Report on the Development of a Suicide Prevention Resource for Korean People

October 2019

한국인들을 위한 자살 방지 도움자료

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Introduction

In September 2019, the Ministry of Health released the *Suicide Prevention Strategy 2019-2029* and the *Suicide Prevention Action Plan 2019-2024* which outline the framework and specific actions that will be undertaken to prevent suicide and support people affected by suicide in Aotearoa New Zealand. The Strategy recognises that "different approaches may be needed to respond to and support the needs of particular population groups" (Ministry of Health, 2019, p.v).

Three hundred Asian people in New Zealand died by suicide between July 2007 and June 2019; the rates of Asian suicide fluctuated between 2.82 and 8.69 deaths per 100,000 people during this period (Office of the Chief Coroner, 2019). Although Asian suicide rates are much lower than the suicide rates for the total New Zealand population (ranged from 11.73 to 13.93 between 2007 and 2019), suicide in any ethnic or population group is a significant issue to address:

One death by suicide is one death too many. Every life matters. (Ministry of Health, 2019, p.iv)

The Asian population is the fastest growing ethnic population in New Zealand over recent decades. Since 2001, Asians have surpassed Pacific people to become New Zealand's third largest ethnic group, after Europeans and Māori, and are set to surpass Māori by 2020 (Statistics New Zealand, 2017). The Asian population is highly diverse. It includes people not just of differing and multiple ethnicities, but also differing ages, immigration status, settlement histories, socio-economic status, English language proficiency, religious beliefs and acculturation (Ho, 2015). Understanding the shared and unique risk and protective factors for suicide of the diverse groups within the Asian population in New Zealand, is highly relevant to the development of prevention and intervention strategies to reduce suicide, and support individuals, families and communities affected by suicide.

In 2018, Asian Family Services and a group of Chinese mental health professionals (The Asian Suicide Prevention Advisory Group[1]) developed the Cantonese and Mandarin suicide prevention resources for Chinese people living in New Zealand. They were developed due to the lack of culturally appropriate suicide prevention resources available in New Zealand, the increasing number of suicides among Chinese people living in New Zealand alongside population growth, and concerns from Asian service providers, clinicians and researchers.

This year, with funding from Auckland and Waitemata District Health Boards, Suicide Prevention, Funding, Planning and Outcomes team, and the combined efforts of Asian Family Services, the Asian Suicide Prevention Advisory Group and a group of Korean mental health professionals, a suicide prevention resource for Korean people living in New Zealand has been developed.

The Korean ethnic group is the fourth largest Asian ethnicity in New Zealand, after Chinese, Indian and Filipino. As one of the fastest growing Asian ethnic groups in this country since the 1990s, the mental health concerns and suicide risk of this group have drawn attention from Asian service providers and communities in recent years (McKenzie-McLean & Van Beynen, 2010). Yet, to date, there is limited availability of culturally and linguistically appropriate resources to address the issues; hence this suicide prevention resource for Korean people has been developed to help fill this gap.

The next two sections provide an overview of suicide in South Korea and the complex factors contributing to the risk of suicide among Korean people living in New Zealand. Understanding the cultural context and migration-related risk factors for suicide is critical for the development of

[1] Members of the Asian Suicide Prevention Advisory Group in 2018 were: Dr Gary Cheung, Dr Elsie Ho, Patrick Au, Rebecca Zhang, Kelly Feng, Ingrid Wang, Kung Zhang and Ivan Yeo.

prevention resources for this group. The fourth section documents the process of developing the suicide prevention resource. The video reinforces the message that suicide is preventable and encourages people to ask for help when needed. The report concludes with insightful reflections from Korean clinicians who have contributed to this project.

Suicide in South Korea: An Overview

South Korea, officially named the Republic of Korea, is a country in East Asia. It occupies the southern portion of the Korean peninsula, and shares a land border with North Korea (the Democratic People's Republic of Korea). The population of South Korea is highly homogeneous; almost the entire population is ethnically Korean (Yu et al., 2019).

Suicide statistics

South Korea has one of the highest rates of suicide deaths among developed countries. While suicide rates across developed countries have fallen or stayed stagnant since the 1990s, they have rapidly increased in South Korea. In 1995, there were 12.7 deaths by suicide per 100,000 people in South Korea. That number more than doubled to 33.3 by 2010. In recent years, suicide rates in South Korea have started to decline. In 2019, the suicide rate was 26.9 per 100,000, which was still two times higher than the average suicide rates of other OECD countries (World Population Review, 2019).

Suicide rates for males are about 2.5 times higher than those for females. In 2019, the suicide rate was 38.4 per 100,000 for males and 15.4 for females (World Population Review, 2019).

Suicide by people over the age of 65 comprises nearly 30% of all suicide deaths in South Korea. Other than the elderly, young people aged between 10 and 39 years have higher suicide rates compared with other OECD countries (Premack, 2017).

