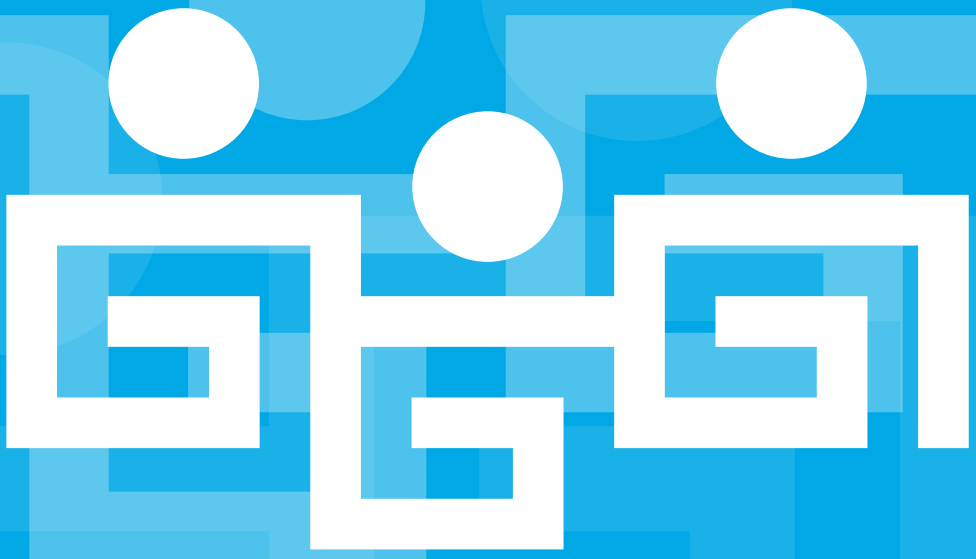
KOREAN NEEDS ASSESSMENT OF THE BAY AREA 2014-2015

POLICY BRIEF

REDUCING MENTAL HEALTH DISPARITY BY INCREASED EFFICACY IN CULTURALLY RELEVANT COMMUNITY ENGAGEMENT



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REDUCING MENTAL HEALTH DISPARITY BY INCREASED EFFICACY IN CULTURALLY RELEVANT COMMUNITY ENGAGEMENT

Significance

According to NIMH (National Institute of Mental Health, 2010), approximately 57.7 million (or 26.2%) of American adults suffer from a diagnosable mental disorder in a given year. The number is increasingly alarming, as WHO has reported mental health problems are a leading cause of disability and a major burden of disease in the workforce. In the United States, 200 million days are estimated to be lost from work each year due to depression—a loss of approximately 30-40 billion US dollars (WHO, 2000).

Despite how common mental illness is among US adults, recent studies indicate that certain subgroups of the population have higher risks of mental health disorders and receive fewer mental health services. According to the California Health Interview Survey (CHIS, 2001, 2003, 2005, 2007), Korean adults reported the highest rates (5%) of serious psychological distress among Asian adults in the survey, with Korean seniors (at 9%) reporting 4.5 times the rate of serious psychological distress (SPD) compared with the overall California state average (2%).

Serious psychological distress, as measured with brief scales such as the K10/K6 scales, is strongly associated with mental illness such as major depressive disorder (Kessler et al., 2003). As with the elevated reports of serious psychological distress among Korean-Americans, the rates of major depression may also be elevated, based on preliminary studies of local Korean-American samples. Individual studies have shown depression rates ranging from 39% in Los Angeles to 24% in New York (Lee, Moon, & Knight, 2004; Mui & Kang, 2006). In a study by Hastings, Jose et al., which used United States death data from 36 states and DC from 2003-2011, Korean men had high rates of suicide (15.9 per 100,000) compared to all other Asian groups and Non-Hispanic Whites.

