a challenge, as the sampling methods were designed to be simple, straightforward,

and manageable. At the same time, because recruitment was done in a snowball fashion, so, too, was sampling because everyone who joined the program took part in the evaluation.

We were successful in outreaching and recruiting Hmong adults and elders into the HHH Intervention. The three main criteria that we used in selecting participants were ethnicity, age, and health. Participants needed to be Hmong, be an adult, and physically well enough to engage in all of our activities. As shown in Table 1, our overall goal was to have 100 participants served by our HHH Intervention, with an 80% participation rate. Yet, despite some drawbacks from the COVID-19 pandemic and one of the partners discontinuing, we managed to exceed our goal and served 113 participants, with a 92% completion rate. We had 9 participants who dropped out, or 8% overall attrition for our intervention. The main reasons for participant attrition were physical health issues, moved out, and supporting childcare needs. For data purposes, lowest number of participants completed the Pre and Post SWE measures were 92 participants. Some Pre and Post SWE measure indicators might only have 89 participants. For the demographic information there were 109 participants recorded out of the 113 participants.

Table 1 : Hmong Helping Hands Intervention Participants 2018 to 2020

	Males		Females		Total	Drop out		Completion	
Cohort	*n*	%	*n*	%	*n*	*n*	%	*n*	%
Cohort 1									
Fresno	6	26	17	74	23	2	9	21	91
Merced	1	11	8	89	9	0	0	9	100
Stockton	0	0	4	100	4	1	25	3	75
Cohort 2									
Fresno	4	19	17	81	21	3	14	18	86
Merced	1	9	10	91	11	0	0	11	100
Stockton	0	0	7	100	7	1	14	6	86
Cohort 3									
Fresno	5	24	16	76	21	2	10	19	90
Merced	2	12	15	88	17	0	0	17	100
Overall Total	19	17	94	83	113	9	8	104	92

The overall age distribution of our HHH Intervention population is shown in Table 2. It was skewed toward older adults, with 60% ($n = 65$) of the participants in the 59- to 64-year old

range and 22% ($n = 2$) of the participants in the older than 65 years age range. Additionally, there were significantly more female ($n = 94$, 83%) than male ($n = 19$, 17%) participants in this intervention. Different numbers contributed to the limitation of this intervention's generalization to the Hmong community. A power analysis was not necessary since a subsample of the population was not being selected for comparison.

Table 2

2018-2020 HHH Intervention Participants by Age Group

Age group	*n*	%
18-25	7	6
30-39	8	7
40-44	1	1
45-49	4	4
50-64	65	60
> 65	24	22
Total	109	100

Note: Table 1 & 2. Overall N=113, with N=109 age group available; minimum age = 19 years old, oldest age = 96 years old, average age = 56.5 years old. Completion N=92.

Measures and Data Collection Procedures

The evaluation approach to our HHH Intervention was based on a Community-Based Participatory Research (CBPR) and its principles. It was defined as:

> A collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities. (Minkler et al., 2012, p. 10)

The Hmong Mental Health Collaborative Partners worked with the Hmong communities in Stockton, Merced, and Fresno and identified key community members to form an advisory group. Their purposes were to assist us in identifying mental health challenges and needs in the

Hmong community, adapt strengths and resources within the culture to be implemented as part of the HHH Interventions, advocate for sustainability of CDEP, and assist in the dissemination of information and outcome data from our CDEP. Together, the partnership used this CBPR approach to develop the HHH Intervention to be culturally and linguistically appropriate CDEP for addressing the mental health needs of this community.

Quantitative Measures

We utilized the pre- and post-SWE core measures, Subjective Happiness Scale, and Hmong Helping Hands Activity Survey to quantitatively assess the effectiveness of our Hmong Helping Hands Intervention. The SWE Survey is a 63-item survey created to assess a number of areas, such as mental health access, utilization, stigma, and barriers, to help seeking advice. The survey also looks at psychological distress, functioning and social isolation/marginalization, as well as protector factors. The Subjective Happiness Scale is a 4-item scale of global subjective happiness, with two questions asking participants to rate themselves in general and two questions asking them to rate their happiness on an absolute rating scale of 1 to 7. Lastly, the two Hmong Helping Hands surveys, the HHH Activity Survey and the HHH Hmong Talk Survey, each have four questions. The first three questions asked participants to rate on a scale of 1 to 5, and the last questions asked them for feedback. All of these surveys were translated into Hmong, but it was only the pre- and post-SWE core measures that the 5-point scale questions were reduced to 3-point scale questions to make them more culturally appropriate and relevant to the Hmong participants.

For the qualitative approach, to assess the effectiveness of our Hmong Helping Hands Intervention, at the end of each cohort we conducted a postexit interview with our participants. For quantitative approach, the pre- and post-SWE core measures and Subjective Happiness Scale were administered in a group setting at the three different community locations before they started and after a week of completion in the Hmong Helping Hands Intervention. The surveys were translated into Hmong, and a facilitator read each of the survey questions while trained bilingual staff in each location sat alongside and assisted participants in penciling in their answers and, if needed, staff reinterpreted and/or restated the questions in Hmong for the participants again. Once everyone completed responding to the question, the facilitator moved on to the next question. The pre-SWE core measure with the Subjective Happiness Scale took an average of 90 minutes to complete, while the post-SWE core measure with the Subjective Happiness Scale took an average of 60 minutes. For a few participants who could read and write either in English or Hmong, they completed the survey by themselves. We had one mute participant, and a staff member who was familiar with sign language assisted that person in completing the surveys.

The evaluator was present to monitor this process but did not speak or read Hmong, so was not involved in assisting the participants in this activity. When the questionnaires/tools were

completed, the program staff collected them and proceeded with data entry. It should be noted that there was great effort involved in training and administering all of the assessment tools and SWE questions with the participants, but a number of them grew tired and restless and became disinterested in finishing the questions, as it was felt to be "too long," and several refused to take the surveys. There were also questions directed to the staff interpreters related to what the questions meant as the participants did not understand some of them, and the interpreters did their best with answers, trying to avoid any bias or answering the question for the participant.

For the Hmong Helping Hands Activity Survey and the Hmong Helping Hands Hmong Talk Survey, one was specific for the Hmong Talk and one was specific for the rest of the other four Hmong Helping Hands components. These two surveys were collected from clients whenever they completed the components for that week. We used the last 5 minutes of the session to collect these surveys. It was conducted in a group setting with four to five staff walking around to help participants fill out the short survey, if needed. Therefore, these quantitative data were collected for each of the 24 weekly activities (one activity each week for 6 months) in all three cohorts. This evaluation was conducted with the participants to learn if the activities were helpful, enjoyable, and if they would like to do them again. In the evaluation there was also a space to include any comments they wished to make related to the activity.

Qualitative

The qualitative measures that were utilized for the HHH Intervention included having participants in each of the three cohorts being a part of scheduled focus groups where the participants could express their opinions and concerns, clarifying and elaborating on their experiences of the 24 weeks they had spent together (Bader & Rossi, 2002; Barbour, 2008; Cyr, 2016; Morgan, 1988). At the end of their last weekly meeting, the evaluator, along with an interpreter, met with the participants in each location and asked them:

- What are some of the most enjoyable aspects of this Hmong Helping Hands Intervention?
- In what ways have you benefitted from participating in the Hmong Helping Hands?
- What sort of changes have you made in your life after participating in the Hmong Helping Hands?
- How would you improve Hmong Helping Hands? What would you change or include?

The interpreter explained the process of the focus group and why we wanted to hear from them, established some ground rules, and secured permission to record the session. All of the cohorts agreed to the recording, and each one was later translated and transcribed into English for the evaluator, who later coded the data and provided the information to the project manager (Bader & Rossi, 2002; Cyr, 2019). The evaluator was able to closely observe the participants and made notes as they were answering the questions being delivered by the interpreter. The

evaluator was known and accepted by the participants as she had been present earlier at several of the weekly activities and graduation.

As part of the qualitative evaluation process, staff also conducted a review together at the end of each week in all three cohorts, reporting what was good and what could be improved upon so the next time the activity was presented changes could be made, if necessary. These data were collected by the program staff and given to the program manager for each of the cohorts.

Fidelity and Flexibility

For the HHH fidelity and flexibility assessment, the three dimensions of quality delivery, adherence, and participant responsiveness were chosen for further examination. The measurement tools utilized in the participant weekly activity reviews and the staff weekly program reviews and reflections provided the opportunity to quickly be able to hear from the participants and provide feedback to the staff on the morning sessions, and the staff's program discussions then immediately gave them the opportunity to learn what had gone well and address what could be improved and/or changed. These evaluations were utilized for the programming of the next cycles in all three locations and, when combined with the Activity Self-Satisfaction Surveys that came directly that day from the participants, the staff had the ability to quickly make needed changes for planning further activities.

