HEALTH CARE EQUITY FOR ETHNIC MINORITY OLDER ADULTS

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Notes on Terminology

Caregiver: This term has been used consistently throughout the book to denote family members and friends who provide care to older persons on a voluntary basis, usually in their home. They are most often spouses and adult offspring, although the term can be used to apply to anyone fulfilling this role. The term 'carer' is more commonly used in the U.K. literature.

Ethnic or ethnocultural minority older adults (EMOA): This term is applied to both immigrant older adults and some visible minorities who have aged here. Despite the diversity among them, they are united in their experience of health inequities in Canada. These are primarily related to difficulties with the complex process of accessing suitable services and supports.

Racialized older adults: This term is sometimes used rather than "visible minority" more commonly used by the Government of Canada because it acknowledges the problems arising from discrimination based on essentializing generalisations that reference phenotypic characteristics rather than an assessment of the whole person.

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Chapter One: Partnering to Promote Health Care Equity for Ethnic Minority Older Adults

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Introduction

Recent immigrant older adults and some visible minorities who have aged here—to whom we refer collectively as ethnic or ethnocultural minority older adults (**EMOA**)—both experience health inequities in Canada. These are primarily related to difficulties with the complex process of accessing suitable services and supports. However, Canadian research on the topic is extremely fragmented and hard to find, and knowledge users charged with designing policy and programs do not have the evidence they need to help them to address access barriers experienced by EMOA. This collection of literature reviews prepared by a team of multidisciplinary academics and multisectoral knowledge users begins the process of consolidating existing evidence. It serves three purposes: (1) in areas in which the body of evidence is sufficient, it provides guidance to policy makers and frontline providers who seek to improve access by EMOA to health services and/or health promotion programs and information; (2) in domains in which there is a paucity of relevant research, or lack of consensus within the research record, it identifies future directions; and (3) it introduces the reader to the value of the Candidacy Framework for understanding facilitators and barriers to access, particularly for underserved populations.

Ethnocultural minority older adults and determinants of health

In urban metropolises, such as Metropolitan Vancouver, over one half of persons aged 65+ are immigrants and one third are visible minorities.[47] Recent immigrant older adults, primarily from Asian countries, are more likely to experience multiple barriers to services and challenges to mental and physical wellness,[17,26,36,50] but many visible minorities who have aged in Canada are similarly disadvantaged by the effects of lifelong intersections of economic and social discrimination rooted in racialization.[4,15,17,35] The majority of research on EMOA has been conducted in the United States (U.S.) and its relevance to Canada—where the immigrant mix and health care context are distinct–is limited.[24] Of the 816 sources that met the eligibility criteria for our scoping review on the health and health care of EMOA, completed in 2010, more than 70% were published in 192 peer-reviewed journals representing diverse disciplines and research traditions.[24] Hence there is little coordination or recognition amongst studies. Decision-makers with limited time and resources therefore access only the most readily available reports.[1,13]

Especially significant for EMOA are the compounding effects of social determinants of health which have a bilateral relationship with health policy, service delivery, and clinical practice.[11,37,43,44,49] Today's immigrant older adults primarily reside in Canada's three largest census metropolitan areas (Toronto, Montreal and Vancouver), arrive from South Asia and East Asia rather than Western Europe (as did earlier arrivals to Canada), do not know any of Canada's official languages (69%), remain in the labour force longer than their Canadian counterparts, and are likely to be married or in a common-law relationship. Compared to

earlier immigrants, more will have attained a higher education.[12,37] Intersections of identity nonetheless generate considerable diversity among them even within a single ethnocultural group.[24]

The healthy immigrant effect has shown that the health of new immigrants is initially better than their age peers;[11] however, disadvantaged groups with low socioeconomic status, high un- and under-employment, and lack of social support networks, have significantly lower life expectancy, poorer health, and higher prevalence of disability than the average Canadian, with members of immigrant and ethno-racial groups falling disproportionately into these categories.[20,39] Gender differences have also been identified: the healthy immigrant effect applies primarily to midlife males, specifically those who immigrated less than ten years ago, whereas women are disadvantaged no matter the time since immigration.[22,38,54] The healthy immigrant effect does not hold true for sponsored (Family Class) older adults or refugees whose health is poorer than that of their Canadian-born age peers.[17] The recent immigrant status of older adults is positively associated with their level of depression, number of difficulties with instrumental activities of daily living and the type of health insurance they are able to access.[29] However, this last finding and the interaction of immigrant status with race and ethnicity, are more salient in the U.S. than Canada, pointing to the material and institutional causes of such disparity.[42]

Increasingly, research is identifying the complex interactions of socioeconomic status with other social determinants of health and health care access. For example, among ethnic and racial minority older adults in the U.S., 'race' and 'ethnicity' decreased access to care, and increased less intensive and lower quality care when controlling for socioeconomic status.[19] Engagement in occupations and activities can benefit social capital (particularly as manifested in informal social and attitudinal ties and organizational assets), and both are positively correlated with health and quality of life or satisfaction among immigrant older adults.[27,48] Social support (which can be conceptualized as a functional dimension of an individual's social capital) may buffer the negative effects of macro-structural forces to which older adults are subjected.[6]

Researchers have identified 'subjective social status' as the key means by which education and occupational class influence health in old age.[8] Among EMOA, particularly newer immigrant older adults, subjective social status is undermined by language barriers, transportation difficulties, lack of knowledge of local resources, and child-minding responsibilities. These factors are in turn compounded by immigration policies, such as those rendering older sponsored immigrants dependent on their children for 10-20 years.[14] Such policies limit their access to services,[39] and compromise their health and wellbeing.[4,19,20,22,27,29,35,42,48,54] These same factors result in poor access to and utilization of health and social services.[3,6,8,9,14,16,21,46] Inappropriate use of emergency services, delayed help-seeking, repetitious but unsatisfactory visits to family doctors and low referral rates attest to their inequitable and ineffective access and represent financial and health costs to healthcare systems and EMOA respectively.[4,15,25,31,32,34,40,55] Women in particular often lack decision-making power in the family and in relation to their own health[7] and are more susceptible to poor mental health[46] and various forms of domestic violence.[18,51]

The assumption found in policies and among health care practitioners that immigrants take care of their aging parents is not always viable in the post-migration context,[2,23,28,30,33,41,45,52,53] and shifts the onus of responsibility onto the person in need of care and his/her family, which can render both parties vulnerable to exploitation and abuse.[1,15,30] Thus while health care services are listed by the Public Health Agency of Canada as a social determinant of health, access to those services is influenced both by the configuration of the services themselves as well as other determinants such as social support networks, culture, gender, education

and literacy, socioeconomic status, personal health practices and coping skills, and physical location.

Review Methodology

Topics for inclusion in this inquiry were identified by the knowledge user members of our six teams (five dyads and one triad) of researchers who focus on the health and healthcare of EMOA and their knowledge user partners. The latter represent local, provincial or federal organizations with some degree of interest in EMOA. Three teams are located in British Columbia and one team is located in each of Alberta, Ontario and Newfoundland. Their interests in EMOA are broad, encompassing the influence of determinants of health on health status, health promotion interventions, strategies to address abuse, dementia care service improvement, mental health treatment interventions at the health care delivery and systems levels, and provision of services for very small groups and/or geographically isolated/rural EMOA.

A literature search was undertaken to identify relevant studies for review according to each topic of interest. This search was primarily conducted in a database developed during a scoping review on the health and health care access and utilization of ethnocultural minority older adults.[24] Studies included in the scoping review were peer-reviewed and published in English from 1980 to 2010. Search terms pertinent to each research question are listed in the Appendix. Additionally, the reference lists and citing articles

Candidacy Framework

The Candidacy framework for understanding access to care speaks to the patient/client's dynamic and continually negotiated sense of legitimacy in using healthcare,[21] which is "subject to multiple influences arising both from people and their social contexts and from macro-level influences on allocation of resources and configuration of services."[9] Establishing access entails identification of the need for care, finding your way to it, presenting a credible claim for care to service providers who will judge its credibility, and accepting or rejecting offers made. The 'openness' and compatibility of the system and local operating conditions also play a role. The seven dimensions of Candidacy shed light on the roots of inequities in health and health care, by tying seemingly individual behaviors in utilization to socially patterned influences."[21] Increasingly, it is recognized as a valuable framework for understanding the complex process of attaining care by underserved populations across diverse health care domains[3,16,21,25,40] as well as public services.[32] Here we expand its application to include health promotion and disease and abuse prevention initiatives that are found outside of the realm of statutory services.

for the selected publications were inspected for relevance. Post-2010 publications as well as reports and documents from the grey literature recommended by experts in the field of EMOA and health (academics and knowledge users) were also included. Emphasis was placed on ethnic minority populations in Canada; however examples from the U.K. (which has a comparable health care system), U.S., Australia, and New Zealand were also selected.

The research assistants hired by each team reviewed between 25 and 53 articles.[†] Findings from the articles were highlighted relative to the seven dimensions of the Candidacy framework.[9] This systematic approach to understanding access enabled research assistants to consider the knowledge users' questions in their discussion of the findings. An exception to

† Literature on geographically isolated/rural EMOA and that on intervention strategies for EMOA experiencing abuse from war-torn countries was relatively sparse. However, tangential literature was examined and examples are included where possible.

this was the literature reviewed by Chappell and Powell's team (Appendix; research assistant, S. Browning). The broad scope of this question did not lend itself to the same type of consideration in relation to the Candidacy framework. Rather, the findings have been incorporated into this introduction.