Despite these serious rates of mental health problems, California's Korean American population had significantly lower rates of seeking help for self-reported SPD (30%), compared to African Americans (47%), Hispanics (50%) and the overall California population (57%). Furthermore, only 6% of the Korean population saw a healthcare provider for mental health issues, two times less frequent than in the overall California population (12%), African American population (14%), and white population (14%).

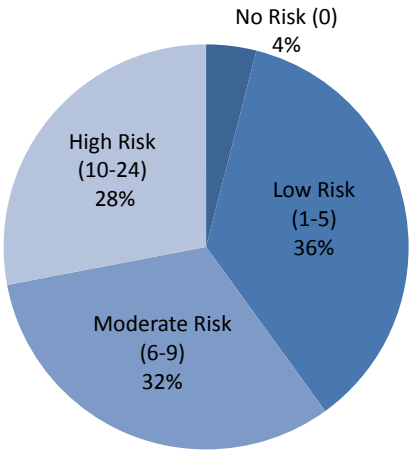
Discussions

As a proactive response to the lack of data on mental health needs of Bay Area Koreans, the Korean Community Center of the East Bay (KCCEB) and Health Research for Action (HRA) center at UC Berkeley partnered to assess the current mental health needs of the Korean population in the San Francisco Bay Area in order to determine what kinds of intervention strategies or programs might help improve the overall health of Korean Americans. 111 Koreans participarted between March and September 2015. The majority of the sample reported speaking Korean at home (97%) and said that they had limited English proficiency (90%). Almost two-thirds (62%) of the Bay Area sample were US citizens while 34%

were green card holders. Sixty nine percent had household income lower than $50,000 per year, including 35% with household income equal to or less than $20,000 per year. Over one-sixth (17%) of the Korean sample did not have health insurance coverage. In this sample, the participants had low self-rated health status, as 45% of the population rated their health as poor or fair. Seven percent of the participants reported being food insecure and 12% reported inability to afford balanced meals in their daily lives. Moreover, 65% reported having exposure to secondhand smoking in their daily lives. We adjusted demographics of other data referenced and compared to our survey results to existing CHIS data in this study.

Bay Area Koreans have unusually high Serious Psychological Distress (SPD) and rates of Functional Impairment Related to SPD. Our study shows significantly high levels of SPD, and functional impairment among Bay Area Koreans. Thirteen percent of the survey participants reported SPD, and 28% were at high risk of developing SPD. Forty-five percent of the participants reported that emotional distress has severely or moderately interfered with performance at work, 50% reported such interference in relationships with family and friends, 48% with social life, and 42% with household chores over the past 12 months.

Figure 10. High levels of Psychological Distress



Factors related to immigration and minority status may contribute to higher SPD and Functional Impairment. An insight into such high prevalence rates can be found in a widely held perspective in the sociology of minority mental health, the ***stress process paradigm*** (Moritsugu & Sue, 1983; Vega & Rumbaut, 1991). Immigrants experience unusually high stress caused by uprooting processes such as adjustment to a new language, sense of isolation and marginality, homesickness, social discrimination, financial hardships, etc. ***(Social Stressor)***. They also experience erosion of self-esteem and sense of mastery due to changes in role identity and structure in the family and society, leading to defense mechanisms that are not typically functional or socially acceptable in their new setting ***(Psychological Resources)***.

In spite of high SPD and functional impairment, Koreans do not seek help for mental health issues due to values maintained by traditional cultural norms. In spite of the high rates of SPD and functional impairment, the awareness for the need to seek help and the utilization of services are extremely low. Only 9% of the respondents with functional impairment related to SPD reported they might need to see a healthcare professioonal. Among those who felt that they needed help, only 10% actually sought help from other sources and only 1 respondent sought help from a healthcare professional - regardless of the self-reported need to see a professional for their mental health problems. A good framework for such lack of recognition can be found in ***cognitive barriers*** as defined by Rogler, Malgady, and Rodriguez (Rogler, Malgady & Rodriguez, 1989). ***Koreans consider behaviors as signs of mental illness only if they are upsetting to the social group.*** Such signs include psychotic, dangerous or disruptive behaviors (Moon & Tashima, 1982), but do not entail typical personal problems or general emotional distress (Tracey, Leong, & Glidden,