Periodic visits from the evaluator were scheduled in order to visit the three locations to observe the activities and see the participants engaging and being involved in the session, as well as observing their interest in completing the Activity Self-Satisfaction Surveys, actively providing their comments and contributions to the various activities. The participants were encouraged to let the staff know if they were not satisfied and would prefer different types of activities.

The program staff was also present at each of the cohort focus group meetings so they were able to hear directly from the participants what they had enjoyed, found useful, and benefitted from during the last 24 weeks and the changes they personally had made in their lives as a result of being in the program. The participants were very eager to offer their views and comments on how the program could be changed and improved so the program staff was able to make those transitions to the next groups of cohorts. The focus groups were well-attended and lengthy as the participants wanted the staff to know how much they appreciated the energy and work that they had done for them each week and how much it meant to them.

The program staff met weekly to discuss any needed changes in the weekly themes and activities in each location and were then able to quickly make any changes that were needed. All of the staff participated in monthly Zoom calls to access the progress of the program and were able to ask for assistance with any issues they were having or what was needed for agreed

changes. The evaluator provided all of the program staff with the results of the focus groups and the weekly activity evaluations at the end of each of the cohort groups for further discussion and planning for the next groups.

Data Analyses Plan Implemented

Quantitative

Pre- and Post-SWE. The Hmong Helping Hands Intervention is part of the California Reducing Disparities Project, 2017-2021. This evaluation addresses six research questions, which are:

1. To what extent will the HHH Intervention participants show reductions in psychological distress? (Outcome)

2. To what extent will the Hmong Helping Hands Intervention strengthen participants physically, psychologically, and spiritually? (Outcome)

3. To what extent will the Hmong Helping Hands Intervention strengthen participants' sense of belonging? (Outcome)

4. How consistently will the participants participate in each of the components? (Process)

5. How satisfied will the participants be with each of the components? (Process)

6. To what extent will the partnership between The Fresno Center, Merced Lao Family, Community, Inc., and Stockton Lao Family Community Empowerment, Inc., be collaborative and successful? (Process)

Variables by research questions. The first three research questions were addressed by collecting data on variables from the SWE Core Assessment. Research Question 1 utilized data from these variables at both pretest and posttest: (a) nervousness, (b) hopelessness, (c) restlessness/fidgetiness, (d) depression, (e) effort, (f) worthlessness, (g) matched negative experiences, (h) emotional interference with house chores, (i) emotional interference with social life, (j) emotional interference with relationships, and (k) matched negative emotions.

Research Question 2 utilized data from these variables at both pretest and posttest: (a) cultural strength, (b) cultural importance, (c) good cultural emotions, and (d) importance of traditional religion.

Research Question 3 utilized data from these variables at both pretest and posttest: (a) feeling cultural connections; (b) mind, body, and spirit balance; (c) marginalization, and (d) isolation.

Recoding of Research Question 1 variables: The first research question about reductions in psychological distress and negative emotions was addressed by measuring the following eleven indicator variables at both pretest and posttest: (a) nervousness, (b) hopelessness, (c) restlessness/ fidgetiness, (d) depression, (e) effort, (f) worthlessness, (g) matched negative experiences, (h) emotional interference with house chores, (j) emotional interference with social life, (j) emotional interference with relationships, and (k) matched negative emotions. It should be noted that these variables, (a) nervousness, (b) hopelessness, (c) restlessness/fidgetiness, (d) depression,(e) effort, (f) worthlessness, were originally designed to be measured on the pretest on a 5-point scale as follows: 1 = all of the time, 2 = most of the time, 3 = some of the time, 4 = a little of the time, and 5 = none of the time. However, a decision was made that only three of those points would be utilized for both the pretest and the posttest: 1 = all of the time, 3 = some of the time, and 5 = none of the time.

The reason for this reduction in coding usage was that those who administered the instrument felt the participants might not have the same understanding of these codes as did the designers of the instrument, and using all the codes had the potential of introducing measurement error that would reduce the reliability of the instrument and subsequently reduce the power of the analyses (Shaw et al., 1991). Also, in this original counterintuitive coding, a high score meant that a person has less of the quality being measured and a low score meant a person has more of the quality. To rectify these issues, the original scores were recoded twice so (a) that scores would assume the consecutive values of 1, 2, and 3, and (b) the score values were 1 = none of the time, 2 = some of the time, and 3 = all of the time. In this way, a higher score value indicates a higher amount of the trait being measured and a lower core value indicates less of the trait.

Recoding of Research Question 2 variables. The second research question about strengthening participants physically, psychologically, and spiritually was addressed by measuring the following four indicator variables at both pretest and posttest: (a) cultural strength, (b) cultural importance, (c) good cultural emotions, and (d) importance of traditional religion. Data for these four variables (cultural strength, cultural importance, good cultural emotions, and importance of traditional religion) were originally coded as: 2 = agree, 3 = I am neutral, and 4 = disagree. These four variables were recoded to make the values consistent across

the variables and to make low numerical values correspond to low scores on that variable and high numerical values correspond to high scores on that variable as follows: 1 = disagree, 2 = I am neutral, and 3 = agree.

Recoding of Research Question 3 variables. The third research question about participants' sense of belonging was addressed by measuring the following four indicator variables at both pretest and posttest: (a) feeling cultural connections; (b) mind, body, and spirit balance; (c) marginalization, and (d) isolation. Data for these variables--feeling cultural connections; mind, body, and spirit balance; marginalization; and isolation--were originally coded as 1 = all of the time, 3 = some of the time, and 5 = none of the time. However, these variables were recoded as 1 = none of the time, 2 = some of the time, and 3 = all of the time.

Subjective Happiness Scale. The Subjective Happiness Scale is a 4-item instrument that is designed to measure happiness on a 7-point scale. The first item has respondents rate their own happiness, the second item has respondents rate their own happiness in comparison to their peers, and the third item has respondents rate their own happiness in the context of people who are generally happy. For the first three items of this instrument, a high score indicates a higher level of happiness, and a low score indicates a lower level of happiness. The fourth item has respondents rate their own happiness in the context of people who are generally NOT happy. The instrument designers instruct users to reverse this item. An additional variable, total happiness, was created by averaging items 1, 2, 3, and reversed item 4.

For each of the three cohorts and for all cohorts combined, the following analyses were performed: pre- and posttest means and standard deviations, dependent *t* tests, with *p* values and Cohen's effect sizes, along with correlations between the pre- and posttests with their probabilities were calculated. Pre-posttest correlations are often used as an index of the reliability of an instrument. When this is done, the assumption is made that the trait being examined is stable, which means that participants who scored lower on the pretest will also be in the lower ranges of the posttest, and those who scored higher on the pretest will be in the higher ranges at posttest. The minimum acceptable test-retest reliability coefficient is roughly .70 (Groth-Marnat, 1999). However, the Hmong Helping Hands Intervention was run on the premise that all participants can improve in their functioning, which means that it is expected that even individuals with low functioning can make great improvements. This would result in correlations that are considerably lower than .70, which was, in fact, the case for this intervention. That result, coupled with the significant improvements documented by the dependent *t* tests argues for the effectiveness of the HHH Intervention. Furthermore, intercorrelations between different measures were not presented as they are not deemed as evidence of program effectiveness.

Qualitative Analysis

Postexit interviews. The qualitative measures that were utilized for the HHH Intervention included having the participants in each of the three cohorts being a part of scheduled focus groups where they could express their opinions and concerns, clarifying and elaborating on their experiences in the 24 weeks they had spent together (Bader & Rossi, 2002; Barbour, 2008; Cyr, 2016, Morgan, 1988). At the end of their last weekly meeting, the evaluator, along with an interpreter and a note taker, met with the participants in each location for 1½ hours.

The interpreter, evaluator, and note taker were introduced to the group and explained the purpose and process of the focus group and why we wanted to hear their thoughts regarding their time in the intervention. Some ground rules were agreed to and established, along with permission to record the session. All of the cohorts agreed to the recording, and each one was later translated and transcribed into English for the evaluator, who coded the data and provided the information to the project manager (Bader & Rossi, 2002; Cyr, 2019). The interpreter presented the questions to the participants, and the evaluator was able to listen attentively and closely observe the group, noting body language and other subtle clues, making notes as questions were being answered. The evaluator was well-known and accepted by the participants as she had been present earlier at several of the weekly activities and graduation.

After all eight of the Hmong Helping Hands focus groups had met and the recordings of each group had been translated, the evaluator coded the data, making a written record for each of the cohort groups. In this process, the evaluator became very familiar with the data and began to decide how to organize and systematize them, clearly delineating the sections that were focused on each of the questions. Since the evaluator had also taken notes during these sessions, there was the opportunity to go back through the transcript and acknowledge the body language that had been observed, as well as laughter, some tears, speaking tones, and other nonverbal cues, including participant expressions and the amount of time spent on answering the questions.