Topical reports were prepared by research assistants under the supervision of academic team members. They were then sent to the team's knowledge user partner for feedback and modified accordingly. These reports were consolidated into a single document that informed our discussion at a 1.5 day team meeting (June 2014) in Vancouver, B.C., that included academics and knowledge users. The meeting was facilitated by Dr. Simon Carroll. Its outcomes will be reported in a forthcoming publication. We have also translated these insights into grant applications. The team further agreed that each of the topical reports and the consolidated document should be openly shared as an e-publication, in order to further knowledge and promote additional research in this area. We therefore encourage you to disseminate these findings widely.

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Chapter Two: Optimizing Health Promotion for Ethnocultural Minority Older Adults

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Introduction

In 2011, visible minorities constituted 17.7% of the population aged 65 years and older in British Columbia.[31] The largest ethnocultural group was the Chinese (8.1%) followed by South Asians (5.1%).[31] As the proportion of ethnic minority seniors will significantly increase over the coming decades, closer attention must be paid to the health needs of this population.

The BC Ministry of Health conceptualizes health promotion as 'health improvement' that is supported by enabling individuals to take control of their own health.[32] The Ministry has developed a number of tools and resources to promote active aging among the older adult population. These initiatives are largely targeted toward individuals and organizations. For example, the 'Healthy Eating for Seniors' handbook was created to promote healthy eating habits and is available in English, French, Chinese and Punjabi. Similarly, the Age-friendly BC program provides grants and resources for local governments to create age-friendly communities.

These initiatives, although commendable, must be enhanced in order to fully address the complexities inherent in the uptake of health promotion interventions by BC's ethnocultural minority older adults (EMOA). Comprehensive regulatory strategies for behaviour and lifestyle modification are difficult to implement in 'less prescriptive' domains such as healthy eating because ethnocultural minority groups in Canada are extremely diverse. An added complexity in the development, dissemination, and uptake of health promotion interventions is that there is no formal system attached to health promotion in BC. Public education and social marketing strategies tailored to EMOA are required to promote healthy lifestyles among BC's communities.

The health-related needs of EMOA are very diverse. Literature underscores the impact of multiple axes of inequity related to language, culture, income, gender, social class, place of birth, and immigrant status.[2,17,20,33] While recent immigrants may have better health than the mainstream population due to a self-selection bias and pre-immigration health screening,[6,26] the 'Healthy Immigrant Effect' is less apparent among foreign-born individuals who immigrate in mid-to-later-life.[14] Furthermore, EMOA face significant challenges accessing health care services and materials.[17]

Research Question

Our knowledge user, Donelda Eve from the BC Ministry of Health, proposed the following inquiry: What health promotion interventions optimize the uptake of available health promotion materials/services/amenities by EMOA?

Methods

A literature search was undertaken to identify relevant studies for review. The search terms included: ethnic minority seniors; intervention; health promotion; health promotion strategies; health promotion and ethnicity; chronic disease; and access. A total of 25 articles were reviewed for this report. The Candidacy lens[11] was used to review the literature and findings from the articles have been highlighted relative to the seven dimensions of the framework. Each dimension is identified and discussed in greater detail below.

Findings

i) Identification of Candidacy

Dixon-Woods *et al.* (2006) note that recognition of an individual's health symptoms as requiring intervention or attention is crucial to Candidacy. In a U.S. study of health-promoting measures among 30 older women from three ethnocultural backgrounds, understanding the older adults' own perceptions of 'health' was an important step toward conducting health assessments.[34] Holistic views of health among South Asian immigrant women, for example, are related to lower rates of participation in cervical cancer screening, i.e., participation in screening in the absence of symptoms.[15] As the individualism-collectivism framework indicates, strong kinship and familial ties within visible minority families may result in the creation of a certain ambiguity of boundaries between one's own health and the health of close family members (i.e., spouses, children or parents). In addition, the cultural gender hierarchy within visible minority families may lead to situations where female members may ignore or deny their own symptoms.[1]

The idea of 'mastery', or an individual's belief that his or her choices and actions influence outcomes in later life, is an important construct positively related to self-efficacy and self-evaluation of health.[9] For immigrant older adults, achieving mastery is strongly impacted by their life-course transitions.[9] Among South Asian widows in Canada, ambivalence towards leisure activities was determined by cultural and tradition-driven prescriptions, such as strict gender-based normative ideals constructed during earlier life stages in their country of origin.[30]

Psychosocial factors, such as the stigma attached to cancer as an untreatable disease, are underscored as barriers to the identification of candidacy among EMOA.[8] Indian patients are likely to deny health problems due to stigma, especially for mental health issues.[21] For sponsored immigrants who co-reside with adult children, the feeling of stigmatization can be compounded by social isolation and a sense of indebtedness brought about by their immigrant status.[17] EMOA may downplay symptoms in an effort to remain inconspicuous and avoid troubling their children.[18] Acculturative stress, role reversal or loss of role in the family, and overwhelming financial, physical and emotional dependence on younger family members can result in 'double barreled social debilitation'.[4] Feelings of debilitation negatively impact identification of the need and deservingness for care that necessarily precedes the individual's or family's efforts to establish candidacy.

ii) Navigation

The navigation dimension of Candidacy recognizes that utilization of services requires considerable effort on the part of individuals.[11] Effective uptake of health resources and

supports requires not only awareness of the services available but also mobilization of practical resources such as transportation or time off work.[11] For example, difficulty arranging transportation to community support centres prevents EMOA from participating in health promotion programs.[7] In a Canadian study, immigrant older adults reported challenges such as cold weather, transportation issues, and administrative barriers.[21] Resource constraints prevent family members from providing support to older adults with navigation, and not all older immigrants have children in Canada.[18] Correspondingly, the success of an active living program for South Asian seniors was attributed to offering programs where older adults naturally gather (such as at parks and temples), providing childcare for grandchildren, and reducing cultural and language barriers.[19]

Limited health literacy and poor understanding of chronic disease,[24] low levels of linguistic literacy,[13] fear and distrust of bureaucracy,[4] as well as misinformation and lack of trust in formally organized health interventions[7] undermine access for EMOA. Poverty, distrust of formal systems, transportation issues, and language barriers negatively impacted engagement in health promoting behaviours by Chinese American and African American women.[34]

In addition to poor linguistic proficiency and health literacy, limited prior exposure to formal or institution-based health promotion initiatives is a significant barrier to system navigation and service uptake.[1] Canadian research reports that expectations held by older women from China and India regarding health information did not align with the material that was actually available.[1] EMOA may prefer to use alternative sources for health information, such as practitioners of traditional or complementary medicine.[34]

iii) The permeability of services

Service permeability describes the ease with which individuals can access health services and materials.[11] More permeable services impose fewer qualifications on individuals for uptake and utilization, such as the mobilization of fewer resources.[11] Lack of charter language skills (English and/or French) and the limited availability of translation services or translated materials results in low service permeability.[18] In a study of immunization rates among Hispanic older adults, participants were more receptive to health messages from Spanish speaking *promoteras* (promoters) than those who spoke only English.[22]

In considering service permeability, it is important to distinguish between the 'targeting' of health promotion interventions and more appropriate 'tailoring' of programs to EMOA groups.[1] Health promotion programs that do not align with internalized cultural norms can deter older women from participating due to life course experiences in their country of origin such as gender segregation, patriarchal protection, and preparation for marriage and family life.[34] Menu plans with limited options adversely impact participation in nutrition programs for older adults.[7] In parallel, the ability to wear culturally appropriate clothing during community-based fitness classes greatly facilitated participation among Indian and Pakistani women.[19]

iv) Appearances

The appearances dimension of Candidacy describes how individuals must clearly articulate the health issue for which help is being sought in order to gain access to health services.[11] Underserved populations may be unable to coherently advocate for their health-related needs.[11] It is crucial to note the impact of cultural differences on patient-practitioner dynamics which can ultimately affect patient outcomes such as levels of compliance and adherence.[25]

Literature emphasizes the key role of language during appearances. EMOA who experience

depressive symptoms may express their mental health issues as 'stress' or a 'spiritual crisis', partly because the terms 'depression' and 'anxiety' are not customary in their country of origin.[17] Linguistically diverse older adults face difficulty articulating needs related to falls risk and prevention,[13] and asthma self-management.[24] They may also face challenges communicating through a health information telephone hotline.[4] Having a family doctor who speaks the same language inspires trust and confidence in patients during appearances.[24] However finding a family physician, let alone one who shares a cultural background, is a significant challenge for older Canadians.[3]

v) Adjudications

Once a patient has presented their claim for candidacy, health professionals make judgment calls that facilitate or impede access to health interventions.[11] Cultural assumptions made by practitioners neglect the complexities involved in facilitating access and can reinforce stereotypes of EMOA regarding uptake of Western health services.[27] In a study of new immigrants, health professionals incorrectly assumed that older women would be too pre-occupied with settlement issues to consider exercising.[12] Physicians may avoid discussing certain topics, such as Pap testing, with older immigrant women in order to avoid causing embarrassment.[15] A lack of culturally sensitive policies and limited training for care providers results in misguided referrals.[4] Cultural sensitivity among health professionals is paramount.[27]

vi) Offers and resistance

Individuals may choose to accept or resist offers made by health professionals for referrals or treatment options.[11] The decision to accept or reject health intervention depends, to a great extent, on an individual's belief system.[16] Cultural beliefs influence the ability of patients to understand and act on the instructions of health practitioners regarding chronic disease management.[25] EMOA may reject formal support in favour of assistance from their extended family due to cultural and traditional expectations.[13] Fatalistic health beliefs based on ideas that illness is beyond one's control or that becoming less active is a normal part of aging may lead to rejection of offers.[16] Conversely, EMOA may view declines in health as a warning from God and modify their lifestyle accordingly.[10]