One of the most common methods of suicide in South Korea is poisoning via carbon monoxide (Chen, Park, & Lu, 2009; World Population Review, 2019). Other prevalent methods are hanging and jumping off a height / bridge (Kim et al., 2011).

Socio-cultural and familial factors in suicide risk

Korean people's traditional beliefs stem from Buddhism and Confucianism; both place great value on the family as a unit. To achieve peaceful coexistence with the family and others, harmonious interpersonal relationships and interdependence are emphasised. Education is a way of glorifying the family's reputation. Consequently, parents have high expectations of their children's success; children who do not do well in school are seen as bringing shame to their families (Phosaly, Olympia & Goldman, 2019).

Due to the high level of parental expectations of their children's educational success and the competitive educational environment, students often experience an enormous amount of pressure to study in order to succeed academically. When they do not achieve the goals that their parents have set for them, they may feel that they have dishonoured their families, resulting in low self-esteem, anxiety and depression, which are factors associated with suicide risk. Sleep deprivation, poor social relationships and substance use (tobacco, alcohol and inhalants) can also put students at increased risk of suicide (Chung & Joung, 2012; Singh, 2017).

Exposure to childhood adversity increases the risk of later suicidal behaviour among young people. Elevated rates of suicidal behaviours are found among Korean young men when they experience maternal death from the age of either zero to four, or five to nine; women have increased risk of suicidal behaviour when they experience maternal death from the ages between five and nine (Jeon et al., 2013). Other than childhood parental death, adverse childhood experiences such as parental separation or divorce, parental psychopathology, parental violent behaviour, sexual, physical and emotional abuse or neglect, are also risk factors for later suicidal behaviour (Brown et al., 1999; Gould et al., 2003).

Suicide among the elderly in South Korea, which has been increasing since the late 1990s, is associated with poverty and the breakdown of the traditional family structure. Traditionally, children have been expected to care for their ageing parents. However, this customary practice of family-based parent care has been changing (Sung, 2000); many retired elderly with no source of income have found that they have no one to rely on. Loneliness, physical illness, and loss of social and financial support in the elderly are associated with a subjective decrease in well-being and self-esteem, and these psychosocial stressors are linked to increased risks of suicide (Kim, 2014).

High-profile suicides

One of the many examples of highly reported suicides in South Korea was the suicides associated with the Sewol ferry disaster. In April 2014, the Sewol ferry sank in South Korean waters taking the lives of over 300 people; most of whom were children on a school excursion. The disaster resulted in widespread social and political reaction within South Korea. Two days after the disaster, a high school principal who was rescued completed suicide; he had organised the trip for the students. The president of the ferry company was also found dead in a suspected suicide later in the same year (Revolvy, n.d.). While there are complex causes behind each case of suicide, the connection between suicide and honour has a historical basis in collectivist societies, including South Korea. People may consider suicide as a means to rebuild or reclean their image of shame or guilt, and in order to restore honour for themselves or for their families (Irvine, 2009).

High-profile suicides can make for sensational headlines for the media and are less than helpful in combating suicide rates. Sensationalising suicides from the media is common in Asia, especially among celebrities; often the local or national media publish in-depth details of suicide methods. A surge of suicides after the deaths of celebrities was common. In addition to the increased suicide rates, celebrity suicides may lead people who are already vulnerable to use the same methods to commit suicide. For example, following actress Lee Eun-ju's death in 2005, more people used the same method of hanging to commit suicide (Revolvy, n.d). The lack of media guidelines in South Korea could have contributed to the occurrences of copycat suicides in the country (Ju et al., 2014).

Stigma, shame and help-seeking

Although research findings suggest that a range of biological, psychological, spiritual, familial, social, economic and cultural factors make contributions to risks of suicide, by far the largest contribution comes from mental health problems (Beautrais et al., 2005). These findings imply that suicide prevention efforts should, among other goals, aim to improve the identification, treatment, management and prevention of mental health problems in the population.

In many Asian cultures including Korean, however, suicide and mental illnesses are highly stigmatising. In the traditional belief system, mental illnesses are caused by disruption of harmony within individuals, or by evil spirits coming back to haunt individuals because of wrongdoings committed in a past life. Many Korean people with mental health issues, therefore, are reluctant to seek treatment, because it is considered shameful, both to the individual and to the collective esteem of the family (Kramer et al., 2002). Some Koreans with depression and related mental health conditions may choose to seek medical treatment not for their mental health issues, but for physical symptoms such as fatigue, poor concentration, abdominal pain and headaches (Watkins, 2018). Some may turn to self-medication to solve their problems. Even among those who have sought psychiatric treatment, many are afraid of doctors keeping records. They are fearful of the potential for having a record of treatment or medication for depression which could mean losing custody of their children if their husband or wife were ever to sue for divorce (Kim, 2014; Singh, 2017).