The evaluator began the task of a more in-depth approach to analyze the words that had been transcribed, using a system to code the units of data following Cyr's (2019) suggestion of colors, symbols, or notes, splitting it into several parts that could be reassembled into a few different ways. The goal was to capture both the context and content in the analysis of all eight HHH groups. Content analysis was used to begin the focus on identifying patterns in the data. The coding system that was utilized was a compilation of those developed and described by Bader and Rossi (2002) and Cyr (2019).

The words and phrases used were color coded, which answered the questions that had been asked. Of interest was what did they mean; were they the same words, or was there a variety of words used; and were they the same across all of the groups. Next was coding the frequency

the words were used by the number of times the word or phrase appeared in the transcription. The analysis then went to how many of the participants had used the words, did they appear several times, were they across all of the groups, and how specific were the participants in their answers. The evaluator specifically tried to assess how consistent the participants were in their responses across all of the groups and tracked the patterns that had emerged, separating them into different themes.

It was also important to explore the nonverbal factors and how they might have impacted the groups. Consideration was given to the intensity of expressions, dominance of persons answering the questions, consistency in the responses, if more time was spent on some of the questions, and if there were some of the questions that might not have been understood.

The evaluator used the most common analytical approach that is also known as using the computer for cutting and pasting in the analysis; color coding; categorizing the data; capturing the general themes, trends, and patterns that were identified within and across the focus groups while answering the following questions:

- What are some of the most enjoyable aspects of this Hmong Helping Hands Intervention?
- In what ways have you benefitted from participating in the Hmong Helping Hands?
- What sort of changes have you made in your life after participating in the Hmong Helping Hands?
- How would you improve Hmong Helping Hands? What would you change or include?

Self-Satisfaction Surveys. The HHH Self-Satisfaction Activity Survey and the HHH Self-Satisfaction Hmong Talk Survey were also collected as part of the learning process about the effectiveness of each of the components. These surveys were given out to all of the participants approximately 10 to 15 minutes before the conclusion of every activity. However, due to illiteracy, these surveys were conducted in a group setting where a facilitator read each of the translated questions were read in Hmong, and other staff walked around to assist participants in selecting the responses.

These two self-satisfaction surveys asked participants to rate on a scale of 1 to 5,with 1 being the lowest to 5 being the highest, on three questions, and with the last question being an open-ended question. These questions were:

1. On a scale of 1 to 5, how much this learning/activity helped you?
2. On a scale of 1 to 5, how much you liked today's learning/activity?
3. On a scale of 1 to 5, how likely do you want to see us conduct this learning/ activity again?

4. What I like best about today's learning/activity is?

Once all of the surveys were collected from each of the weekly activities, the data were inputted into the components (Hmong Talk, Maij-Maij, Ncig Teb Chaw, Cultural Therapeutic Arts and Crafts, and Spiritual). The average was calculated to compare how each of the locations rated the various activities in each of the components.

Data triangulation. Data triangulation is the use of more than one approach to researching a question, and the objective is to increase confidence and increase the credibility and validity of the findings (Hale & Forbes, 2013). In the evaluation of the Hmong Helping Hands Intervention, data triangulation was achieved in several different forms. With each of the research questions, we compared the quantitative findings from the pre- and post-SWE core measures and Subjective Happiness Scale, weekly activity survey data with our qualitative findings from the focus group comments/data, and attendance records.

Results

The Hmong collaborative partners conducted the Hmong Helping Hands Intervention project in Fresno, Merced, and Stanislaus Counties. They targeted 104 Hmong participants within the 3-year period. The goal of the project was to improve the participants' physical, psychological, and spiritual well-being, and sense of belonging while also reducing their psychological distress by engaging them in different activities from the five cultural components during the 6-month period. Using a mixed-method design of both quantitative and qualitative evaluation approaches, the partners answered the following six research questions:

1. To what extent will the HHH Intervention participants show reductions in psychological distress?

2. To what extent will the Hmong Helping Hands Intervention strengthen participants physically, psychologically, and spiritually?

3. To what extent will the Hmong Helping Hands Intervention strengthen participants' sense of belonging?

4. How consistently will the participants participate in each of the components?

5. How satisfied will the participants be with each of the components?

6. To what extent will the partnership between The Fresno Center, Merced Lao Family, Community, Inc., and Stockton Lao Family Community Empowerment, Inc., be collaborative and successful?

The study population was a homogeneous group consisting of only Hmong participants with older age and female participants' skewness. The average age in the study participants was 57 years old, with 87% ($n = 89$) being over the age of 50 years old. This was significantly different than the make-up of the Hmong population in the U.S., where there was a much younger population. The Hmong median age population in the U.S. and California was at 20.4 years old and less than 14% were over the age of 45 years old (Pfeifer & Yang, 2013). Additionally, gender was another skew factor in this study. There were 83% ($n = 94$) of the participants who identified as female. According to Pfeifer and Yang, there was almost an even percentage of the Hmong male and female population in the U.S. The estimate was about 49.3% of the Hmong population were male, while 50.7% were female. In California, the authors noted similar percentages as well, with 51% being male and 49% being female, indicating that skewness might have a higher power effect on the *t* test (Reineke et al., 2017).

Research Question 1: To what extent will the Hmong Helping Hands Intervention participants show reductions in psychological distress?

This question was addressed by measuring 11 indicator variables at both pretest and posttest: (a) nervousness, (b) hopelessness, (c) restlessness/fidgetiness, (d) depression, (e) effort, (f) worthlessness, (g) matched negative experiences, (h) emotional interference with house chores, (i) emotional interference with social life (j) emotional interference with relationships, and (i) matched negative emotions. Those pre- and posttest means and standard deviations are presented in Table 3, along with *t* tests, degrees of freedom, one-tailed *p* values and effect sizes.

Table 3

Means, Sample Sizes, Standard Deviations, t Tests, df, p Values, and Effect Sizes: Nervousness, Hopelessness, Restlessness, Depressed, Effort, Worthlessness, Matched Negative Experiences, Emotional Interference With House Chores, Emotional Interference With Social Life, Emotional Interference With Relationships, and Negative Emotions

Paired Samples	*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 1 Prenervous	2.32	97	.62	-4.56	96	< .001	-.46
Postnervous	1.98	97	.61				
Pair 2 Prehopeless	2.22	97	.71	-4.53	96	< .001	-.46
Posthopeless	1.85	97	.58				
Pair 3 Prerestless	2.11	97	.58	-1.54	96	.064	-.16
Postrestless	1.99	97	.64				
Pair 4 Predepressed	2.33	97	.63	-5.54	96	< .001	-.56
Postdepressed	1.84	97	.75				
Pair 5 Preefort	2.48	97	.65	-4.92	96	< .001	-.50
Posteffort	1.97	97	.74				
Pair 6 Preworthless	2.15	97	.70	-3.07	96	.001	-.31
Postworthless	1.85	97	.73				

Table 3 (continued)

Paired Samples	*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 7 Prematched Negative Experiences	2.28	96	.47	-4.36	95	< .001	.56
Postmatched Negative Experiences	2.03	96	.49				
Pair 8 Preemotional Interference House Chores	2.09	92	.80	-1.64	91	.052	.95
Postemotional Interference House Chores	1.92	92	.78				
Pair 9 Preemotional Interference Social Life	1.97	89	.63	-3.44	88	< .001	.95
Postemotional Interference Social Life	1.62	89	.80				
Pair 10 Preemotional Interference Relationships	2.03	92	.62	-4.41	91	< .001	.85
Postemotional Interference Relationships	1.64	92	.72				

Table 3 (continued)

Paired Samples	*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 11 PreMatched Neg Emotions	2.13	94	.55	-4.83	93	< .001	.66
PostMatched Neg Emotions	1.80	94	.50				

Note. For all Pairs 1 through 11, higher means a higher amount of the trait.

All of the *t* tests in this document were calculated as follows: Postmean minus premean divided by a standard error. All *t* tests were negative, which indicated mean decreases or losses.

The group of 11 variable that were analyzed for Research Question 1 can be divided into two sets. The first six variables were the measures of psychological distress. For all six of these variables, the postsurvey means were lower than were the presurvey means, indicating a decrease in such distress, and this beneficial outcome was the preferred outcome for the HHH program. For five of these six variables, the significant *p* values were at .001 or < .001. Restless/ fidgetiness, though in the preferred direction, only approached significance with a *p* value of .064. A possible reason for lack of significance is that not all people experience extreme restlessness.

There were five remaining variables in the second set that were analyzed for Research Question 1, which measured negative emotional interferences. All of the postsurvey means for those five variables were lower than the presurvey means, indicating a greater decrease or elimination of negative emotional interferences and was the preferred, beneficial outcome. The results for four of these five *t* tests were significant at < .001. Emotional interference with household chores, though in the preferred direction, only approached significance at .052. It is possible that the participants who were primarily women did not experience chores so negatively and may have even felt some sense of satisfaction in completing them and maintaining their household.