Stigma surrounding illness and disease further complicates the conditions surrounding offers and resistance.[5,15] Fear of stigma had a negative impact on acceptance of cervical cancer screening among immigrant South Asian women.[5] Gender norms are also noted, as resistance can result from interactions between opposite-gender patients and physicians.[15] Internalized values of modesty and propriety played a role in the reluctance of older women to discuss Pap testing with male practitioners[15] and to their reluctance to participate in a mixed-gender fitness class, despite acknowledging the benefits of exercise.[23]

Resistance to offers also results from distrust of formal or westernized systems of healthcare among EMOA.[1] As previously noted, older immigrants may be more familiar with, and therefore have more faith in, informal sources of health information, such as their network of family and friends.[1] Health messaging through ethno-cultural print and visual media may best facilitate acceptance of health promotion strategies.[1] Lastly, language barriers can impede the ability of EMOA to effectively communicate their preferences for intervention and support.[13] Physicians may also fail to provide EMOA with adequate written or verbal instructions for chronic disease self-management, leading to unintentional noncompliance.[24]

vii) Local operating conditions

The final dimension of Candidacy considers the impact of local influences on the production

of candidacy.[11] Neighbourhood contextual effects such as environmental and socioeco-
nomic factors are partly responsible for regional health disparities.[29] Local conditions can also
influence physical activity levels and healthy eating. For example, although traditional diets
of Indian immigrant families in Newfoundland aligned closely with recommendations from
Canada's Food Guide to Healthy Eating, the relative non-availability of reasonably priced
ethnic foods in local markets contributed to poor nutritional practices.[28]

The BC government has taken some steps towards acknowledging the complexities inherent
in targeting health promotion interventions for EMOA. The recently published 'Healthy
Eating for Seniors Handbook' is an educational resource that assists older adults in making
informed dietary choices. This guide has been culturally adapted and translated into Punjabi
and Chinese. However, in light of the increasing heterogeneity of EMOA in Canada, such
resources must be adapted for additional groups in order to maximize uptake. Another
health promotion initiative is the Intercultural Online Health Network (iCON), which aims to
optimize knowledge exchange across BC's ethnocultural communities. Finally, PlanH is a
partnership program between BC Healthy Communities and BC Healthy Families that may
facilitate the development of specific health promotion grants for EMOA.

Discussion

This literature review indicates several overlapping issues that impact the uptake of health
promotion interventions among EMOA. These are discussed in more detail below, followed by
recommendations for knowledge users to consider in optimizing the uptake of health promo-
tion materials, services and amenities by ethnic minority seniors.

Language

English language proficiency is a salient issue affecting the uptake of health promotion
materials. Limited ability in mainstream languages was seen to play a role in all aspects of
Candidacy in considering access to health promotion intervention. In particular, permeability
of health promotion resources is restricted by a lack of adequate translation services and
limited availability of materials (such as pamphlets and brochures) in minority languages.
Language factors also impact the ability of EMOA to advocate for themselves during
appearances and successful knowledge exchange during adjudications and offers for
support.

Mobility

While transportation is a barrier to access for all older adults, the impact of reduced mobility
may be more pronounced for EMOA and affect attendance rates at health promotion
settings. Those who immigrated later in life may be dependent on adult children for naviga-
tion or have fragmented kin networks and thus limited familial support. Low levels of knowl-
edge about using public transportation and cold Canadian weather also restrict mobility.
The lack of autonomy that results can affect the ability of EMOA to effectively self-advocate.

Gender

Traditional gender norms have a great impact on access to health promotion services by
EMOA. Older women may be used to relying on men due to patriarchal cultural practices,
resulting in low levels of autonomy and self-efficacy. Norms surrounding modesty can impede
effective communication and trust-building with male health professionals and also preclude
participation in exercise and fitness programs when there is a lack of same-gender instruc-

tors, gender-segregated classes, or limited options to wear traditional clothing.

Immigration

Immigration is a significant life course transition for EMOA. New immigrants face difficulties accessing health promotion information due to a lack of knowledge about formal support and/or a history of reliance on informal means of information gathering in their country of origin. Immigrant older adults may be resistant towards western medicine and distrust the Canadian health system and formal health settings.

Culture

Culture is an overarching factor that can both facilitate and impede access to health promotion resources. Cultural beliefs, such as a fatalistic view of health and illness, may prevent identification of the need or deservingness for health promotion. Paradoxically, a spiritually-based recognition of illness as a 'warning sign' can motivate acceptance of health intervention. Health promotion programs that do not align with the cultural norms of EMOA are much less likely to be accepted. Feelings of cultural disconnectedness can affect the ability of EMOA to establish rapport with health care professionals or discern the relevance of health promotion materials to their lifestyle.

Recommendations

1. Health education and interventions should foster self-efficacy and autonomy so that EMOA feel empowered to advocate for their health needs. Similarly, health promotion settings must support a sense of agency among EMOA.
2. Health promotion tools and resources must be culturally relevant and use simple and straightforward language that is familiar to EMOA. With regard to health and fitness programs, culturally congruent activities such as Yoga, Tai-chi and Bollywood-style aerobics may prove popular, particularly among women. Activities must not only attend to language but also cultural conventions that impact EMOA's continued participation.
3. In order to facilitate participation in health promotion activities and programs such as fitness classes, the Ministry of Health may partner with community organizations to arrange transportation and childcare services as well as provide familiar settings for activities.
4. In order to effectively reach target groups, media outlets such as ethnocultural newspapers, radio and television channels (such as Sher-e-Punjab Radio, Fairchild Radio Vancouver, ATN, Alpha Punjabi, BTV, and TalentVision) may be used. Health campaigns should promote health literacy, healthy eating, and preventive screening for chronic disease.
5. Collaborative engagement between older adults, family members, community partners, religious and spiritual leaders and health care providers is crucial to building trust among EMOA of health promotion resources. Outreach workers and community volunteers inspire trust, particularly among EMOA who are socially isolated. Partnership initiatives should facilitate knowledge exchange in the production, marketing, and delivery of health promotion tools and interventions.
6. Within the context of economic constraints (i.e., limited government funding and budget cuts), existing grants and programs need longer term funding and should include criteria such as community outreach and partnerships between health agencies (such as local governments, health authorities, and community agencies). The Ministry of Health must work collaboratively with not-for-profit and community organizations in order to adapt and distribute resources to EMOA.
7. In order to design and implement cost effective health promotion strategies, policymakers must be cognizant of the unique health needs, beliefs and preferences of EMOA. To this end, it is critical to develop effective needs-assessment strategies, such as community surveys. There is also a need for evaluation studies that track the efficacy of health promotion initiatives.

Conclusion

The health promoting behaviours of EMOA are influenced by multi-level and intersecting factors. The findings from this review clearly indicate that in order to effectively engage EMOA, health promotion must address diverse factors such as linguistic ability, transportation and mobility, cultural competency, immigrant status, and life course events and transitions. Health promotion is best conceptualized as part of a continuum of comprehensive care, involving not only the provision of health promotion services and programs but also the facilitation of access to these resources.

Recommendations from this review highlight the need for collaborative engagement with stakeholders (including family, peers, community partners and health practitioners) and the development of concise, culturally appropriate health promotion tools tailored to the complex needs of EMOA. Health communication and promotion must be fashioned as a collaborative, two-way dialogue model with a focus on information *exchange* as opposed to information *transfer*.[1] In order for such a model to gain currency in British Columbia, the government must address salient issues surrounding cultural competency training – what it looks like and who it serves – across all health care contexts including health promotion.

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Chapter Three: Dementia Care Services for Older South Asians

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Introduction

The Fraser Health Authority is one of British Columbia's six publicly funded health care regions. Its jurisdiction includes a number of communities in the Fraser Valley from Burnaby and Delta in the west to Chilliwack, Agassiz and Hope in the east. This area is seeing rapid population aging; Fraser Health (FH) is home to 40% more seniors than the province's next two largest health authorities.[7] In addition, an increasing number of immigrant seniors are settling in the FH region. In 2012, 60% of the immigrant seniors arriving in British Columbia settled in the area.[7] In particular, the Fraser Health Authority has the province's largest South Asian community.[8] South Asians represented almost half of the region's population growth between 2001 and 2011, and comprise 15% of the current population.[8]

The unique circumstances of South Asian seniors have important implications for the delivery of health services in this region. Of special concern is the provision of dementia care services, where an improved understanding of the experiences of older immigrants and their families has been underscored in order to inform best practice.[1] Where older adults may often have complex health needs, immigrant seniors in particular may face a 'quadruple jeopardy' of dementia, age, ethnic minority status, and low socio-economic status.[3] It is crucial to understand these factors and how they affect access to dementia care in order for the health authority to plan and deliver effective services, curb health costs, and best serve British Columbians residing in this area.