Korean People in New Zealand: Suicide Risk Factors and Prevention

The first recorded Korean immigrants to New Zealand settled in the South Island, particularly in the Canterbury and Otago regions, from about mid-1960s (Chang, Morris & Vokes, 2006). The majority of these early settlers were employees of Korean shipping firms, and there were also a small number of agriculturalists who were mostly involved in fur farming. However, the total number of Koreans in New Zealand during that time was very small, compared to the predominant Asian ethnic groups, Chinese and Indian.

It was not until the economic and social reforms in the 1980s, and especially since 1991, that Koreans began to arrive in New Zealand in significant numbers (Lidgard, Bedford & Goodwin, 1998a). Between 1986 and 2006, the Asian community that recorded the fastest growth was the Koreans. In 1986, only 441 Koreans were recorded to be residing in the country. The numbers increased to 927 in 1991, 12,753 in 1996, 19,023 in 2001 and then to 30,792 by 2006.

However, during the second half of the 1990s, the rate of Korean immigration to New Zealand began to slow. This was largely due to the introduction of much stricter English language requirements for all new migrant applications in 1995, and the effects of the Asian financial crisis of 1997 (Chang, Morris & Vokes, 2006). In 2013, the Korean population in New Zealand was 30,171. Below are some unique characteristics of the Korean population as recorded in the 2013 Census:

- 47.2% were males, 52.8% females
- 89% were born overseas
- 72.8% lived in the Auckland Region
- The median age was 31.2 years
- 17.9% were aged under 15 years, 78.4% aged 15-64 years, 3.7% aged 65 years and over
- 24% aged 15 years and over did not speak English
- 93.2% aged 15 years and over had a formal qualification
- 55.5% aged 15 years and over were in the labour force
- For those in the labour force, 62.8% were employed full-time, 25.9% part-time, 11.3% unemployed
- For those aged 15 years and over, the median income was $11,500.

In the 2018 Census, the Korean population increased to 35,664. The Korean ethnic group remained the fourth largest Asian ethnic subgroup, after Chinese, Indian and Filipino.

The experiences and challenges of living in New Zealand

The 2013 Census statistics provide some insights into the challenges faced by Koreans living in New Zealand. One of the biggest challenges is that of English proficiency. As many as one in four Koreans aged 15 years and over did not speak English. The proportions of Korean women who do not speak English are higher than men, and increase with age. For example, only 9.3% of Koreans aged 15-24 years (Male 9%, Female 9.6%) did not speak English in 2013; the proportions increased to 20% of those aged 25-44 years (Male 16.5%, Female 22.4%), and then to 35.9% of those aged 45-64 years (Male 33.4%, Female 38%). Among Korean elderly aged 65 years and over, a majority did not speak English (Male 52.3%, Female 71.2%, Total 61.4%).

In addition, the Korean ethnic group had one of the highest rates of unemployment and one of the lowest levels of personal median income in New Zealand. In 2013, the unemployment rate of Koreans aged 15 years and over was 11.3% (Male 10.8%, Female 11.9%), compared to 7.1% in the total New Zealand population. The median personal income of Koreans aged 15 years and over was just $11,500;

much lower than the median income of New Zealand Europeans ($30,600), Māori ($22,500) and Chinese ($16,000).

Studies have found that the migration of Korean families to New Zealand has been motivated by a desire to escape the stress of life in the homeland in terms of the education system, work regimes and gendered family roles, along with the promise of a more relaxed life in a Western country and the possibility of a better future for their children (Chang, Morris & Vokes, 2006; Lidgard et al., 1998b). However, immigration can be a stressful process for families, and not all dreams can be fully realised. Although many Korean migrants were from a middle-class background with high educational qualifications and considerable professional work experience, they had not found it easy to find jobs that matched their qualifications and skills. Many were forced to take up relatively unskilled work such as taxi driving or factory work, or worked for small-scale businesses (e.g., grocers, restaurants) which existed largely to serve the Korean community (Chang, Morris & Vokes, 2006). A language barrier was part of the reasons for the high rates of unemployment found in this group; many Korean migrants also reported experiences of discrimination when entering the labour market (Lidgard et al., 1998b).

Because of the great difficulties encountered by Korean migrants in finding a job in New Zealand, some families chose to live in separate households where the husband stayed in the homeland to work while the mother and children lived overseas. The Korean media call these families "wild geese families" — this phenomenon is also known as "astronaut" families and is not confined to Korean families in New Zealand; Australia, Canada and the United States also have astronaut families from many Asian countries (Pe-Pua et al., 1996; Skeldon, 1994). However, this living arrangement adopted by some families can place a great strain on family relationships and add the burden of family separation to the already significant challenge of settlement (Lidgard et al., 1998b; Waters, 2002). The "wild geese fathers" can also become lonely and depressed; some also have alcohol problems and inadequate nutrition (Tan, 2010).