The answer to Research Question 1 was that there were significant reductions on all but one variable measuring psychological distress, which decreased over the course of the program. This was the hoped-for outcome and fulfilled the motive of the Hmong Helping Hands Intervention. In addition, there were greater eliminations in negative emotional interferences at the posttest for all five variables, and four of these five were significant.

Research Question 2: To what extent will the Hmong Helping Hands Intervention strengthen participants' physically, psychologically, and spiritually?

This question was addressed by measuring the following four indicator variables at both pre- and post-survey: (a) cultural strength, (b) cultural importance, (c) good cultural emotions, and (d) importance of traditional religion. The pre- and post-survey frequencies, percentages within the pre-survey, and the percentages within totals by survey responses and totals are presented in Table 4. Only descriptive statistics were run to answer this research question as chi-square tests of independence were not appropriate because at least six cells for each of the variables had a frequency of 5 or fewer (Marascuilo & McSweeney, 1977).

Table 4

Pre- and Post-Survey Frequencies, Percentages within Pre-Surveys, and Percentages within Totals: Cultural Strength, Cultural Importance, Good Cultural Emotions, and Religious Importance

Pre-Survey		Post-Survey			
		1 Disagree	2 Neutral	3 Agree	Total
Cultural Strength					
1 Disagree	count	0	0	0	0
	% w/in pre-survey	0.0%	0.0%	0.0%	0.0%
	% w/in total	0.0%	0.0%	0.0%	0.0%
2 Neutral	count	0	2	5	7
	% w/in pre-survey	0.0%	28.6%	71.4%	100.0%
	% w/in total	0.0%	2.1%	5.2%	7.2%
3 Agree	count	1	12	77	90
	% w/in pre-survey	1.1%	13.3%	85.6%	100.0%
	% w/in total	1.0%	12.4%	79.4%	92.8%
Total	f	1	14	82	97
	% w/in pre-survey	1.0%	14.4%	84.5%	100.0%
	% w/in total	1.0%	14.4%	84.5%	100.0%

Cultural Importance					
1 Disagree	count	0	0	1	1
	% w/in pre-survey	0.0%	0.0%	100.0%	100.0%
	% w/in total	0.0%	0.0%	1.0%	1.0%
2 Neutral	count	0	0	3	3
	% w/in pre-survey	0.0%	0.0%	100.0%	100.0%
	% w/in total	0.0%	0.0%	3.1%	3.1%
3 Agree	count	1	7	85	93
	% w/in pre-survey	1.1%	7.5%	91.4%	100.0%
	% w/in total	1.0%	7.2%	87.6%	95.9%
Total	f	1	7	89	97
	% w/in pre-survey	1.0%	7.2%	91.8%	100.0%
	% w/in total	1.0%	7.2%	91.8%	100.0%
Good Cultural Emotions					
1 Disagree	count	0	0	1	1
	% w/in pre-survey	0.0%	0.0%	100.0%	100.0%
	% w/in total	0.0%	0.0%	1.0%	1.0%
2 Neutral	count	0	0	6	6
	% w/in pre-survey	0.0%	0.0%	100.0%	100.0%
	% w/in total	0.0%	0.0%	6.2%	6.2%
3 Agree	count	1	6	83	90
	% w/in pre-survey	1.1%	6.7%	92.2%	100.0%
	% w/in total	1.0%	6.2%	85.6%	92.8%
Total	f	1	6	90	97
	% w/in pre-survey	1.0%	6.2%	92.8%	100.0%
	% w/in total	1.0%	6.2%	92.8%	100.0%
Religious Importance					
1 Disagree	count	0	1	0	1
	% w/in pre-survey	0.0%	100.0%	0.0%	100.0%
	% w/in total	0.0%	1.0%	0.0%	1.0%
2 Neutral	count	1	3	6	10
	% w/in pre-survey	10.0%	30.0%	60.0%	100.0%
	% w/in total	1.0%	3.1%	6.2%	10.3%
3 Agree	count	1	5	80	86
	% w/in pre-survey	1.2%	5.8%	93.0%	100.0%
	% w/in total	1.0%	5.2%	82.5%	88.7%
Total	f	2	9	86	97
	% w/in pre-survey	2.1%	9.3%	88.7%	100.0%
	% w/in total	2.1%	9.3%	88.7%	100.0%

Inspection of the frequencies and percentages for these four variables relating to culture is notable because there is so little variation between the pre-survey and the post-survey responses. For cultural strength, cultural importance, cultural emotions, and religious importance, the percentages of participants who "agreed" on both the pre-survey and the post-survey were 79.4%, 87.6%, 85.6%, and 82.5%, respectively. Assuming that the Hmong elders in this sample had the same understandings of these survey questions as the survey authors and HHH staff intended, such remarkable consistency suggests that these participants have a high degree of resiliency. Though they may experience depression or negative emotions at times, their cultural connections related to their physical, psychological, and spiritual lives are strong.

Research Question 3: To what extent will the Hmong Helping Hands Intervention participants' sense of belonging strengthen?

This question was addressed by measuring the following four indicator variables at both pretest and posttest: (a) feeling cultural connections; (b) mind, body, and spirit balance; (c)marginalization; and (d) isolation. The pre- and posttest means, dependent t tests,p values, and effect sizes for Research Question 3 are presented in Table 5. This set offour variables can be divided into two sets. For cultural connection and mind, body, spirit balance, the means increased over time, indicating improvement in these important cultural concepts. The mean differences were .31 and .34, respectively, and both were significant at< . 001. For marginalization and isolation, the means decreased over time, which also indicated improvement in these negative experiences. The mean differences were -.35 and -.20, respectively. Marginalization was significant at< .001, and isolation was significant at .012.

Table 5

Means, Sample Sizes, Standard Deviations, t Tests, df, p Values, and Effect Sizes: Feeling Culturally Connected; Mind, Body, Spirit Balance; Marginalization; and Isolation

Paired Samples		*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 1	Prefeeling culturally connected	2.33	97	.55	6.33	96	< .001	.64
	Postfeeling culturally connected	2.74	97	.46				
Pair 2	Premind, body, spirit balance	2.14	97	.63	4.18	96	< .001	.43
	Postmind, body, spirit balance	2.48	97	.54				
Pair 3	Premarginalization	1.98	96	.63	- 3 . 93	95	< .001	.46
	Postmarginalization	1.63	96	.73				
Pair 4	Preisolation	1.74	97	.67	-2.28	96	.012	.23
	Postisolation	1.54	97	.72				

Note. For Pairs 1 and 2, higher means a higher amount of the trait. For Pairs 3 and 4 lower means a lower amount of the trait.

Research Question 4: How consistently will the participants participate in each of the components?

To evaluate this research question, we looked at the weekly sign-in sheets and the number of participants participating in each component per week. Table 1 (p. 13) shows the percentages of participation by cohorts and by each of the locations.

Overall, the answer to Research Question 4, the weekly sign-in attendance sheets indicated that the participants did consistently participate across all of the cohorts and locations. The attendance for the eight groups was overall 92%.

Research Question 5: How satisfied will the participants be with each of the components?

To answer Research Question 5, we used the postexit interviews, post-SWE questions 21, 22, 23, 24, and 26, and the two Self-Satisfaction Surveys with the participants to help answer whether participants were satisfied with each activity in each of the components.

Focus Groups

In an interesting comparison of the three different locations by cohorts, they appeared to be very similar in both themes and patterns, and it may well be related to the compatibility of the number of males and females that were in each of the three groups. There was a total of 78 females and 16 males across the locations. All of the cohorts experienced the same weekly activities for Cohort 1; however, for Cohorts 2 and 3, each location conducted their own activities as long as they could be connected to any of the five components. But for the 1-day long exploration activities and their graduation ceremonies, the partners brought all of the participants together. There was a high percentage of the cohort participants who were present for the focus groups (see Table 6).

It was very clear that at each location the cohorts had bonded over the 24-week sessions and "enjoyed coming together with other people" and "finding new friends." Many of them (both women and men) were living alone as widows and widowers and told us that coming to HHH helped them "feeling not so alone anymore," "I learned how to be happy again," "This is a support group for those folks who do not have it at home," and "I felt that I had a dark life--like a pigeon in a bird cage when I first came here. Now my dreams are coming true and I can be more honest and see the world being much brighter now."

Table 6

Number of Postinterviews by Cohort for Each Partner

Cohort and Location	Male		Female		Total	
	n	%	*n*	%	*n*	%
Cohort 1						
Fresno	6	29	15	71	21	100
Merced	1	11	8	89	9	100
Stockton	0	0	4	100	4	100
Cohort 2						
Fresno	4	22	14	78	18	100
Merced	1	9	10	91	11	100
Stockton	0	0	4	100	4	100

Table 6 (continued)

Cohort and Location	Male *n*	Male %	Female *n*	Female %	Total *n*	Total %
Cohort 3						
Fresno	5	26	14	74	19	100
Merced	2	11	17	89	19	100
Stockton*						
Total	19	20	78	80	97	100

*Stockton partner dropped out of Cohort 3.