South Asians immigrate to Canada from many countries, predominantly India, Pakistan, Sri Lanka, Bangladesh, East Africa, and Fiji.[9] Among them are represented diverse languages, religions and ethnocultural backgrounds. As Illife and Manthorpe (2004) emphasize, "cultural differences and shared understandings of meaning undoubtedly matter in the ways in which dementia care is organized and experienced, but a focus on ethnicity alone may promote misunderstanding and potentially stands in the way of tailored, wrap-around services for diverse individuals" (p.290). Rather, it is more useful to consider factors such as immigration, language, health beliefs, and socioeconomic status.[10] This report will provide an overview of these factors and how they influence the experience of dementia among older South Asians and their families, with the ultimate aim of promoting equity of access to dementia care.

Research Question

Our knowledge user Kathleen Friesen, director of Population Health at the Fraser Health Authority, proposed the following inquiry: How can the health authority improve dementia care services for minority older adults, particularly South Asians?

Methods

A literature search was undertaken to identify relevant studies for review. This search was primarily conducted in a database developed during a scoping review on the health and health care access and utilization of ethnocultural minority older adults (EMOA).[15] The search terms used included: ethnic minority seniors, dementia, South Asian, and patient centred care. The studies selected were peer-reviewed and published in English from 1980 onwards. Additionally, the reference lists and citing articles for the selected publications were inspected for further studies. Reports and documents from the grey literature recommended by experts (academics and knowledge user) were also included. Emphasis was placed on older South Asians in Canada, however examples from the U.K. (which has a comparable health care system) and other ethnic-minority populations were also selected. Twenty-seven articles were reviewed for this report,[11] of which include a focus on South Asian populations. The Candidacy lens was used to review the literature, whereby findings from the articles have been highlighted relative to the seven dimensions of the framework.

Findings

i) Identification of Candidacy

The first dimension of Candidacy, identification, describes how symptoms are recognized as requiring and deserving of medical attention.[6] Ethnic minorities may be disadvantaged by alternative understandings of health and illness, where individuals may not only fail to identify themselves as potential service users but alternative understandings of dementia are often not incorporated into existing service models.[19] Professional and lay understandings of dementia are influenced by the knowledge, beliefs and attitudes of both individuals and groups, and are thus culturally determined.[1] Within the South Asian community, discourses of collectivism and divinity are common and may not align with Western representations of health and illness.[1] South Asian caregivers have expressed traditional religious and spiritual beliefs about the cause and nature of dementia.[18] Dementia was seen as a mental illness impacting the entire family, and its symptoms were attributed to 'spirit possession' and 'the evil eye'.[18]

Participants were commonly described as having little to no previous knowledge of or experience with dementia.[3,17,21,33] There is no set terminology for dementia within South Asian languages.[29] South Asians may not be familiar with the words 'dementia' or 'Alzheimer's disease', despite having varying levels of impaired memory themselves.[17] Normalization of dementia symptoms is underscored as a barrier to early diagnosis.[4] Older South Asians have attributed symptoms of dementia to "somebody getting old and funny" (p.392),[3] a "natural process of decay" (p.202),[31] and also as a result of social isolation and poor physical health.[32] Although symptom normalization may in part be due to socioeconomic status and education level,[1] similar processes were found among Chinese-Canadian caregivers and people with dementia, across diverse educational and professional backgrounds.[14] Symptoms of dementia may also be misidentified as "absent-mindedness",[32] misattributed to pre-existing personality traits including anger and depression,[20] as well as physical illness (e.g. diabetes, heart disease) and life transitions, such as retirement.[22]

While family members may also misidentify dementia symptoms for normal aging, people close to the person with dementia generally play a key role in symptom recognition. Cues include repeated questioning, problems with driving, difficulties managing finances, general forgetfulness, and changes to personality and usual behaviour.[14] Members of both the immediate and extended family may recommend help seeking, especially upon noting safety risks to the person with dementia,[20] and when family life is disrupted by dementia

symptoms.[3] In one example, a family's lifestyle was radically altered when it was felt they could no longer pray at home because an older family member with dementia had incontinence. In their view, the entire home was rendered 'dirty'.[3] This case was compounded by the fact that the family wanted to avoid the temple in order to conceal the symptoms of the person with dementia from the rest of the community. Literature describes the negative perceptions and stigma attached to mental illness.[1,3,4,16,24] For families, concealing dementia from the rest of the community may be a coping mechanism to preserve family dignity and avoid problems during arranged marriages for example.[3,18] One study found that a common belief among people of Punjabi Indian origins is that dementia symptoms are caused by a lack of care by either one's self or family.[16] Memory impairment may also be viewed by some men as a threat to their position in the community.[17]

Similarly, symptoms may be hidden from one's family for fear of the negative consequences.[33] Immigrant South Asian older adults do not always share health problems with family members; in many instances familial responsibility may take precedence over help seeking, which is delayed until the family encourages the older adult to see a health care provider.[9] Caregivers may also delay identification in order to avoid causing anguish or betraying the person with dementia.[22] Dementia is thus viewed as a personal or family matter, rather than an issue requiring medical attention.[22] However, when help is not sought, identification may still take place within health settings during treatment for other medical conditions,[3,14,20,22] or in response to a tipping point such as bereavement,[4] leading to referrals to memory specialists.

ii) Navigation

After a person's need and deservingness for health care have been identified, individuals and their families must locate relevant health services. Dixon-Woods et al. (2006) describe navigation in reference to one's awareness of the services available and mobilization of the practical resources required to access them. South Asian caregivers have compared this process to "a battle in which they were constantly fighting to receive information, advice and practical assistance" (p.57).[21]

Parallel to the process of identification, common barriers to navigation include knowledge-related factors, such as beliefs about the cause and purpose of a dementia diagnosis; societal factors, including stigma and cultural expectations; as well as factors related to health-care, such as resistance to approaching health practitioners and structural service barriers.[22] Punjabi immigrants in the U.K. expressed the belief that "there was nothing that could be done" and thus there was little point in seeking help from professionals.[16] They also referred to the effect of stigma where "people would gossip about you if something went wrong" (p.609).[16]

In addition to a lack of knowledge about health services, families may encounter challenges in negotiating formal support due to language and communication difficulties.[11] This may be true even for immigrants who have been living in Canada for an extended period of time. For example, despite having lived in Vancouver for three years, a female caregiver experienced significant isolation as she spent the majority of her time at home caring for her child and aging mother.[14] Thus the contribution of immigrant status and a heavy caregiving burden can isolate people who will thus have little awareness of available services or how to find information about accessing them.[14]

Support from family is crucial during navigation, as persons with dementia may not seek health services on their own.[20] Caregivers may filter services to those they deem will be accepted by their family member with dementia.[5] Adult children may be a particularly important resource in providing information and assistance that facilitates access to the western health care system, and to emotional and instrumental supports.[9] For example, older women often depend on family members for transportation since they do not drive, cannot afford a taxi, and avoid public transit due to their lack of English language skills.[9]

On the other hand, instances of delayed navigation due to family support have been noted. Out of respect for family and community hierarchies, family members may choose to discuss dementia related issues amongst themselves or with a religious leader before mobilizing support from health care providers.[22] In other cases, obtaining any informal support at all may be difficult, especially among recent immigrants whose social networks are fragmented.[11]

Community organizations, such as the Alzheimer's Society, play a significant role in supporting navigation.[4,14] Community outreach has been emphasized as a strategy to establish links with ethnocultural populations, such as organizing 'roadshows' at community centres and religious establishments.[21] Bicultural workers are instrumental in using cultural knowledge to help families navigate mainstream services and in acting as a liaison between clients and health providers.[2] Bicultural workers may also facilitate confidentiality, where family members may make contact "on a friend's behalf" without having to admit to having a problem of their own.[2]

Multipurpose leaflets outlining symptoms and the help available that use neutral terms, such as 'memory problems' rather than 'dementia' and 'looking after' instead of being a 'caregiver' are recommended as effective strategies for service promotion and health messaging.[21] Information provision via DVD and video may be especially critical for individuals who are not literate in either English or their mother tongue.[21] Radio broadcasting, websites, and telephone help lines may be best to connect with people in their own homes.[29] In addition to delivery, content, and audience, the source of health messaging must be considered. Since the government may be perceived with mistrust, information provision may have more impact if delivered by an independent source.[24] Recent research suggests that awareness campaigns may be useful to reduce stigma, but more evidence is required to determine their effect on actual help-seeking behaviour.[24]

iii) The permeability of services

Service permeability describes how accessible services are based on the qualifications one needs in order to use them.[6] Factors that commonly affect service permeability include the location of clinics, hours and language of operation, required levels of health literacy, and funding models that limit the time health practitioners have per patient.[12]

Literature suggests that there is a paucity of desirable resources and services for older South Asians with dementia and their families. Families emphasized the need for tangible support in dementia care, with one caregiver stating, "We don't need advice anymore, we need somebody to come and help us. We need somebody to come and give us respite. We need money. We need funding. We don't need talks" (p.390).[3] Study participants have expressed the desire for improved services in the post-diagnostic period including access to community care, respite, as well as social and psychological support.[4] High service demand and inefficient referral processes also decrease service permeability.[3] As one participant explained, "It took us a long time to get the help we needed… All they kept telling you is that there isn't enough money or the waiting lists are too long" (p.10).[29]

The organization of health services is also salient. Partnerships between mainstream services and those offered by the community sector can have a significant effect on service permeability.[3] Divergent views surrounding who should deliver what kinds of services as well as poorly integrated care may significantly minimize service access.[3] Stereotypes held by organizations and practitioners regarding the care preferences and family supports of older immigrants with dementia can also deter service use.[19]

In order to maximize service permeability, flexibility is paramount: services must accommodate both people with dementia and their families, and offer multifaceted support such as regular phone calls and home visits.[2] As with navigation, outreach programs are essential to connect services and service users.[2] Moreover, bicultural workers with training in dementia care, who are proficient in community languages, have an understanding of cultural norms,

and are knowledgeable about the healthcare system as well as principles of health equity and access may be indispensable.[2] It is crucial for communities to be offered support services that are led by staff and volunteers who speak community languages, held at convenient locations and times, and consider practicalities such as transportation, caregiver involvement, and childcare arrangements.[21,29]

iv) Appearances and Adjudications

The appearances dimension of Candidacy describes the presentation of a patient at a health service to articulate their health issue and make a credible claim for care.[6] This dimension relates specifically to the interaction between a client and health professional, and may be influenced by the client's language skills, cognitive functioning, socioeconomic status, gender, and age for example. The second element in describing this interaction is captured by the adjudications dimension of Candidacy. After a client presents their need for health care, practitioners must make judgment calls based on their own knowledge and biases.[6] Appearances and Adjudications are presented here together as these dimensions often take place concurrently when accessing dementia care.