1985). Pang's study on ***Hwabyung*** provides an interesting example of the tendency to somatize psychological symptoms among Koreans (Pang, 1990). Because of Korean culture's esteem of restraint, suppression of verbal aggression, and avoidance of confrontation, Hwabyung is a uniquely Korean culture-bound syndrome in which suppressed emotions reflecting anger, disappointment, sadness, misery, hostility, grudges, and unfulfilled dreams of expectations manifest themselves physically. Symptoms include chronic indigestion, poor appetite, constipation, heart palpitations, pains in knees or legs, cold hands or feet, vomiting blood, altered sensory perception, nightmares, decreased urine output, and hypothyroidism. While Korean culture imposes "inappropriateness" or stigmas on expressing psychological symptoms in Western clinical terms such as mental illness or psychological distress, Hwabyung allows Koreans to approach their mental health issues through a model congruent to their own cultural context that links emotional and bodily distresses.

Cost, Stigma, Lack of Awareness and Trust about available Resources, and different values associated with Western psychotherapy and psychiatric treatment are barriers to service utilization. Reasons for not seeking help among people who recognize emotional and functional impairment issues and are willing to seek help include: 1) concerns about the cost of the treatment (47%), 2) stigma such as public knowledge of their problems (34%), and 3) feeling uncomfortable talking with a professional about these problems (30%). Furthermore, a sizable percent of those who did not seek care said that they had difficulty scheduling appointments with mental health care providers (25%).

For those who do seek help, mental health treatments need to be culturally responsive. Even when they seek services, premature termination occurs at a much higher rate than in non-minority clients, which is an outcome with varied (and sometimes obscure) determinants. For instance, the cultural orientation (and potential bias) of the therapist may affect their clinical judgment, leading to misunderstanding and/or mismanagement of the patient; this could include the inappropriate use of diagnostic and personality tests, misattribution of symptom expression, constraints on communication due to mismatched language capacities, and the natural variability in expression of psychological disorders, due to complex, interacting cultural and environmental contextual factors, which can vary over time. Traditionally, Koreans seek help for Hwabyung (somatic cultural-bound expression of mental health symptoms) from oriental medicine as it links emotional and bodily distresses in a model congruent to their cultural context. Collective values that are traditionally held by Asian Americans (Triandis, 1988), oppose the values associated with Western psychotherapy (Leong, Wagner, & Tata, 1995). Many studies supported the effectiveness of ethnic-specific mental health services (ESS) however, most studies used proxy

MH CHIS Comparison Table

Mental Health Care: Needed help for emotional/mental health problems or use of alcohol/drug				
Overall (YES), %	9.0	12.0	9.0	16.0
Mental Health Care: Sought help for self-reported mental/emotional and/or alcohol-drug issue(s)				
Overall (YES), %	10.0	30 [3]	43.0	57.0
Mental Health Care: Saw healthcare provider for emotional / mental and/or alcohol-drug issues in past year				
Overall (YES), %	8.0	6.0	5.0	12.0

CHIS 2011 – 2012; age 21-85

variables of cultural match (language, ethnicity, etc.), without employing more direct tests of the culturally appropriateness of services to illuminate what elements of the services lead to enhanced outcomes when can then be implemented outside of ESS facilities.