Another major challenge facing new Korean migrants is culture change. In particular, individuals who migrate from predominantly collectivist societies to individualistic societies may face high levels of acculturation stress and serious adaptation problems (Ratkowska & De Leo, 2013). Because of cultural differences and a language barrier, many Korean migrants feel lonely in their new home. School adjustment poses additional challenges to migrant students, who often feel an enormous demand to excel academically (Cho & Haslam, 2010). Within migrant families, not all members take the same adaptive course; differential rates of acculturation between family members can result in intergenerational tensions or conflicting gender roles within a family (Jeon, 2011).

The attitudes of the host country can influence the outcomes of immigrant adaptation. In the case of Korean migrants in New Zealand, research has suggested that while most enjoy and appreciate the more relaxed life in New Zealand and the opportunities provided (especially a better future for their children), many have experienced exclusion and rejection by mainstream society, and conveyed a general sense of frustration concerning the difficulties of 'fitting into' New Zealand society (Chang, Morris & Vokes, 2006).

The challenges confronting Korean migrant families in New Zealand discussed above are very similar to those experienced by other groups of Asian migrants living in this country. However, the recency of their arrival in New Zealand, the small size of the ethnic group, a language barrier, stigma around mental illness, and the limited availability of appropriate social and other support services, have meant that some families within this community are more at risk of social isolation, mental and emotional distress, and other threats to health and family wellbeing, such as suicide.

Risk and protective factors for suicide

Any suicide can have tremendous impacts on family, friends and the community, especially in a close knit community. The sudden, multiple deaths in a Korean family in Christchurch in 2010 was widely publicised and has left a community shocked and upset.

A mother and her two daughters aged 13 and 17, first came to Christchurch several years ago while the father worked in South Korea to support the family.

The 17-year-old daughter posted on Korean social media, messages which conveyed her feelings of anguish and loneliness, just hours before she died along with her younger sister and mother. Their bodies were found by an immigration officer who visited the house after the family failed to turn up for an interview about immigration matters. The grief-stricken father arrived in Christchurch two days later. He too took his life before his family's funeral (McKenzie -McLean & Beynen, 2010).

The context of multiple deaths by suicide in a family are complex. However, the incident exemplifies that many issues such as family separation, mental distress, loneliness, immigration issues, financial stress and academic pressure, if left unresolved, could culminate in a tragedy.

Ho, Au & Amerasinghe (2015) and other literature (Forte et al., 2018; Ho et al., 2002) provided an overview of risk and protective factors relevant to our understanding of suicide in the Asian communities in New Zealand; these factors play a critical role in the prevention of suicide for both individuals and communities.

Risk factors

- Depression or other forms of mental health conditions
- History of substance or alcohol abuse or misuse
- Previous suicide attempt(s); family history of suicide
- Disruption of traditional family roles, family separation, loss of status and social network, discrimination and feelings of exclusion following migration
- Acute life events, such as job or financial losses, family conflict, relational losses
- Adverse childhood experiences, such as parental separation or divorce, parental psychopathology, a history of sexual, physical and emotional abuse or neglect
- Socioeconomic factors, such as poor socio-economic status, social exclusion and deprivation
- Social isolation and hopelessness
- Barriers to help-seeking due to stigma attached to suicide and mental illnesses, and a lack of linguistically and culturally appropriate services.

Protective factors

- Confiding, supportive relationships
- Strong support within the family, and from friends and the community; social connectedness
- Strong religious and/or spiritual values
- Good physical and mental health
- Effective problem-solving skills, good self-esteem, positive cultural identity and an ability to seek help when needed.

Prevention

Although the overall suicide rates for Asians appear low in New Zealand, it is important to address the risk factors for suicide within Asian families and communities because suicide may be the final outcome of a variety of acculturation stresses that have been overlooked. In regard to the Korean community, education to reduce stigma around mental illness and suicide, and actions to promote

early help-seeking are of fundamental importance for the advancement of suicide prevention to reduce risk factors. Further actions that can be undertaken across the suicide prevention continuum to increase protective factors and reduce risk factors are discussed in Ho, Au & Amerasinghe (2015).

The next section documents the development of a video resource to create awareness of suicide and mental health issues within the Korean community.

The Development of Suicide Prevention Resources for Korean People

Purpose

- To produce culturally and linguistically appropriate resources to address suicide for the Korean community.

Goals

- To improve mental health literacy in the Korean community and to expose the community to suicide prevention information
- To educate Korean people about suicide and its prevention using online videos that are culturally and linguistically appropriate, with a longer-term plan to follow up.

Suicide Prevention Advisory Group and meeting summary

The Advisory Group was formed in 2018 with support from Asian Family Services, to provide leadership and direction in co-creating suicide prevention resources for Asian communities to reduce stigma around suicide and encourage help-seeking behaviour.