For persons with dementia and their families, appearances commonly begin with the primary care provider (i.e., family physician) as the first point of contact.[4,14,20,22] Family doctors were the initial contact in the pathway to diagnosis among 70% of a Chinese-Canadian sample.[14] From here, a referral to a memory specialist (e.g., geriatrician, psychiatrist, neurologist) is likely to be made in order to obtain a diagnosis.[14,20,22] However, in a study of South Asians in Toronto, the time between symptom recognition and consultation with a primary care provider varied from one to four years.[20] If a primary care provider misses dementia symptoms then it may take a crisis event for the older adult to receive proper diagnosis and care.[22] Delays in receiving a diagnosis have also been underscored in the World Alzheimer Report,[27] which reports a waiting period between 3 and 6 years for individuals to receive a dementia diagnosis.

Further delays in obtaining help may be caused by a lack of faith in health professionals, which can deter persons from making any appearances at all.[22] The importance of a sympathetic and supportive primary care provider must be emphasized.[22] Older immigrants and their caregivers may be disinclined to use services if they feel health practitioners lack the competency required to address their language and cultural background.[21] This aspect speaks to the degree of ethno-cultural alignment between service users and providers. For example, language barriers were eliminated by a high degree of ethno-linguistic alignment between a Chinese-Canadian sample of persons with dementia and their family doctors.[14]

Nevertheless, a practitioner may speak the same language as their client yet do so in a manner which is overly professional or does not reflect the client's dialect, particularly when working with older adults.[2] Cultural conventions, such as how to address someone, and non-verbal communication including eye contact and gestures, are also important in order to build trust with clients.[21] Once trust has been established between a client and health professional, families may ask for advice more readily, confide fears, and recommend services to friends.[2,16] Researchers have elaborated on this point by stating that in working with older immigrants, ethno-cultural alignment goes beyond addressing language barriers.[10] There is a need to overcome age differences and limits in vocabulary (especially when discussing Western notions of mental health), address varying levels of comfort with medical environments and testing, and accommodate family members.[30] Researchers have argued that dementia care services must respect "the diversity and complexity within the life stories of persons with dementia" (p.5).[21] Among older immigrants, important facets of one's life history to consider include country of origin, age at immigration, migration route and reasons for migrating.[10]

Past negative experiences can also affect appearances: the literature has described a general wariness among ethnic minority populations toward health services due to past

experiences of racism, discrimination, and dismissive behaviour by practitioners.[23] Individuals with memory impairment have described memory clinics as 'shocking' and 'frightening' places.[4] In one study, appearances by South Asian participants were hindered by the sentiment that practitioners were not willing to help, were dismissive of symptoms, and even attributed complaints to old age.[16] These issues may speak to power dynamics, where gender-based power imbalances between clients and health professionals can silence an older adult's concerns.[14] Caregivers have reported feeling that they were not being listened to, which ultimately led to significant delays in their diagnostic pathway.[22]

Appearances of older immigrants at health services are commonly supported by family members. Daughters in particular play a key role in communicating with physicians, providing translation, and explaining treatments to their parents.[9] While older people may have confidence in their family to represent them during appearances, adult children may have competing family and work commitments preventing them from assisting the older adult.[9] Using a family member for interpretation, especially a younger person, can lead to inaccuracies, embarrassment, and miscommunication.[10] While the presence of a family interpreter may be comforting for the person with dementia, policy requirements may demand an independent interpretation service in order to avoid biases and miscommunication.[28] Use of family for interpretation is counter indicated in situations when the dependency borne of sponsorship status may render some older immigrants susceptible to abuse and neglect from family.[13] It is recommended that interpretation services be responsive to the cultural dynamics of the person with dementia and their families, especially in terms of ethno-cultural alignment.[28]

Adjudications in dementia care are complicated by a lack of culturally sensitive assessment tools for screening and diagnosis.[1] Not only must diagnostic tools show adequate validity after being translated into South Asian languages, but also cultural specificity.[3] Cultural biases in instruments may skew estimates of dementia severity as instruments are often developed using samples from the general population.[21] A timely and accurate diagnosis of dementia is critical as it enables access to dementia-specific services, such as particular treatment plans according to dementia type, home care and respite, and also facilitates future planning with regard to care preferences and representation agreements for example.[21]

The literature described several instances wherein primary care providers missed dementia diagnoses.[4,14,20] This may speak not only to diagnostic difficulties but also to the limited awareness among health professionals of both the disease and treatment options.[3] In one study, 60% of the sample reported delays in diagnosis because the primary care provider dismissed caregivers' reports of dementia symptoms.[14] There were also instances when physicians decided not to assess memory since they deemed drug therapy too costly.[14] Technology innovations such as decision support software for primary care physicians may improve the diagnosis of dementia in health settings.[22]

Poor medical communication is also responsible for creating confusion between dementia and other conditions.[3] This may be especially salient when practitioners fail to communicate with and provide support for caregivers.[14] Communication difficulties with an older adult with dementia, regardless of ethnic background, may be exacerbated by the nature of the disease.[10] As persons with dementia may not be able to remember details from consultations, excluding caregivers from client-practitioner interactions can cause delays in obtaining dementia care.[22] Physicians may also delay access to care due to concerns with breaching confidentiality, when they withhold information about the person with dementia from their family caregiver.[4] Service providers who are preoccupied by cultural differences may have reduced confidence in properly responding to patients from ethnic minorities.[3] There is a clear need for dementia-specific training that focuses beyond culture to the provision of individually responsive care.[3]

v) Offers and resistance

Dixon-Woods et al. (2006) describe the offers and resistance dimension of Candidacy as acceptance and resistance among patients to the offers made by health professionals for referrals, medication, and additional health support. Readiness to accept a diagnosis of dementia varies, where both caregivers and people with dementia may aim to "preserve identity and autonomy in the face of increasing symptoms" (p.7).[4] Such resistance may be less a form of denial than a strategy for self-maintenance.[4] Dementia diagnoses are more likely to be accepted when families have previous experience, either personally or professionally, with the disease.[4] When families lack knowledge about dementia, they may feel hopeless about options for care beyond family support.[3] Recent work suggests that South Asians are less likely to know about the available treatment options for dementia, although be more likely to believe dementia is curable versus Caucasians.[32] Hope can thus influence acceptance of treatment, however attitudes toward medication may become negative as one's sense of hope diminishes over time.[4] Availability of financial resources may also impact decisions about accepting or resisting offers.[2]

A significant portion of the literature focuses on the preference for ethnic minorities to 'care for their own' due to cultural norms and religious obligations surrounding filial responsibility.[1,17,18,23] Families may be resistant to accept outside help due to the concept of belonging to a family clan, or 'biraderi'.[28] Offers from services and agencies may be rejected since acceptance could imply that families need supplemental support and are incapable of fulfilling their duty to care.[28] Caregivers are reported to believe that acceptance of mainstream support would lead to placement in long term care, and cause shame to the family who were perceived as abandoning their relative.[18] Services must take into account the perspectives of the client's family in order for support to be accepted, and the fact that service use may be intermittent since acceptance can fluctuate over time as health care providers build trust.[2]

Not surprisingly, research underscores home care as the preferred service by South Asians.[3,16] Remaining in the family home may be imperative both emotionally and practically for older South Asians with dementia.[17] However, there may also be reluctance to allow strangers, even if they are health providers, into one's home.[3] The literature generally emphasizes strong resistance among South Asians to accepting residential care,[17] which has been deemed "ideologically unacceptable and culturally inappropriate" (p.390).[3] It is difficult for families to choose and accept long-term care when no suitable options exist.[25] There is thus a great need for caregiver respite, with day care (versus home-based respite or short-stays in care homes) likely to be the most acceptable option.[21]

Acceptance and resistance of offers may be impacted by the quality and quantity of informal support among different types of South Asian households.[11] Gender norms can play a role[11] where husbands, fathers, and grandfathers may be primary decision makers in families, and have the ultimate say regarding accepting or resisting medical treatments.[9,28] Where men may play a role in decision making and compensatory support, women are likely to provide more 'hands-on' care. For caregivers and care-receivers with traditional values, the issue of cross-gender caring, especially from persons outside the family, may be unacceptable.[11]