The majority of the participants felt that being in the program helped them to come to a place that gave them "hope" where they felt "worthwhile" and "could express their feelings," "helping to relieve their stress and depression so they again feel happy." "Coming here brightens our day with talking about our thoughts and feelings and makes us want to live." "We had the opportunity to come in express and share what we do all week--we question each other, we interact, we encourage one another listening to where we all are."

"Happiness" was a key word across several of the questions and mentioned 36 times: "Happiness is when I come here," "I feel happier when I am here," "have happiness again," "I feel happy and satisfied." The participants felt that the town they lived in was limited in having other similar programs such as this one, even though there were still many Hmong in the area.

"We feel very special and well taken care of while we are here."
"Doing things during the day helped our stress and depression as we've had no other place to go for this type of program."
"I'm just happy to be here rather than at home and feel more energized with less stress."

- In what ways have you benefitted from participating in the Hmong Helping Hands?

The participants reflected on what they had learned from being in the Intervention.

"I felt there was only one of me, but when I am here, I see there is more than me, making me feel happy."
"When I feel angry or depressed or stressed, I look at the wall and I see the certificate

I received and it reminds me it's something I went through to help myself become a better person."

"There is still many out there in the darkness, I would like to help them to come here and see the light. They are isolated, not connected to any peers, services, or activities."

They also felt they had benefitted learning more about mental health issues indicating they "had thought about suicide," and "depression." "I found relief from depression here." "Coming to HHH takes away stress."

As demonstrated in the Activity Evaluations that were filled out at the end of each class day, the participants had their favorite ones and very much enjoyed the field trips that gave them exploration and a change of scenery in Yosemite and Avila Beach. Many of them had never been able to visit historical sites in their own towns--local zoos, fairs, farms, etc.

"For 30-40 years in America, I have never been anywhere, this project has taken me sightseeing to various places that has been fun and brought happiness."

"The field trips were very special and I learned a lot from them. I've never seen where crops are grown and processed."

"The field trips and exploration were so special as many of us have never been out of town before. It empowers us as we are often stuck at home."

"The field trips helped me with my depression because it is always hard to come home when you are alone. It is good to get out of the house and see new things."

The Hmong Talk motivational speakers and make-up activities were also very popular throughout all three cohorts.

"Keep helping people to open up their minds with having good guest speakers and continue having the cross-cultural experiences."

"The inspirational speakers were very motivating and should be continued."

"I started using the make-up and my granddaughter wanted to know why. I told her I was going to find a new husband."

"Making their own Scrapbooks" (with weekly photographs and art supplies) was appreciated, and they liked being able to look back through them, remembering the good times.

"The scrapbook helps me reflect on the pictures taken every week that we cut out and put in our scrapbooks. When I look at my scrapbook, it takes me back to the time I was here."

"When I am stressed or depressed, I open my scrapbook and reflect on things that made me happy here."

The participants received a Graduation Certificate upon completion of the program, and they appreciated having it and have displayed it at their homes.

"I am so happy with my certificate and scrapbook and my children have been able to view them and see what I have been able to do."
"Every time I look at my certificate and scrapbook, it brings me back to the program and the special peers in our group."
"The other day my daughter saw my certificate and she was so happy and said, Mom you have a diploma. Look, you graduated--this is awesome."

• What sort of changes have you seen in your life after participating in Hmong Helping Hands?

There was great pride shown in the many changes that were shared by the participants.
"I felt that I had a dark life--like a pigeon in a bird cage when I first came here. Now my dreams are coming true and I can be more honest and see the world being much brighter now."
"We are people who don't speak English an I have learned there are other places I can go now when I need help who will understand me."
"I have learned how to cope as a widow as my husband is deceased. I am alone, feeling depressed and hopeless, but with this program, I have been able to cope with all that has happened and feel better with all the support I have received."

• How would you improve this activity? What would you change or include?

The participants wanted to have a "Continuing Program," and it should be "more than one day a week and longer than 6 months." "Longer Hours and more Staff" were also desired as well as a needed "transportation system" so more people could attend.

"We all want to come back--this is a place without stress and we're happy to see each other. Home can be overwhelming and I will think about the people I will miss being here and it makes me sad because I always feel better here."
"Continue to challenge and change us to feel more confident in helping ourselves."
"The project has ended, we feel that we have nowhere to go and will be alone and stuck at home again."
"Keep helping people to open up their minds with have good guest speakers and continue having the cross-cultural experiences."

• Are there any other thoughts you would like to share with us today?

"Older folks don't have a lot of time left and we just live day to day, so this program brought light to us while we are still here."

"It's been my getting away place to learn more things--self love and putting myself first. It is eye opening to watch us loving ourselves more and I can now say, I now love myself."

"Like a staircase, we are only at the beginning of the staircase, we want to go up one or more steps."

"For 30 years, I haven't left Fresno. I have no education so to com here to share in activities makes me feel happy and satisfied. I don't have a husband or any children and my parents have passed away so I felt there wasn't anything for me here until I found this program."

Post-SWE. Additionally, Table 7 shows how they self-reported about the Hmong Helping Hands Intervention after having gone through the 6-month cohorts. Over 90% of all of the participants reported agreeing to the following questions:

- I like the services that I received here.
- If I had other choices, I would still get services from this agency.
- I would recommend this agency to a friend or family member.
- The location of services was convenient.
- Services were available at times that were good for me.

Self-Satisfaction Surveys

For each weekly activity either a self-satisfaction activity or Hmong Talk survey was given to each of the participants. Tables 8, 9, and 10 show the average scores for all of the participants' responses to the three questions on a scale of 1 to 5, with 1 being the lowest and 5 being the highest.

Table 7

Self-Report on Hmong Helping Hands Intervention Activities

	Like services		Choices		Recommendation		Location		Time	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Agree	92	95	94	98	93	96	93	96	94	98

Table 7 (continued)

	Like services		Choices		Recommendation		Location		Time	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Neutral	5	5	2	2	4	4	3	3	2	2
Disagree	0	0	0	0	0	0	1	1	0	0
Total	97	100	96	100	97	100	97	100	96	100

Table 8

Total Average Self-Satisfaction Scores for Fresno and Merced Cohort 1

		Hmong Talk		Maij-Maij		Exploration		Arts/Crafts		Spiritual	
Location		Average rating*	Total unit activity**	Average rating*	Total unit activity**	Average rating*	Total unit activity**	Average rating*	Total unit activity**	Average rating*	Total unit activity**
Fresno											
	Q1 Helpful	4.58	86	4.66	152	4.69	62	4.63	54	5.00	15
	Q2 Enjoy	4.66	86	4.67	152	4.77	62	4.56	54	4.93	15
	Q3 Teach again	4.77	86	4.75	152	4.79	62	4.65	54	5.00	15
Merced											
	Q1 Helpful	4.64	45	4.84	51	4.91	32	4.78	32	5.00	7
	Q2 Enjoy	4.64	45	4.92	51	4.94	32	4.94	32	5.00	7
	Q3 Teach again	4.58	45	4.92	51	5.00	32	4.97	32	5.00	7

Table 8 continued)

Location	Hmong Talk Average rating*	Hmong Talk Total unit activity**	Maij-Maij Average rating*	Maij-Maij Total unit activity**	Exploration Average rating*	Exploration Total unit activity**	Arts/Crafts Average rating*	Arts/Crafts Total unit activity**	Spiritual Average rating*	Spiritual Total unit activity**
Total for Fresno and Merced cohorts	4.65	131	4.80	203	4.85	94	4.76	86	4.99	22

Average of all activities for Fresno and Merced	Average rating*	Total unit activity**
	4.81	536

*Rate was done on a 1 to 5 point scale, 1 lowest to 5 highest.
**Total unit activity also equals the total number of responses for that component during the cohort.

Note: Stockton did not collect any data despite being a partner in implementing these activities during this cohort.