The Advisory Group is made up of health and academic professionals who are appointed based on their clinical and academic skills and experience in working with Asian communities, and knowledge of medical and mental health sectors. In 2019, the Advisory Group members are:

- Dr Gary Cheung – Senior Lecturer in Psychiatry, The University of Auckland
- Dr Elsie Ho – Honorary Academic, School of Population Health, The University of Auckland
- Patrick Au – Asian Mental Health Services, Central Auckland
- Rebecca Zhang – Project Lead, Te Pou
- Kelly Feng – National Director, Asian Family Services
- Ivan Yeo – Deputy Director and Public Health Lead, Asian Family Services.

The Advisory Group met eight times from January to September 2019.

After developing the Chinese Suicide Prevention Resources in 2018, Asian Family Services received funding from Auckland District Health Board, Suicide Prevention, Funding, Planning and Outcomes Team in 2019 to further develop resources that are culturally and linguistically responsive to the needs of Asian communities.

The Advisory Group decided to produce a suicide prevention YouTube video in Korean, due to the lack of accessible culturally and linguistically appropriate resources for the Korean community. The video aims to create, in the Korean community, public awareness of suicide as preventable and promote help-seeking.

The following Korean clinicians were invited to contribute to the project:

- Dr Aram Kim, Psychiatrist
- Dr Chohye Park, Psychiatrist
- Dr Hyunok Jeon, Clinical Psychologist
- Imsoo Kim, Social Worker and Counsellor
- Hyunsook Rhee, Counsellor.

The contributing clinicians were asked to give their views on:

- How suicide is viewed in Korean culture
- Why Korean immigrants are vulnerable to mental distress and suicide

- Specific cultural factors that may increase suicide risk
- Warning signs of suicide, especially those which are culturally specific to Koreans
- Suicide is preventable, how and where to get help and support.

The Korean language is used in the video as the intended viewers are Koreans. Sunjin Heo translated the video subtitles from Korean to English.

The video production was outsourced to an external supplier, Joonseob Yi, from *NZ Tribune.*

Dr Hagyun Kim, Lecturer at the School of Social Work at Massey University, reviewed the video and provided feedback on the value of the resource and the clarity and appropriateness of its messages.

The Korean Suicide Prevention Resource will be launched on October 10, 2019, at an event hosted by Asian Family Services.

Evaluation of the resource will be undertaken using Korea Post (a digital media) and the built-in YouTube functions that count the number of hits, duration of visits and number of shares.

Contributors

Dr Hyunok Jeon is a senior clinical psychologist, working in public secondary mental health services in various regions of Auckland since 2009. She also has her private practice. Dr Jeon grew up in Korea and immigrated to Aotearoa as an adult. She trained as a clinical psychologist in New Zealand. Her journey moving between cultures has linked into her particular interests in psychological resilience in the ever-changing contexts, not only for migrants but also people in general, transitioning through different life stages. Dr Jeon's clinical specialities include psychological interventions for adjustment and growth after trauma, psychological assessments for expert witness reports and for intellectual disabilities, and adult ASD. Dr Jeon uses the third wave Cognitive Behavioural Therapy (CBT) models including mindfulness and Acceptance and Commitment Therapy (ACT), and trauma-informed therapy models in her interventions.

Dr Aram Kim is an early career psychiatrist who completed his medical training at the University of Auckland after he emigrated from Korea with his family in the 1990s. He has a strong passion for advocating and raising mental health awareness in the community, as well as special interests and experience in cross-cultural psychiatry, perinatal and infant psychiatry, spirituality, and CBT. Dr Kim also enjoys teaching and is an honorary senior lecturer in the Department of Psychological Medicine at the University of Auckland.

Dr Chohye Park emigrated from South Korea to New Zealand in 1993. She has been working in both the public and private sectors in New Zealand as a child and adolescent psychiatrist, and has a clinic in Hamilton.

Im Soo Kim is a counsellor and public health promoter at Asian Family Services in Auckland. He immigrated to New Zealand from Korea with his wife and two sons in 2001. Im Soo completed a Master of Social Work at Massey University and Graduate Diploma in Psychotherapy at Auckland University of Technology (AUT). He is a strong champion for vulnerable people from various kinds of trauma and psychological distress. Im Soo has been working to remove barriers for CALD (Culturally and Linguistically Diverse) families to access counselling services or psychological support when they are needed. Im Soo now serves as a chairperson at St Peters Trust which supports Korean disabled children and their families in the community.

Hyunsook Rhee is a counsellor and public health promoter at Asian Family Services in Auckland. She is an experienced and certified counsellor, registered with the New Zealand Association of Counsellors (NZAC) as a full member. Hyunsook graduated with a Master of Counselling from the University of Auckland. She has had extensive experience in working with Korean teenagers, young adults, couples and families; currently, with gambling-related and mental health clients.

Sunjin Heo is an experienced and qualified registered counsellor. She graduated with a Master of Counselling from the University of Waikato. Sunjin is a committee member of the New Zealand Association of Counsellors (NZAC), Waikato Branch. She works as a counsellor and coordinator at Diversity Counselling New Zealand.