While some literature has indicated that older South Asians may be cared for by their family to a more advanced stage of dementia as compared to the general population, researchers caution that this may not always be the case.[3] It cannot be assumed that all South Asians have supportive extended families,[11] as acculturation may potentially influence intergenerational attitudes regarding support exchanges and normative expectations to provide care for an older family member.[10] Support from family may also be compromised by immigration laws, fragmented family networks, the growing preference for nuclear households, financial pressures, and the changing social practices of marriage, divorce, and women in the

workforce.[11,13,21] The factors influencing this dimension of Candidacy are dynamic, both within the South Asian population and over time.

vi) Local operating conditions

The final dimension of Candidacy, local operating conditions, pertains to local and specific factors that affect interactions between clients and health professionals, such as the availability and suitability of resources and services.[6] Within the Fraser Health Authority, local operations for older adults include the Home is Best strategy based on in-home and community care.[7] For South Asians with dementia and their families, the majority of direct care services are provided through primary care providers and referrals to specialized clinics including a chronic disease clinic, specialized geriatric clinics, as well as a new Canadian clinic. The health authority also supports the South Asian Health Institute (SAHI), which plays an advocacy role for the South Asian community and individuals managing chronic conditions, and associated South Asian Health Centre, which provides diabetic care among other services.[8]

Researchers emphasize a clear need for further service development in dementia care.[26] Concerns about service sustainability when funding is short-term have been voiced.[21] It takes time to build trust and establish relationships within local communities, and the deliverables required by funders may not be possible within the short period for which funding is provided. Needs-led service development, whereby communities are consulted in order to address the specific circumstances of the local population, is essential.[19] This is an area where more research is required, especially for systematic evidence and evaluations of effective solutions and approaches to service design and delivery.[19]

Discussion and Recommendations

The experience of dementia among older South Asians and their families is a multifaceted and variable phenomenon with extensive implications for promoting equity in access to dementia care. Based on this review of the literature, a number of considerations may be outlined for the health authority in order to improve dementia care services for South Asians in the Fraser Health region. These are presented according to actions that may be targeted to specific groups, as follows.

Clients and families

A lack of awareness and understanding of dementia as a medical condition and associated stigma are significant barriers to identification of the need and deservingness for care. Older adults and their families require appropriate information about the cause and symptoms of dementia, the assessment process, and options for treatment and referrals. It is imperative to reach out to family members of older immigrants, who often play a large role in most dimensions of Candidacy such as identification and providing support (e.g. with interpretation, information-seeking, transportation) during navigation and appearances. Information and decision-making assistance is also needed to help clients understand offers of assistance so as to increase their utilization. Actions should also target caregivers of persons with dementia, who may not identify their need or deservingness for self-care or respite. In order for formal services to be accepted, dementia care must not only provide flexible and appropriate options for individuals, but clients and their families must also understand how these services compliment (rather than displace) family support. However, it cannot be assumed that all older adults have access to a supportive family network. Clients who lack informal support require different types of material and assistance in order to facilitate access to dementia care services.

Communities

Community health education and outreach is crucial to reduce stigma surrounding mental illness and accepting help, to improve knowledge and understanding of dementia, and to promote awareness of available services and supports. Health campaigns tailored to specific communities that use innovative forms of media and provide signposts for services are important to this end. Furthermore, partnerships with community organizations and local leaders are critical to build trust of health services among communities.

Health service providers and family physicians

Family plays a very significant role in accessing dementia care for older South Asians. Health service providers must understand that dementia may be seen as a 'family issue' and consider the needs of the family accordingly. Further, health professionals should consider nuances surrounding gender roles, intergenerational tensions, and issues related to sponsorship that can affect the types of support an older adult may or may not receive from family. It is important for health service providers and family physicians to be aware of the preference for family care yet avoid assumptions regarding the nature and extent of family involvement.

In order to improve ethno-cultural alignment between health service providers and clients, education and training for health professionals is crucial. Professionals should understand how dementia might be conceptualized by clients in light of cultural understandings of mental illness, which could affect how older adults present symptoms and adapt to their experience of dementia. Ultimately, it is important for health providers to focus beyond cultural differences to promote individualized dementia care.

Family physicians are often the gatekeepers to dementia care. Training for family physicians regarding symptoms, diagnosis, and options for treatment and referral is thus imperative. In addition, training should highlight best practice for medical communication, use of appropriate terminology, and call attention to the potential for power dynamics to influence interactions with clients and their families. This may also be applicable to acute care workers who attend to older immigrants in crisis or for another health issue. Health providers should have up-to-date knowledge regarding options for post-diagnostic support including respite, home services, social and psychological support, as well as programs offered by local community centres and organizations.

Health service providers and family physicians must aim to build rapport and trust with clients in working with older immigrants and their families. The importance for sympathetic health workers and supportive non-threatening environments are key. Bicultural and linking workers as well as case management may be essential to establish trust over time with clients and families, and further maximize ethno-cultural alignment. This aspect is also important when considering interpretation services, where older immigrants should have access to an independent yet trusted and reliable interpreter.

Health care organizations

Health care organizations may benefit from an expanded view of health in order to reach a wider array of potential service users. This may be done by incorporating community beliefs and alternative representations of health and illness within existing service directives. Shifting toward a more holistic view of health and dementia would also benefit service promotion and outreach programs, where health messaging should be tailored to communities in order to motivate help-seeking and facilitate navigation. To this end, it would be beneficial for health organizations to engage in inter-organization cooperation and agency partnerships.

To maximize ethno-cultural alignment between services and clients, organizations must provide access to bicultural workers and create comfortable health settings for their clinics and programs. Training materials for professionals should be developed to promote best

practice for personalized dementia care in supporting clients from diverse backgrounds. Ultimately, health providers should be empowered to develop their own strategies for working with older South Asians.

The importance of flexibility in services must be emphasized. The location and environment of health services should be welcoming, central, and familiar to service users, including adequate hours and language of operation. Services and programs should take into account logistical factors that may hinder navigation and appearances for some older adults and their families, such as work, child-care, and transportation arrangements. In certain cases, home visits and assessments may be preferable. Health care organizations should consult with local communities to engage in needs-led service development and create programs that reflect the diverse individuals they aim to serve. In a continuous process of service development and refinement, research should be conducted in order to evaluate the implementation and reach of existing services and programs.

Policymakers

In the current context of population aging and the growing prevalence of cognitive impairment, an increased societal awareness of dementia is warranted. Policy surrounding an information and communication strategy to increase awareness of dementia among communities, health professionals, and decision makers is needed. Policy regarding service development should call for multifaceted supports including home care, caregiver respite, daycare, innovative housing models, and appropriate options for long-term care. There is also a need for further research and technology development (e.g., creating valid and reliable diagnostic tools and decision support software for health professionals).

In addition, funding models must be revised in order to reduce waiting times and facilitate the long-term sustainability of services. For example, the patient-practitioner communication dynamic discussed under 'appearances and adjudications' would benefit from increased time per patient with primary care providers, and services offered by the community sector would be strengthened by funding schemes that allow for a longer period of development and operation. Greater financial support for individuals to reduce the cost of medications and out of pocket expenses is also required.

Conclusion

The experience of dementia among South Asian seniors and their families has important implications for the delivery of health services in the Fraser Health Authority and beyond. Through the lens of Candidacy, this review has shed light on the multilevel and intersecting factors affecting access to dementia care. Findings from this review indicate the importance of an inter-sectorial approach involving multiple stakeholders in order to address equity in access. Clients and families require information and flexible supports and communities would benefit from tailored health campaigns to increase awareness and knowledge of dementia. Health service providers must be given opportunities for sensitivity training and healthcare organizations should engage in inter-agency partnerships and consult local communities to promote both community capacity and trust of formal health services. Finally, policymakers should call for multifaceted supports and revised funding and time models to promote equity in access to dementia care services.

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Chapter Four: Mental Health Treatment Interventions for Ethnic Minority Older Adults: What has the literature told us?

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Introduction

Despite the unprecedented increase in the population of ethnic minority older adults (EMOA) in Canada and well recognized mental health problems they may face, gaps remain in EMOA's access and use of mental health services. Health providers' require an improved understanding of the dynamics of their mental health practice and culturally competent mental health care. The complex and interconnected factors shaping mental health experiences and interventions require examination, as well as an improved understanding of aspects of current mental health treatment interventions (particularly those at the levels of health care system and delivery) that work well for EMOA in Canada.

This literature review explores these influences and promising approaches to mental health interventions for EMOA. Findings are discussed in terms of implications for mental health services for EMOA, with the aim of informing sensitive, appropriate, and effective mental health practice.

Research Question

Bonnie Schroeder, Director of the Canadian Coalition for Seniors' Mental Health, posed the following question: Which mental health treatment interventions (particularly those at health care delivery and system levels) work well for EMOA in Canada?

Methods

A literature search was undertaken to identify relevant studies for review. This search was primarily conducted in a database developed during a scoping review on the health and health care access and utilization of EMOA.[14] The search terms used included ethnic minority seniors; depression; access to services; ethnopsychiatry, and immigrant health. The studies selected were peer-reviewed and published in English from 1980 onwards. Additional references were identified from the bibliographies of selected publications and articles that cited them. Recommended reports and documents from the grey literature were also included. Emphasis was placed on mental health of EMOA in Canada, however examples from the United Kingdom (which has a comparable health care system) were also selected. Thirty-two articles were reviewed for this report, 11 of which include a focus on mental health of EMOA in Canada. The Candidacy lens[10] was used to review the literature, whereby findings from the articles have been highlighted relative to the seven dimensions of the framework. Each dimension is explained below.