Table 9

Total Average Self-Satisfaction Scores for Fresno, Merced, and Stockton Cohort 2

Location		Hmong Talk Average rating*	Hmong Talk Total unit activity**	Maij-Maij Average rating*	Maij-Maij Total unit activity**	Exploration Average rating*	Exploration Total unit activity**	Arts/Crafts Average rating*	Arts/Crafts Total unit activity**	Spiritual Average rating*	Spiritual Total unit activity**
Fresno											
	Q1 Helpful	4.49	57	4.67	114	4.86	121	4.88	99	4.56	16
	Q2 Enjoy	4.61	57	4.68	114	4.84	121	4.89	99	4.47	16
	Q3 Teach again	4.75	57	4.75	114	4.90	121	4.93	99	4.69	16
Merced											
	Q1 Helpful	4.95	64	5.00	51	4.97	65	4.92	39	5.00	7
	Q2 Enjoy	4.92	64	5.00	51	4.95	65	4.85	39	5.00	7
	Q3 Teach again	4.95	64	5.00	51	4.98	65	4.90	39	5.00	7
Stockton											
	Q1 Helpful	4.68	28	4.79	20	4.94	16	4.93	46	4.75	4
	Q2 Enjoy	4.75	28	4.79	20	4.88	16	4.93	46	5.00	4
	Q3 Teach again	4.79	28	4.79	20	4.94	16	4.96	46	5.00	

Table 9 (continued)

Location	Hmong Talk Average rating*	Hmong Talk Total unit activity**	Maij-Maij Average rating*	Maij-Maij Total unit activity**	Exploration Average rating*	Exploration Total unit activity**	Arts/Crafts Average rating*	Arts/Crafts Total unit activity**	Spiritual Average rating*	Spiritual Total unit activity**
Total for Fresno, Merced, and Stockton cohorts	4.77	149	4.85	185	4.92	202	4.89	184	4.79	27

Average of all activities for Fresno, Merced, and Stockton	Average rating*	Total unit activity**
	4.84	747

*Rate was done on a 1 to 5 point scale, 1 lowest to 5 highest.
**Total unit activity also equals the total number of responses for that component during the cohort.

Table 10

Total Average Self-Satisfaction Scores for Fresno and Merced Cohort 3

Location	Hmong Talk Average rating*	Hmong Talk Total unit activity**	Maij-Maij Average rating*	Maij-Maij Total unit activity**	Exploration Average rating*	Exploration Total unit activity**	Arts/Crafts Average rating*	Arts/Crafts Total unit activity**	Spiritual*** Average rating*	Spiritual*** Total unit activity**
Fresno										
Q1 Helpful	4.84	141	4.85	168	4.77	39	4.94	69		
Q2 Enjoy	4.82	141	4.78	168	4.82	39	4.88	69		
Q3 Teach again	4.81	141	4.73	168	4.85	39	4.88	69		
Merced										
Q1 Helpful	5.00	69	4.97	60	4.99	77	4.98	54		
Q2 Enjoy	5.00	69	5.00	60	5.00	77	5.00	54		
Q3 Teach again	5.00	69	5.00	60	5.00	77	5.00	54		
Total for Fresno and Merced cohorts	4.91	210	4.89	228	4.91	116	4.95	123		

Table 10 (continued)

Location	Hmong Talk Average rating*	Hmong Talk Total unit activity**	Maij-Maij Average rating*	Maij-Maij Total unit activity**	Exploration Average rating*	Exploration Total unit activity**	Arts/Crafts Average rating*	Arts/Crafts Total unit activity**	Spiritual*** Average rating*	Spiritual*** Total unit activity**
Average of all activities for Fresno and Merced	Average rating* 4.91	Total unit activity** 677								

*Rate was done on a 1 to 5 point scale, 1 lowest to 5 highest.
**Total unit activity also equals the total number of responses for that component during the cohort.
***Spiritual data were not collected and were embedded into many of the activities.

Note: Stockton partner dropped out.

For all of the cohorts, all the activities that correspond to each of the five components showed that participants overwhelmingly thought these activities were helpful, enjoyable, and very much would like to see these activities continue. The overall average ratings by all of the cohorts are as follows: Ncig Teb Chaw (Cross-Cultural Therapeutic Learning) and Spirituality, 4.89; Cultural Therapeutic Arts and Crafts Activities, 4.87; Maij-Maij (Beauty), 4.84; and Hmong Talk, 4.77.

Overall, the answer to Research Question 5, reported participants were satisfied with the HHH Intervention components. During this time, there was an average of 653 total unit of activities created for each cohort, and they were evaluated through the Self-Satisfaction Activity and Hmong Talk Surveys completed by the participants at the end of each weekly meeting. These evaluations strongly indicated that participants very much enjoyed the activities, felt the activities helped them, and they would like to do these activities again.

Research Question 6: To what extent will the partnership between The Fresno Center, Merced Lao Family Community, Inc., and Stockton Lao Family Community Empowerment, Inc., be collaborative and successful?

To answer Research Question 6, we looked at numbers of weeks and numbers of activities implemented for the HHH Intervention. Then we also included the number of times partners met together with the HHH Advisory Committee members. Lastly, we looked at the number of times the collaborative partners met and attended conferences together.

In total, there were eight different groups in the three different locations. Together, a total of 179 weeks was utilized to implement the HHH Intervention: Fresno, 69; Merced, 71; and Stockton, 39 (only had two cohorts). In all, the collaborative partners worked together and implemented a total of 1,960 unit of activities for all of the three cohort groups: Fresno, 1,193; Merced, 653; and Stockton, 114.

Regarding the partnership/collaborative meetings and conferences, the partners managed to attend three in-person CRDP statewide conferences and API Peer Learning sessions together. Then the collaborative met for a total of 156 times for their weekly meetings for reflections and debriefing. Also, the partners participated approximately 75 times for their monthly collaborative meetings to give program updates, conduct survey trainings, and report changes. There was a total of five collaborative meetings with our HHH Advisory Committee members. Overall, to answer Research Question 6, the collaborative partnership had shown significant efforts in working together to develop, implement, and improve the partnership relationship and the Hmong Helping Hands Intervention.

Subjective Happiness Scale Results

To better understand how the participants perceived our Hmong Helping Hands Intervention, the Subjective Happiness Scale was also used. This is a 4-item scale of global subjective happiness (Lyubomirsky & Lepper, 1999).

The means, standard deviations, dependent *t* tests, *p* values, and effect sizes for Cohort 1 appear in Table 11. Correlations and their associated *p* values appear in Table 12. For all variables measuring self-happiness, self-happiness compared to peers, general self-happiness, general self-unhappiness, and total happiness participants significantly increased in their scores from the pre- to the post-survey after the intervention. The *p* values were .004, < .001, .042, .001, and .001 for those variables, respectively. Correlations for self-happiness, self-happiness compared to peers, and total happiness were moderate and significant at .42, .34, and .46. The correlations for general self-happiness and general self-unhappiness were low and nonsignificant.

Table 11

Cohort 1 Paired Samples Statistics

Paired Samples	*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 1 Q1Postmyself	4.00	34	2.05	2.85	33	.004	.49
Q1Premyself	3.00	34	1.16				
Pair 2 Q2Postpeers	4.26	34	1.85	3.68	33	< .001	.63
Q2Prepeers	2.94	34	1.81				
Pair 3 Q3Posthappy	4.71	34	2.01	1.79	33	.042	.31
Q3Prehappy	3.85	34	2.13				
Pair 4 Q4Postnot happy	4.85	34	1.84	3.24	33	.001	.56
Q4Prenot happy	3.35	34	2.27				
Pair 5 Posttotal happy	4.46	34	1.57	4.18	33	< .001	1.63
Pretotal happy	3.29	34	1.55				

Table 12

Cohort 1 Paired Samples Correlations

Paired Samples	*N*	Correlation	One-sided *p*.
Pair 1 Q1Postmyself and Q1Premyself	34	.42	.007
Pair 2 Q2Postpeers and Q2Prepeers	34	.34	.024
Pair 3 Q3Posthappy and Q3Prehappy	34	.10	.295

Table 12 (continued)

Paired Samples	*N*	Correlation	One-sided *p*
Pair 4 Q4Postnot happy and Prenot happy	34	.15	.198
Pair 5 Posttotal happy and Pretotalhappy	34	.46	.003

The means, standard deviations, dependent *t* tests, *p* values, and effect sizes for Cohort 2 appear in Table 13. Correlations and their associated *p* values appear in Table 14. For the first three variables measuring self-happiness, self-happiness compared to peers, general self-happiness, and total happiness, participants significantly increased in their happiness from the pre- to the post-survey after the intervention. The *p* values were < .001, < .001, .028, and < .001 for those variables, respectively. For the fourth variable of general self-unhappiness, the mean at post-sruvey was lower than at the pre-survey, though there was no significant difference (*p* = .186). Correlations for self-happiness, self-happiness compared to peers, and total happiness were moderate and significant at .41, .63, and .42, respectively. The correlations for general self-happiness and general self-unhappiness were low and nonsignificant.