Joonseob Yi is the director and videographer for the Korean Suicide Prevention Resource. He is currently an overseas correspondent for the Korean news channel, YTN and KBS of New Zealand, and he is also a documentary filmmaker. Joonseob's two short documentaries, *Luthier* and *Our First Immigrants*, were selected in the Official Selection and Screening for a variety of international and local film festivals, including the 2018 DOC Edge International Film Festival and 2019 Wellington Korean Film Festival. He worked as the Deputy Chief Reporter and National News Editor for *Segye Time*, a newspaper in Seoul, before coming to New Zealand. YouTube Channel https://www.youtube.com/channel/UCHOPTM_AF9qlCSW7ZjGR37g

How can we do Better? Reflections from Korean Clinicians

Dr Aram Kim

From the start of the large influx of Korean immigrants in the 1990s, there has been a steady increase in the Korean population in New Zealand until around the mid-2000s. Since then, it has been sitting just above 30,000 according to Census data since 2006. Around two-thirds of Koreans in New Zealand live in the Auckland area. Even at this relatively small number, constituting less than 1% of the total New Zealand population, Korean-New Zealanders are not a homogeneous group. There is variation in terms of length of stay, level of acculturation and state of health within this group. Unfortunately, we still do not have any meaningful quantitative studies looking into the mental health issues of this particular ethnic group in New Zealand. However, recent studies looking at the Asian population in New Zealand, give clear indications of problematic under-detection, diagnosis, treatment, utilisation of services, and late presentations to mental health services. Also, there is no reason to suspect that the Korean population in New Zealand would be an exception to these particular findings. In fact, I firmly believe that mental health and suicides are indeed major issues for Korean-New Zealanders based on anecdotal evidence I have gathered through my work and personal life.

As many people would be well aware, Korea has one of the highest rates of suicide in the world. Around 34 people die of suicide per day in Korea and more than twice that number attempt suicide every day. Moreover, the suicide rate for elderly in Korea is more than triple that of the OECD average, which is even more troubling. In New Zealand, between July 2017 and June 2018, suicide deaths among Asians reached a record high of 8.69 per 100,000, according to the annual provisional suicide statistics for deaths reported to the Coroner's office last year. Due to the relatively small number of incidents and population size, this may not indicate a real change in the rate of suicide among Asians in New Zealand, but it certainly raises a significant concern in the context of increases in Asians seeking mental health support and treatment.

As I am writing this brief reflection on Korean mental health and suicide in New Zealand, I am also grieving for the loss of yet another Korean-New Zealander to suicide this week. This certainly has not been the first, and unfortunately this will not be the last. However, I sincerely hope that we will never become desensitised to such tragic losses, and that we will be able to make a difference in reducing the number of suicides.

Some of the repeated themes I have found over the years whilst working with many Korean clients and families in the context of thoughts of suicide and suicide attempts, are isolation, sense of being a burden, shame, and fear. In particular, the last two issues often act as the main barriers to seeking help for both the clients and families. Linguistic and cultural barriers, strong stigma against mental illness, as well as a lack of information and familiarity with the local health system, further reinforce these barriers. All too often mental illness as well as suicide are still viewed as a sign of weakness rather than ill health. Sometimes people are even actively encouraged to keep silent about their mental health issues, thoughts of death, or suicide attempts, in the fear that this may result in further isolation, discrimination, loss of status, and/or bringing shame to oneself and family. Similarly, even families and friends find it difficult to talk to the person about mental health issues and/or suicide, and to seek help for their loved ones or for themselves in supporting their loved ones. Although every suicide is different, it is the same in that it comes as a shock to all those around him/her, and that it can profoundly impact on others. Likewise, all mental health issues can be experienced and will impact on people differently, but it can carry significant disability and suffering, which will only be amplified by isolation and lack of appropriate and timely support and treatment.

I was so pleased to hear about the effort being made to develop this Korean Suicide Prevention Resource. Suicide prevention needs to happen across sectors and across settings. It requires systemic and institutional changes that involve social services, health, education and beyond, as well as changes at personal levels for all of us. It is the community of us that can prevent suicides. I believe that this booklet will be a small but meaningful seed that will sow hope now, and reap a real change in times to come.

Dr Hyunok Jeon

We are well aware that the stigma regarding mental illness is a significant barrier for Koreans to seek the help they need. We also see family members suffering not only from the grief, but also from the shame that they did not prevent the illness from happening. The shame of mental health issues is reinforced culturally by being interpreted as an individual's failure to meet the responsibilities of the bigger unit (e.g., family), and also the failure of the whole family in raising the individual well. It is noted that Korean culture is a strongly collectivist culture. Although it has continued to evolve in the modern era, collectivism is still a powerful value driving many Korean families and its society. Im, Park & Ratcliff (2018) discussed it in detail, referring to the Confucianism values that are permeated in Koreans' minds for a long time. In addition, away from their original culture, migrants tend to hold onto their traditional values to compensate for their anxiety. They may impose them onto their children, often resulting in immigrants behaving in a "more original" way than their peers who have stayed in the country of origin.