Findings

i) Identification of Candidacy

Identification of one's candidacy for health care involves EMOA's recognition of their symptoms as requiring attention or intervention.[10] Older adults and their family members may have limited awareness of mental health conditions and/or illness symptoms,[18,19,22,28] particularly with respect to common disorders in older adults such as depression, anxiety and cognitive impairment.[23] Family caregivers may be lacking an understanding or awareness due to inadequate information or limited access to appropriate care providers[8,13] or denial.[13] (Although someone may be knowledgeable about mental health, perceptions of one's own mental wellbeing could be inaccurate.[15] Mental health symptoms may be viewed as "being tired," "thinking too much," or "negative thinking," rather than as manifestations of depression or anxiety.[1,15]

Understandings of mental distress and illness are shaped by cultural and religious values and beliefs.[12,17,26,27] EMOA may attribute the causes of mental illness to negative character, personality, behavior, spiritual or emotional imbalance, or lack of personal control.[17,18,27] Literature also cites lack of religion, possession by evil spirits, punishment for sins, and symptoms being seen as a divine test or plan.[18] Cultural norms regarding family also play a role. Symptoms are understood as results of interpersonal stress, family members' failure to fulfill filial duties, and lack of family support.[17,18,27] Mental health challenges have been framed in terms of immigrants' settlement and adjustment to a new cultural context as well as loss and powerlessness.[2,17,19] Symptom normalization and misattribution to 'normal aging' is also common.[8,17]

Although mental health symptoms may be identified, the health issue itself may not be deemed as important.[5] Older adults and family members may believe that there must be a physical or somatic problem in order to legitimize a physician visit.[1,23] Concerns over employment and finances can cause EMOA to put health concerns "on hold".[2] EMOA may view mental health challenges as a personal failure or as an expression of weakness, and may fear of becoming a burden to their families.[15] Chinese older adults are more likely to take care of mental health problems themselves than attain support from mental health services.[26] In parallel, EMOA may prefer to "wait and see" rather than seeking immediate support,[5,28] which can result in help-seeking only when problems become severe.[7,18]

The social or cultural stigma associated with mental health and service use has far-reaching implications for identification of illnesses and help-seeking.[7] Expression of mental health challenges and help-seeking may be avoided due to shame, fear of rejection, or wanting to "save face" and protect family honour and reputation.[8,12,13,15,17,18,23,26,27,28] Family and household roles, such as childcare responsibilities and the fulfillment of gender roles (e.g., completion of expected daily activities) may prevent EMOA from disclosing mental health challenges to their family members.[2,23] Older Indian immigrants reported "staying busy" in household and community duties as a means to control one's 'inner self', which was perceived as a form of moral medicine.[1]

ii) Navigation

Navigation involves awareness of relevant health services and mobilization of the resources required to use these supports.[10] EMOA and their family members often have limited knowledge of available services and treatments for mental health. This includes poor understanding of how to access or obtain services (e.g. how to schedule an appointment) and how to navigate in the service system.[2,5,11,13,15,18,19,22,23,24,27,28] Recent immigrants and immigrant

women who remain at home are particularly vulnerable in terms of having little knowledge of services and access barriers.[13] A compounding factor is the lack of timely, effective, and culturally sensitive information regarding available and acceptable mental health supports.[27] Literature underscores the need for tailored outreach programs that provide health information and promote service access among diverse groups.[27]

EMOA may turn to informal sources (e.g. friends, family members, clergy or church communities, indigenous healers) for support during navigation.[9,15,18,19,21] Literature suggests that greater perceived social support from family and friends is associated with positive help-seeking attitudes among older Chinese immigrants requiring mental health support.[26] Recent and sponsored immigrants may be particularly dependent on family members for transportation to medical appointments and community services, financial support, addressing language barriers[5,13,27] and assisting with physical challenges.[8] Correspondingly, a lack of close social ties can limit service navigation. EMOA who experience kinship loss due to immigration face significant challenges.[5,19,24,27] Even when family networks exist, limited time, energy and finances impede the ability of family members to support or care for older adults.[13,23] EMOA may worry about overburdening family members, and their household or childcare responsibilities limit their ability to seek help.[1,13,23] Logistical challenges, such as lack of computer access, also impede navigation.[20]

Attitudes towards mental health services and beliefs about mental health treatment as an effective strategy impact navigation.[7,26] Negative past experiences with formal services (e.g., painful procedures/treatments and perceptions and experiences of discrimination by health providers) contribute to distrust of health systems by EMOA.[5,18] However, previous interactions with mental health professionals (for example, during a relative's illness) may be associated with a better understanding of mental health and need for intervention.[18] Support from trusted ethno-specific agencies is often key during navigation.[23] Peer support is also important in terms of encouraging help-seeking and health screening, as older adults may be more likely to listen to other older adults.[27]

iii) The permeability of services

Service permeability describes how easily people can access services depending on the qualifications needed to use services as well as the mobilization of necessary resources.[10] Challenges associated with language significantly affect the permeability of mental health services for EMOA. Interpretation services are often unavailable, inadequate or unreliable, forcing older adults to rely on practitioners with limited language skills or to bring their own interpreter, such as a family member, to meetings or appointments.[5,11,23] Unavailability of service documentation (including forms, pamphlets, and handouts) in different languages is also a barrier.[27] So too is the lack of health information in an accessible format for EMOA with literacy challenges.[21] Discrimination (e.g., ethnocentrism, ageism and sexism) at the institutional or structural level of mental health care further restricts service permeability for EMOA.[5,8,13,18,19,24,27]

EMOA report that the quality of mental health care services that they have received is poor.[19] This might be attributed to dissatisfaction with long waiting periods, perceived lack of control in referral processes, perceived cultural or religious inappropriateness of services and supports (such as language and food options), and failure of services to accommodate family involvement.[2,5,11,18]

Logistical factors related to accessibility and transportation also influence service permeability.[11,13,15] Challenges include large geographic distances from home, lack of available transportation options, and the physical design and accessibility of facilities.[1,15,27,28] Researchers

note that culturally specific services, the preferred option by EMOA, are often located in busy downtown centres.[23] Service permeability is especially low for people living in rural communities, with limited services and practitioners.[27] In addition, available services may not be physically accessible for the mobility impaired. Mental illness can be associated with poor physical health and related limitations in functional capacity and mobility.[8,16,17,24,25,26] Service accessibility must therefore simultaneously consider EMOAs' physical mobility in their design and layout.[8,24] Service timing and scheduling issues can also impact permeability. Service times may not align with EMOA's availability due to time-specific obligations such as prayer time or the provision of after-school childcare.[27]

iv) Appearances

The appearances dimension of Candidacy describes EMOA's presentation, formulation, and articulation of the mental health issue(s) for which support is being sought.[10] EMOA are less likely to use specialist mental health services in favour of primary care physicians. The stigma attached to consulting with primary care physicians is typically less and they are more likely to be trusted, thus affording a safer environment in which EMOA can discuss sensitive personal issues.[6,8,18,21,26] Similarly, EMOA are more likely to use mental health supports that are integrated into primary care services (e.g. brief psychotherapy) rather than services offered as specialized mental health care.[3,4]

Cultural factors impact the articulation and presentation of mental health issues. EMOA may not articulate their health concern in a way that is recognizable as a "legitimate" mental health problem according to clinical criteria or the English language.[15, 27] Articulation can be complicated by cultural expressions of symptoms, such as the presentation of mental distress as physical or somatic problems.[17,19] EMOA may present mental distress in terms of headaches, back or joint pain, and/or fatigue.[2,15,17,18,19] In some cases, cultural or religious practices can be mistaken for depression, such as limited communication and social isolation in preparation for spiritual rituals or during periods of grieving.[17,27] In addition, the functional impairment associated with some mental illnesses, such as limitations in sight, hearing, or cognition, can impact appearances. [8]

Appearances by EMOA can be affected by their perceived sense of inferiority in the formal health setting.[15] The communication dynamics between older clients and health professionals are influenced by generational differences in speech patterns, negative attitudes to those in authority, limitations in literacy[19] and cultural norms regarding interactions between men and women.[27] EMOA may feel ashamed to disclose certain personal health issues[5] due to the importance of being respected and honoured by their family and community.[1] The service environment or program location can also influence appearances based on factors such as privacy and comfort, quiet and calm, and lack of distractions.[27] EMOA may feel overwhelmed by the service system and may not understand what is expected of them during their appearances before health care providers.[11]

Language differences between patients and service providers can present significant challenges. A client's inability to describe or explain their concerns and treatment needs impedes access to mental health treatment and support.[11,18,27] The presence of an experienced native-speaking practitioner contributes to higher rates of service uptake.[28] However, native language health professionals and interpreters are often unavailable and EMOA have to rely on family to provide translation.[5] The presence of an interpreter, particularly a family member, can interfere with disclosure of concerns and treatment needs due to feelings of embarrassment, judgment, and lack of impartiality.[11,13,23] In these cases, EMOA may be reticent to discuss stigmatized issues such as elder mistreatment, neglect and substance abuse.[13] Family interpreters may withhold information from either the health professional or

older client in order to control the interaction and protect the patient and/or family.[11,13,21] They may also lack understanding of mental health issues, impacting the accuracy of interpretation.[23]

v) Adjudications

The adjudications dimension refers to judgments and decisions made by mental health professionals, which influence continued access to services and interventions received by EMOA.[10] Cultural differences, psychosomatic expression of illness, language and communication barriers between clients and clinicians significantly affect adjudications.[17,18,19,27] These challenges complicate diagnostic processes such as in establishing patient history and using mental health screening tools based on language recognition and ability.[19] Literature emphasizes the importance of cultural and linguistic adapted screening, assessment, and diagnostic tools (e.g. for depression, cognitive impairment, physical health, social support, life satisfaction, quality of life) in order to ensure that the meaning and content of diagnostic procedures correspond with the clients' needs.[16,17,22,28] Treatment uptake by EMOA is more likely when culturally sensitive psychiatric evaluations are used.[28]