Table 13

Cohort 2 Paired Samples Statistics

Paired Samples	*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 1 Q1Postmyself	5.03	31	1.35	5.23	30	< .001	.94
Q1Premyself	3.58	31	1.48				
Pair 2 Q2Postpeers	5.00	31	1.61	4.98	30	< .001	.90
Q2Prepeers	3.71	31	1.72				
Pair 3 Q3Posthappy	4.97	31	1.64	1.98	30	.028	.36
Q3Prehappy	4.13	31	1.65				
Pair 4 Q4Postnot happy	4.06	31	1.59	-.91	30	.186	-.16
Q4Prenot happy	4.45	31	1.96				

Table 13 (continued)

Paired Samples	*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 5 Posttotal happy	4.77	31	1.11	3.67	30	< .001	1.05
Pretotal happy	3.97	31	1.12				

Table 14

Cohort 2 Paired Samples Correlations

Paired Samples	*N*	Correlation	One-sided *p*.
Pair 1 Q1Postmyself and Q1Premyself	31	.41	.012
Pair 2 Q2Postpeers and Q2Prepeers	31	.63	< .001
Pair 3 Q3Posthappy and Q3Prehappy	31	-.03	.451
Pair 4 Q4Postnot happy and Prenot happy	31	.12	.263
Pair 5 Posttotal happy and Pretotalhappy	31	.42	.010

The means, standard deviations, dependent *t* tests, *p* values, and effect sizes for Cohort 3 appear in Table 15. Correlations and their associated *p* values appear in Table 16. For the first three variables measuring self-happiness, self-happiness compared to peers, general self-happiness, and total happiness, participants significantly increased in their happiness from the pre- to the post-survey after the intervention. The *p* values were < .001 for those three variables and for total happiness. For the fourth variable of general self-unhappiness, there was no significant difference ($p = .244$) from the pre- to the post-survey. Correlations were generally low, ranging from -.20 to .13, and none was significant, which suggests that initial happiness is not related to happiness at posttest.

Table 15

Cohort 3 Paired Samples Statistics

Paired Samples	*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 1 Q1Postmyself	5.47	36	1.46	5.50	35	< .001	.92
Q1Premyself	3.42	36	1.65				
Pair 2 Q2Postpeers	5.11	36	1.70	4.03	35	< .001	.67
Q2Prepeers	3.47	36	1.44				
Pair 3 Q3Posthappy	5.11	36	1.97	3.46	35	< .001	.58
Q3Prehappy	3.81	36	1.41				
Pair 4 Q4Postnot happy	4.86	36	1.85	. 70	35	.244	.12
Q4Prenot happy	4.61	36	1.32				
Pair 5 Posttotal happy	5.14	36	1.59	4.10	35	< .001	.68
Pretotal happy	3.83	36	1.05				

Table 16

Cohort 3 Paired Samples Correlations

Paired Samples	*N*	Correlation	One-sided *p.*
Pair 1 Q1Postmyself and Q1Premyself	36	-.04	.416
Pair 2 Q2Postpeers and Q2Prepeers	36	-.20	.126
Pair 3 Q3Posthappy and Q3Prehappy	36	.13	.222
Pair 4 Q4Postnot happy and Prenot happy	36	.12	.247

Table 16 (continued)

Paired Samples	*N*	Correlation	One-sided *p*.
Pair 5 Posttotal happy and Pretotalhappy	36	-.02	.895

The means, standard deviations, dependent *t* tests, *p* values, and effect sizes for all participants appear in Table 17. Correlations and their associated values appear in Table 18. For all four variables measuring self-happiness, self-happiness compared to peers, general self-happiness, general self-unhappiness, and total happiness, participants significantly increased in their scores from the pre- to the post-survey after the intervention. The *p* values were < .001, < .001, < .001, .030, and .001 for those four variables and total happiness, respectively. Correlations for self-happiness, self happiness compared to peers, and total happiness were low to moderate and significant at .29, .29, and .30, respectively. The correlations for general self-happiness and general self-unhappiness were low and nonsignificant.

Table 17

Paired Samples Statistics for All Participants

Paired Samples	*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 1 Q1Postmyself	4.84	101	1.75	7.56	100	< .001	.75
Q1Premyself	3.33	101	1.62				
Pair 2 Q2Postpeers	4.79	101	1.75	7.00	100	< .001	.70
Q2Prepeers	3.37	101	1.67				
Pair 3 Q3Posthappy	4.93	101	1.88	4.12	100	< .001	.41
Q3Prehappy	3.92	101	1.74				
Pair 4 Q4Postnot Happy	4.61	101	1.79	1.90	100	. 030	.19
Q4Prenot Happy	4.14	101	1.94				

Table 17 (continued)

Paired Samples	*M*	*N*	*SD*	*t* Test	*df*	*p* (1-tailed)	Cohen's effect size
Pair 5 Posttotal happy	4.79	101	1.47	6.83	100	< .001	.89
Pretotal happy	3.69	101	1.28				

Table 18

Paired Samples Correlations for All Participants

Paired Samples	*N*	Correlation	One-sided *p*.
Pair 1 Q1Postmyself and Q1Premyself	101	.29	.002
Pair 2 Q2Postpeers and Q2Prepeers	101	.29	.002
Pair 3 Q3Posthappy and Q3Prehappy	101	.08	.229
Pair 4 Q4Postnot Happy and Q4Prenot Happy	101	.10	.163
Pair5 Total happiness pre and post	101	.30	.001

Discussion and Conclusions

Discussion

Fresno County has a very limited number of mental health services and activities that specifically target the Hmong population. The Hmong Helping Hands Intervention was one of the few available opportunities to actively engage Hmong adults and older adults once a week for 24 weeks as a way to improve their overall mental health well-being. HHH was important, as we heard from our participants that they felt "stuck" or "locked" inside of their homes having nothing meaningful to do that would help to address their mental health well-being. We also heard that some of the participants complained about transportation and reported feeling irritable having to babysit their grandchildren all day at their homes. The participants' high participation and graduation rate for HHH, as well as all of their positive responses about the program activities during the postexit interviews, supported the quantitative and qualitative findings of this intervention.

The Surveys: Translation and Administration

There were five different surveys that the participants took while in the intervention: The pre- and post-SWE core measures, Subjective Happiness Scale, Hmong Helping Hands Activity Survey, and the Hmong Helping Hands Hmong Talk Survey. All of these surveys were translated into Hmong to maintain a consistency of asking the questions and having a translator and/or staff reading the responses to the participants when administering them in individual or group settings. However, the survey translation lacked some of the standard recommendations for cross-cultural adaption of health status measures, such as going through an expert committee review (Beaton et al., 2002) and with the Hmong language not having equivalent terminologies and concepts. Researchers, such as Mouanoutoua et al. (1991), translated and adapted the Beck Depression Inventory to Hmong and found a high coefficient alpha and test-retest reliability with surveying the Hmong participants. However, it is not really known how much the translation of these surveys would have had an impact on the quantitative outcomes of this intervention since reliability and validity on them have not been calculated.

In an attempt to improve the reliability of the evaluation process and methodology, as well as the validity of responses from the participants, a number of adaptions were made, including translation. All of the instruments were carefully translated from English to Hmong by a bilingual, bicultural, Hmong mental health professional, and the staff participated in an 8-hour training on the administration of these surveys. The standard protocol noted a total time of no more than 30 minutes to complete both the pre- and post SWE core measures. Due to a number of factors, its very high illiteracy and low acculturation rates in this Hmong population group, combined with the fact that the majority of the participants were 50 years old and older ($n = 89$,

82%), it should be noted that it took an additional 60 minutes for these participants to complete both the pre- and post-SWE measures. The pre-SWE measure took an average time of 75 minutes, while the post-SWE measure took about 60 minutes to complete. Afterwards, with the participants' permission, the staff filled in the demographic information for the survey using information from the participants' intake forms. The HHH Activity Survey took less than 5 minutes to implement as it only had four questions. These efforts were made to minimize the participants' survey exhaustion and boredom, as these can be factors that affect the outcome of the evaluation (Lavrakas, 2008).

Other changes included addressing questions that were considered culturally inappropriate, including personal and private information such as age and gender. These were not asked directly to the participants in the group setting but were obtained indirectly from their intake forms. For other questions like the SOGI (sexual orientation and gender identity) questions, since they were optional, we opted to skip asking these questions without having built any rapport and in the presence of another person, as it could make the participant shy and affect their participation.

All of the 5-point scale responses were changed to 3-point scale responses. This was important since different culture groups would respond differently to a Likert scale (Lee et al., 2010). This was done to make sure it was culturally and linguistically appropriate for this group, as the 5-point scale might be confusing and difficult for them to distinguish the small differences in each of the response choices. Changing to a 3-point scale made it easier for the participants to comprehend and at the same time minimized staff time with each participant because they did not have to explain it more than once.

Overall, these efforts were made to improve the reliability of the evaluation process and methodology, as well as the validity of responses from the participants. These adaptations and translations were necessary to minimize other confounding effects, such as exhaustion, boredom, and confusion, on the outcomes of the evaluation of this CDEP project.

Five of the six research questions did show support that our CDEP was effective, there was consistent participation and satisfaction with all of the activities, and there was a strong collaboration work among the partners in the three locations in implementing the HHH Intervention. For the other research question, there was a little change, but responses were positive on both the pre- and post-survey.