If we imagine family members, or the individuals suffering from mental health issues, and the significant shame attached to having these issues, it is easy to understand how overwhelming this must be. Also imagine that you are in a small immigrant community in this relatively quiet and small country where no anonymity is guaranteed. It makes it extremely difficult to know where to start in terms of who to talk to, what to talk about, and how to understand why your feelings are so conflicted and painful. It is understandable that people choose not to talk, not to process these feelings, but just to survive from the overwhelming pain and confusion. I believe we need to speak openly about the issue of stigma, and how talking about mental health issues is considered taboo among the Asian population. This will help us to understand the function of these behaviours psychologically; that it is about survival and avoiding the distress. This needs to be understood, and sometimes it is beneficial strategically to just "go with it," until the individuals/communities feel more comfortable, rather than directly challenging the behaviours. Clinicians still need to oversee the situation, but not perpetuate existing issues, and to ensure the safety of the person/people. This is the difficult part of suicide prevention work, or engaging with individuals and families around risk management. The proper work takes time, and requires extensive support and training for clinicians and organisations working with the vulnerable Asian migrant population.

I would also like to reiterate that immigration is a hugely challenging process for individuals, potentially pushing them to their limits. The majority of Asian migrants, including Koreans, are still first-generation migrants who struggle with language, cultural differences, and grief from losing their previous social networks. I do not mean that the 1.5 or second-generation migrants have easier lives, as they too have cultural conflict and identity confusion sometimes even more so. I do wonder, as a first-generation (or 1.75 generation) migrant myself, how much we understand the psychological and social struggles we have, and the possible impact on our mental health. Perhaps then we could see how easy it is to avoid and minimise those impacts or inner struggles when we just have to get on with life and put on the mask of being "successful model migrants."

Many migrants carry (as local people do) their trauma from the past. Most of them face enormous immigration challenges yet many also demonstrate a strong ability to make their life work, raise their families and make use of the opportunities. Often when we lose things, it frees up space for new stuff

as well. Maybe it is time to slow down, put aside the task of survival for a minute, and take the courage to talk about the vulnerabilities as well as the learnings that we as immigrant individuals and collectives have accumulated. As I mentioned before, the culture is changing rapidly, but traditional values still hold us strongly. The flexibility to handle both is one of the strongest measures of resilience that people living across multiple cultures can cultivate. At the same time, it is a challenging task and it can make us feel very insecure, especially when we are anxious and depressed, away from family and friends, feeling different from others. That is the time we just need to ask for help.

Hyunsook Rhee

Recently, a growing need for a better understanding of mental health issues among immigrants and ethnic minorities has emerged worldwide, and recent research has demonstrated that immigrants may be at a higher risk of suicidal behaviour. Several authors have also suggested that suicide risk may vary among ethnic minorities, and they may have different and more specific risk factors for suicidal behaviour than the general population such as, acculturative stress, language barriers, worrying about family back home, and separation from family. In addition, lack of information on the healthcare system, loss of status, loss of social networks was identified as possible triggers for suicidal behaviour.

In my professional experience of working with Korean teenagers and adults in New Zealand, I've found that mental health issues do not harm them initially, so even though they may feel depressed, anxious, worried, fearful, and suicidal, if they receive immediate support from professionals and communities, it reduces risk. Mental health symptoms are often suffered for a long period of time, and if families themselves are the primary resource for helping family members with mental health problems, it affects the whole family. If one person is mentally ill, other family members can develop mental health issues such as depression due to the pressure and stress of dealing with the sickness. Those issues can cause financial burden, conflicts between family members, isolation from other people, and more destructive ways of thinking and feeling, which can lead them to suicide.

Another issue in the Korean community is that the migrant population is relatively small, and due to the cultural norms about mental health issues, they do not seek help, despite having severe mental health problems. Currently, in Korea, people try to break through the norms preventing them from receiving treatment, but in New Zealand, many migrant people retain the old ideas they had when they left Korea. They are isolated from the mainstream, therefore they have a fear of becoming diagnosed as a mental health patient. Even young people, who have been brought up in New Zealand, show the same attitudes towards mental health issues as their parents have. Furthermore, they mistakenly believe that mental health patients cannot have a proper job as their medical records will be revealed to potential employers, so many Korean parents avoid psychiatric treatment to protect their children's future career. In my experience of working at high schools, and research work undertaken with Korean teenagers about their stress factors, I have found they do not have any knowledge about how to seek help and support, and when they have an issue, they talk to their friends, not with adults or professionals.