- *Unusually High Serious Psychological Distress(SPD)*
- *High rates of Major Depression and Suicide*
- *Lack of Awareness and Recognition on SPD*
- *Cultural Barriers in Western Mental Healthcare Models*
- *Underutilization of Mental Health Services*

Culturally Effective Engagement to improve Service Utilization is equally important as Culturally Responsive Services. We conducted a thorough literature review and examined current behavioral health care models for Asian American Native Hawaiian Pacific Islander (AANHPI) population prior to conducting this research. We were struck by the lack of population-specific data, culturally relevant mental health services, and culturally inappropriate and sporadic community engagement, such as efforts to find Koreans in a Chinatown library. In the process, the Korean community is not offered care that they deserve, with no evidence of what constitutes adequate care, and spotty, uncoordinated and fragmented services provided in the 5 Bay Area counties. Our study demonstrated the need for an approach that holistically looks at the impact of diverse factors including immigration-related social stressors, empowerment to strengthen psychological resources to overcome socioeconomic and role changes, building social support in the community, understanding barriers coming from cultural differences as well as impact of employment, housing, education, poverty, neighborhood safety, and other social determinants of health. In addition, culturally competent care should start from the target population's behavioral patterns and be delivered in a less stigmatizing environment that requires creating innovative coordination between existing and new resources. Our survey tells us that Bay Area Koreans often get healthcare from someone other than a physician: acupuncture (30%), oriental medicine doctor (23%), massage therapy (15%), chiropractic (14%), physical therapy (12%), herbal medicine (7%), and mental health counseling (4%). Our survey also shows that more than half of Koreans form networks through Korean faith institutions, and gain health information through the internet (51%), friends and relatives (29%), primary care physician's offices (27%), ethnic newspapers (26%), and television (22%).

Recommendations

Increase Mental Health Service Utilization and decrease Stigma by:

- Diversifying access points or "front doors" beyond community behavioral health clinics. "Front doors" should be patient/consumer defined, friendly and non-stigmatizing; Consider integrating a holistic approach to care based on cultural definitions of health and pathology – including traditional healing practices that do not separate the mind, body and spirit;
- Increasing efficacy of Prevention and Early Intervention (PEI) funding by 1) employing culturally relevant innovative strategies that engage in attitude change via participatory process and experiential learning;
  2) diversifying investment to community-based organizations and other relevant entities beyond traditional mental health service providers; Hiring in-language staff and conducting traditional outreach is current approach by most service providers, that is a simple solution to a complex problem

and insufficient strategy; Diversification and investment is likely to include:

  - Community Based Organizations that have track record for successful community engagement with wide reach for different sectors, and in changing behaviors and attitude
  - Faith-based organizations
  - Community Health Workers: support building of a community health workers (CHW) network beyond clinical setting, based on the empowerment model to improve service utilization. CHW is fundamentally different from support staff that provides assistance to healthcare professional in clinical setting. They are most effective in facilitating self-directed change leading to community capacity development and empowering Korean to successfully take ownership in recognizing issues and developing willingness to seek care non-threatening way.

- Providing systems for collaboration between traditional mental health service providers and innovative engagement agencies; no innovation and real collaboration happens when service providers are in comfort zone to continue their old practices with sustained funding;
- Modifying eligibility requirements to include cultural manifestations of symptoms to meet medical necessity;
- Considering high internet usage by Koreans including low income and some elderly, consider utilization of technology for dissemination of mental health information among Koreans; consider piloting tele-health models for behavioral health care to address the lack of Korean-speaking mental health professionals and privacy related to stigma; such technology enables culturally and linguistically competent clinicians the ability to extend their reach into isolated communities; Use mobile health technologies such as text messaging or apps to support those with mental health needs.

Increase efficacy of funding decision by:

- Reducing disparities by collecting disaggregated data to accurately capture the mental health and service needs of various AANHPI communities including Korean community, by supporting culturally appropriate outcome measurements, and by providing continuous resources to validate culturally appropriate programs.

Limitations

The sample population in the Bay Area included only adults ages 21-85, therefore, the challenges that youth face were not captured in this study. Intergenerational aspects, relationships between first generation immigrants and second generation, and challenges for second generation Korean Americans growing up with high expectations and little support from parents, all warrant further study.

References

All references cited in the text are available in the on-line. [http://kcceb.org/konabayarea/]

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