In Research Questions 1 and 3, we found that our Hmong Helping Hands Intervention was effective in reducing psychological distress and strengthening the participant's sense of belonging. All of the indicator variables, with the exception of two variables, were significant. This were the results we predicted, understanding that such an intervention would provide the opportunity for our participants to come out of their homes and do something different from their usual tasks. The two indicator variables that were not significant were restlessness/

fidgetiness and emotional interference with household chores. It is possible that the participants, who were primarily women, did not experience chores quite so negatively and may have even felt some sense of satisfaction in completing them and maintaining the household. While a possible reason for lack of significance for restlessness was that not all people experience extreme restlessness. These two significant findings provided further support for the hypothesis that depression in this population is not an intractable challenge but can be overcome with well-thought-out, planned, and implemented interventions.

For Research Question 2, it was not possible to calculate a test of significance. Participants responded to all four questions with very strong agreement on both the pre-survey and the post-survey. These variables did not show physical, psychological, or spiritual change or strengthening at the post-survey because most participants were already strong in agreement at the pre-survey. These results were not what we expected. On this survey the meaning of culture was defined as the many different things to different people, but it is something that is usually shared by a relatively large group of people. For some it refers to customs and traditions. For others it brings to mind their heritage and way of life. It can refer to beliefs, values and attitudes, your identity, and common history and membership in a group. It is possible that participants already feel comfortable within their Hmong families and community and responded to these questions from that perspective. They may not have viewed these questions as referring to the broader American culture which might require more adjustment.

The four variables in this Research Question 2 highlighted the positive attributes that are deeply rooted within the Hmong people. These positive attributes were noted in the beginning of the intervention with the very high percentages of pre-survey agreement responses. Therefore, any changes in responses might have a meant a lowering of physical, psychological, or spiritual strengths and would not have been a preferred outcome.

For Research Question 4, the participants' weekly attendance records were used, and they showed a high degree of participation ranging from 80% to 84% for the Fresno cohorts, 81% to 94% for the Merced cohorts, and 87% to 94% for the Stockton cohorts, showing an 86% participation rate for all participants. We believed that the preparation of morning cultural snacks, incentives, graduation celebration, and some luncheon for each activity and providing consistent transportation were critical to our participants' active participation and completion of the intervention. Another important factor in the successful implementation of HHH was the staff's ability to build and maintain rapport with the participants in each of the cohorts. Their bilingual and bicultural skills helped the participants to not only build meaningful friendships with the staffing, but also with the other participants in the intervention. It was noted with our

Stockton partners that these were their biggest challenges, and it resulted in their early departure from the partnership.

For Research Question 5, three different data sources were used to answer this question, and the high degree of triangulation and agreement among the data sources provide similar pictures. For the five SWE questions about liking services, choosing services from this agency over others, recommending this agency to others, location of services, and times of services, the percentages of participants agreeing to those statements ranged from 95% to 98%. The average ratings of the satisfaction score about the five activities (Hmong Talk, Maij-Maij, Ncig Teb Chaw, cultural arts/crafts, and spiritual activities) ranged from 4.65 to 4.99 on a 5-point scale, with an overall average of 4.85 for all of the 1,960 total units of activities. These highly favorable results were matched by the qualitative focus group results. Every participant in each of the cohorts at all three locations took part in a focus group. Their comments were overwhelmingly optimistic and repeatedly focused on the positive outcomes despite feeling suicidal previously. Here is a small sample of those comments.

"When I feel angry or depressed or stressed, I look at the wall and I see the certificate I received and it reminds me it's something I went through to help myself become a better person."
"I found relief from depression H.E.R.E."
"Coming to HHH takes away stress."
"I feel happier when I am here."
"We feel very special and well taken care of while we are here."
"We are people who don't speak English and I have learned there are other places I can go now when I need help who will understand me."
"Keep helping people to open up their minds with have good guest speakers and continue having the cross-cultural experiences."
"I felt like had a dark life--like a pigeon in a bird cage when I first came here. Now my dreams are coming true and I can be more honest and see the world being much brighter now."

Research Question 6 was answered by reporting the number of weeks and number of activities implemented for the HHH Intervention, the number of times staff met together (156 times for weekly meetings and debriefings, 75 monthly collaborative meetings, 5 meetings with the HHH Advisory Committee members, 3 in-person CRDP statewide conferences, and API Peer Learning sessions). In addition to these standard meetings, the partners supported each other by joining together to administer the surveys and conducting many of the activities together. This resulted in a very strong working relationship and partnership.

Limitations

The quantitative methods for this evaluation required a tremendous effort and time to collect data for this population. There were adaptations made to shorten the surveys, as well as translation and changes in the administration of the surveys. The length of the survey often made it difficult for the participants to remain actively engaged in the process. At the same time, due to the participants' lack of formal education and high illiteracy rate, self-administration of the survey was not possible, and staff assistance was necessary to fully complete the quantitative surveys. As a result, there were limitations to data collection that may account for some of the mixed results. Despite all of the evaluation tools that were used in the HHH Intervention, most of the evaluation questions were answered, but there may be questions about their cultural and linguistic appropriateness for this population. There is still more to do to be able to have results that can be more generalizable to the larger Hmong community.

Another limitation of the Hmong Helping Hands Intervention was the amount of time it took to coordinate and provide weekly transportation of the participants from their home to the activity locations and back again after the activity. This had a direct effect on the morale of staffing, since the staff often worked long hours to prepare for the program while also supporting the transportation needs of participants to ensure participation. This was a significant factor for our Stockton partner, who dropped out after the second cohort due to their limitations in staff capacity.

Recommendations

It was an ideal strategy to want to conduct the intervention in multiple locations with multiple partners, especially if the goal was to show generalizability and effectiveness. However, given the number of activities and limited funding that each of the partners had to implement in HHH, we recommend focusing the resources to only one organization to operate the project. If multiple partners are to be involved, we recommend at minimum $150,000 per year for each partner to ensure adequate resources for staff and program needs.

Take-Away Message

1. Working effectively with the Hmong elderly population requires adequate resources to support staff with language and culturally-specific needs. In particular, the program needs more staff and resources to implement these activities with multiple partners and locations, including providing transportation for the weekly meetings.

2. Evaluation needs to consider how to better assess the participants with multiple barriers (language, low illiteracy, hearing and vision impaired, etc.) to ensure

culturally and linguistically appropriate data collection. As evidenced with participants in this intervention, the evaluation process required an extensive amount of resources and time. There are still questions that remain about the validity of the data, given the cultural and linguistic limitations for this population.

Conclusion

We used quantitative and qualitative data to show whether our CDEP project, the Hmong Helping Hands Intervention, was effective in improving the Hmong adults' and elders' physical, psychological, and spiritual well-being and their sense of belonging in reducing their psychological distress. There were 6 research questions, 3 of which were quantitative, and 3 of which were qualitative. For one of the research questions a statistical test of significance was not possible, though participant responses were consistently favorable. Two of the three quantitative research questions had significant results, and the qualitative data showed that the participants had a high participation rate, with nearly all of them reporting being satisfied with all of the weekly activities from each of the five components. Nearly all of the quantitative indicator variables were significant or approaching significant levels in the expected direction.

The Hmong Helping Hands Intervention provided a strong and positive program both in terms of its implementation and participant outcomes. The program recruited a strong, capable, and hard-working, bilingual, bicultural staff with appropriate skills, especially in terms of speaking Hmong, familiarity with the Hmong culture, and respect for elderly clients. Together they were the best resources to brainstorm the topics to cover, speakers to invite, the activities to create to address cultural issues, and what instruments to use. Furthermore, the staff at the three locations were able to successfully work together to bring in speakers and to provide activities that participants found to be motivational and engaging. The staff also designed the logistics of travel, parking, scheduling, field trips, and other program activities to meet the cultural and linguistic needs of the participants and to enable them to continue in the program. Program leadership and staff are to be commended on the high degree of positive and successful implementation of the HHH Intervention. Although one cohort in Stockton dropped out due to staffing shortages, the constraints of the COVID-19 pandemic made this decision unavoidable.

Although the program participants had been in this country for some time, adapting to the new culture still may not have fully taken place. This strain was seen in their low acculturation and penetration rates in accessing Western services and resources. They had difficulties in finding and keeping employment, accessing health care, and negotiating familial hierarchies as the younger generation became more Westernized. It is also possible that choosing alternative instruments measuring these constructs may have made these issues clearer to the participants as they often found the current instruments and translations to be challenging to understand. In spite of these challenges, the HHH Intervention offered one of the most promising, compelling, helpful, and successful services available for the older Hmong population, as the participants liked what was being offered and those who were offering it,

wanted to come back, were recommending it to others, and, most importantly, experienced profound changes and improvements in themselves.

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