As I addressed earlier, it would be difficult for Korean migrants and their children to seek professional help when they suffer from mental health issues, without firstly helping them understand the New Zealand mental health system and how it works in terms of confidentiality and privacy. Suicide prevention for the Korean community, therefore, would be to help break the cultural norms, enable them to be connected to linguistically appropriate mental health organisations, and to provide information about mental health and suicide prevention, along with practical approaches.

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Appendix – Helplines

Helplines from Mental Health Foundation https://www.mentalhealth.org.nz/get-help/in-crisis/helplines/

After a suicide, information for families, whanau and friends https://www.afterasuicide.nz/

Victim Support http://www.victimsupport.org.nz/

Suicide Prevention from Health Navigator https://www.healthnavigator.org.nz/health-a-z/s/suicide-prevention/#Overview

Below is a list of some of the services available in New Zealand that offer support, information and help. All services are available 24 hours a day, seven days a week unless otherwise specified.

National helplines

- Need to talk? Free call or text **1737** any time for support from a trained counsellor
- **Lifeline** – 0800 543 354 (0800 LIFELINE) or free text 4357 (HELP)
- **Suicide Crisis Helpline** – 0508 828 865 (0508 TAUTOKO)
- **Healthline** – 0800 611 116
- **Samaritans** – 0800 726 666

Depression-specific helplines

- **Depression Helpline** – 0800 111 757 or free text 4202 (to talk to a trained counsellor about how you are feeling or to ask any questions)
- **www.depression.org.nz** – includes The Journal online help service
- **SPARX.org.nz** – online e-therapy tool provided by the University of Auckland that helps young people learn skills to deal with feeling down, depressed or stressed

Sexuality or gender identity helpline

- **OUTLine NZ** – 0800 688 5463 (OUTLINE) provides confidential telephone support

Helplines for children and young people

- **Youthline** – 0800 376 633, free text 234 or email talk@youthline.co.nz or online chat
- **thelowdown.co.nz** – or email team@thelowdown.co.nz or free text 5626
- **What's Up?** – 0800 942 8787 (for 5– 18-year-olds). Phone counselling is available Monday to Friday, midday–11pm and weekends, 3pm–11pm. Online chat is available from 5pm–11pm, 7 days a week, including all public holidays.
- **Kidsline** – 0800 54 37 54 (0800 kids line) for young people up to 18 years of age. Open 24/7.

Help for parents, family and friends

- **Commonground** – a website hub providing parents, family, whānau and friends with access to information, tools and support to help a young person who is struggling.
- **Parent Help** – 0800 568 856 for parents/whānau seeking support, advice and practical strategies on all parenting concerns. Anonymous, non-judgmental and confidential.
- **Family Services 211 Helpline** – 0800 211 211 for help finding (and direct transfer to) community-based health and social support services in your area.
- **Skylight** – 0800 299 100 for support through trauma, loss and grief; 9am–5pm weekdays.
- **Supporting Families In Mental Illness** – For families and whānau supporting a loved one who has a mental illness. Auckland 0800 732 825. Find other regions' contact details here.

Other specialist helplines

- **Alcohol and Drug Helpline** – 0800 787 797 or online chat
- **Are You OK?** – 0800 456 450 family violence helpline
- **Gambling Helpline** – 0800 654 655
- **Anxiety phone line** – 0800 269 4389 (0800 ANXIETY)
- **Seniorline** – 0800 725 463 A free information service for older people
- **0508MUSICHELP** – The Wellbeing Service is a 24/7 online, on the phone and in-person counselling service fully funded by the NZ Music Foundation and provided free of charge to those in the Kiwi music community who cannot access the help they need due to hardship and other circumstances. Call 0508 MUSICHELP.
- **Shine** – 0508 744 633 confidential domestic abuse helpline
- **Quitline** – 0800 778 778 smoking cessation help
- **Vagus Line** – 0800 56 76 666 (Mon, Wed, Fri noon–2pm). Promote family harmony among Chinese, enhance parenting skills, decrease conflict among family members (couple, parent-child, in-laws) and stop family violence
- **Women's Refuge Crisisline** – 0800 733 843 (0800 REFUGE) (for women living with violence, or in fear, in their relationship or family)
- **Shakti Crisis Line** – 0800 742 584 (for migrant or refugee women living with family violence)
- **Rape Crisis** – 0800 883 300 (for support after rape or sexual assault)

Warmlines for consumers of mental health services

Free peer support services for people experiencing mental illness or those supporting them:

- **Canterbury and West Coast** – 03 379 8415 / 0800 899 276 (1pm to midnight, seven nights)
- **Wellington** 0800 200 207 (7pm–1am, Tuesday to Sunday)
- **Auckland Central** 0508 927 654 or 0508 WARMLINE (8pm to midnight, seven nights)

See also: **Apps, e-therapy & guided self-help**

Asian Family Services

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Need help? Call us 0800 862342 It's professional and confidential