Adjudications are negatively affected when service providers are lacking cultural competency,[18] reflecting an inadequate specialized training regarding best practice with EMOA.[21] Low levels of cultural understanding among health providers are associated with a lack of confidence, trust, and compliance among EMOA.[17] Practitioners may be perceived as not listening[15] and EMOA may believe that the practitioner is unable to meet their needs.[21] Indeed, language barriers become a more significant issue without an understanding of culture.[27] Literature emphasizes the importance of focusing on EMOA's personal and familial cultural history (including immigration status, social support and levels of acculturation) when considering mental health supports for EMOA.[19]

Mental health practitioners vary in their level of training, skill, and confidence in terms of identifying mental health issues among EMOA populations.[8,20,21,27] Practitioners may view indicators of depression, anxiety, and cognitive impairment as normal symptoms of aging.[8] Value-based decision-making can impede adjudications.[15] This includes biases or prejudice in terms of cultural stereotyping, over-generalizations, or "statistical discrimination" (making decisions based on knowledge of probability of groups having certain conditions).[18,19] Ageist attitudes can also lead to inaccurate or insufficient treatment for older adults with mental illness.[8] In addition, structural level factors influence adjudications. Immediate pressures on time available for consultation and treatment, staffing shortages, lack of resources, paperwork, workplace culture (e.g., interest or support from management), competing clinical priorities, and capacity to integrate different aspects of care all impede the ability of mental health providers to establish a trusting relationship with EMOA.[13,15,27]

vi) Offers and resistance

This dimension describes resistance and acceptance by EMOA to service referrals and/or offers of treatment and medication made by professionals.[10] Literature emphasizes the importance of a practitioners' language when making offers for mental health treatment or support.[20] Alarming, stigmatizing, or discouraging terminology and tone can cause resistance among EMOA.[20] A lack of trust, either in the treatment (e.g. medication) or in the prescribing mental health professional,[5,7] poor understanding of a service's purpose, as well as feelings of embarrassment or shame to receive support[5] commonly result in resistance. The stigma associated with mental health service use is a very salient barrier to accepting offers.[8,12,13,15,17,18,23,26,27,28] Beliefs and values about self-control and "self help" may also play a role.[1,5,9,15,26] Fear that use of services will result in loss of independence highlights the importance of freedom

and autonomy with respect to mental health.[1,5,11,15]

Services on offer may be perceived as inappropriate for cultural or religious reasons.[5,18] EMOA may prefer homeopathic, alternative, or traditional treatments and remedies.[2,5,16,18,25] Religious or spiritual healing practices (e.g. meditation, prayer, fasting, rituals) are also important for some EMOA in coping with mental health challenges and mental distress[1,9,11,18] and often influence health perceptions and decisions.[11,17] Western medicine may only be accepted if the problem does not eventually resolve.[18] EMOA's beliefs can influence the effectiveness of medical interventions and treatment compliance and therefore must be incorporated into treatment and care plans.[11] Difficulties arise when practitioners view mainstream care as superior to traditional healing practices.[11] This can result in cultural tensions between professional views concerning the patient's 'best interests' versus EMOA's preferences for care.[21]

Cultural norms related to expectations of, and reliance upon, family care and support impact acceptance and resistance.[11,18,19,21,27] EMOA may feel that health concerns are best addressed within the family context and thus involve family members in personal decision-making.[11,13] Values based on filial piety and kinship care, support, and reciprocity will determine what care is needed and acceptable by EMOA.[18] Home support may be resisted out of concern for respect and the belief that care should be provided by family or community rather than by "outsiders".[21,27] Support from trusted ethno-specific community agencies[18,23] as well as through social groups and day centres[5,27] may be better accepted by EMOA over formal services focused on mental health (e.g. day hospitals, community nurses). Community based mental health support may be especially crucial for EMOA who lack family and peer support. Ethno-specific mental health workers are perceived as the most acceptable support by EMOA who appreciate receiving treatment from someone of the same ethnic background.[18,23]

EMOA with mental illness are at particular risk of non-adherence to prescribed treatment.[18] Mental health challenges can be associated with functional impairment and cognitive deficits, which impact understanding of treatment offers and instructions for medication.[8] Language and literacy barriers also impede understanding of health materials.[19] EMOA may feel overwhelmed by formal services, treatment procedures, and expectations, resulting in noncompliance and poor outcomes.[11,19] Clients may pretend to understand or agree with practitioners in an attempt to please, appear compliant, or avoid embarrassment,[11] even when they are dissatisfied with allocated supports.[15]

Financial challenges also impact compliance. Cost determines which referrals or treatments EMOA and their families can or cannot accept.[2,11,13,27] Ineligibility for insurance benefits, delays in health care cost reimbursements, and lack of pension negatively impact acceptance of offers, particularly for older immigrants.[13,27] In addition, EMOA face significant economic challenges related to employment including non-recognition of education and work experience as well as ageism.[13,16,27] These prejudices are compounded for persons with mental health challenges.[8] Finally, transportation needs and physical accessibility influence EMOA's ability to comply with service and treatment offers.[11,13,15,27,28]

vii) Local operating conditions

This dimension describes locally specific influences on Candidacy that impact interactions between EMOA and practitioners, including the perceived or actual availability and suitability of resources.[10] Generally, culturally appropriate mainstream services for EMOA are lacking as are services or resources that combine mental health or psychiatric, geriatric, and ethno-cultural care.[13,17,18,23,27] Bilingual/bicultural health professionals, who can provide culturally and linguistically competent services, are often unavailable within mainstream

services.[5,20,23] In addition, there is a paucity of age-appropriate mental health services and programs for older adults (e.g. mental health education, clinical or rehabilitative programs) that address issues such as social isolation and socio-emotional support.[8,18,27] Poor coordination and integration across service delivery networks (e.g., between mental health and elder abuse services), has been noted.[8] Environmental factors, such as neighbourhood and housing quality, also impact the dimensions of Candidacy. Service access is compromised when older adults live in deprived or unsafe areas[5] or when they experience home insecurity or poor housing conditions.[24]

Discussion

This review has uncovered a number of complex and intersecting factors that impact access to and use of mental health services by EMOA and contribute to our understanding of what sensitive, appropriate, and effective mental health treatment interventions may look like. Generally, there is a lack of effective and culturally appropriate mental health intervention strategies for EMOA in Canada, as well as a lack of research examining best practices for diverse communities. However, a range of interconnected and overlapping factors influence the dimensions of Candidacy and are further discussed below. This is followed by recommendations for knowledge users to consider in the provision of mental health supports for ethnic minority seniors and their families.

Identification of Candidacy for mental health care is affected by limited knowledge and/or awareness of mental health conditions. Cultural and religious beliefs also shape EMOA's understanding and expression of mental health challenges. Other influences on identification include beliefs about self-control, fear of stigma associated with mental illness, negative perceptions and experiences of mental health care, and family influences including cultural norms of family support and household roles. Navigation of mental health services is negatively impacted by limited knowledge of available services, lack of service options, language barriers, as well as a reliance on traditional, informal, and non-specialist care. Family support is key during navigation, where dependence on family ties affects resource mobilization (i.e. social capital). The availability of interpretation services, physical and geographic accessibility, and institutional discrimination (including racism, ageism, and sexism) affect navigation and the permeability of mental health services. Financial difficulties, employment challenges, and limited insurance coverage (particularly for older immigrants) negatively influence the resources available to locate services and accept offers for support.

Appearances by EMOA at mental health services are shaped by cultural expressions of illness symptoms and language barriers. Communication challenges impact diagnostic processes, practitioners' understanding of patient concerns, and adjudications and treatment offers. Other influences on adjudications include practitioners' limited understanding of cultural beliefs and values, discriminatory attitudes or practices, as well as institutional constraints and pressures. Resistance or acceptance of referral, intervention, or treatment by EMOA may be based on negative perceptions of practitioners or services, a lack of understanding, and fear of shame or stigma. Offers for support may be resisted based on perceived cultural or religious appropriateness as well as preferences for traditional or spiritual treatment, family and peer supports, and practical concerns related to finances and transportation.

Finally, local conditions impacting access include a general lack of appropriate options for mental health services, a lack of bicultural/bilingual mental health workers, negative perceptions among EMOA of service quality and of service providers (including issues of trust and confidence), as well as structural discrimination in terms of service configuration. Geographic and neighbourhood contextual factors also play a role, as do immigration and settlement

processes such as acculturation, available family support, and financial insecurity.

Recommendations

1. Mental health interventions must respond to the cultural and language needs of EMOA. Bilingual and bicultural service workers are needed to provide culturally sensitive services. Service documentation and health information (including forms, pamphlets, handouts) must be translated into different languages, use culturally sensitive content, diverse means of transmission, and be considerate of the time and place of delivery.

2. Practitioners must recognize that mental health issues among EMOA may not correspond with English or clinical definitions. Screening, assessment, and diagnostic tools must be culturally and linguistically adapted and validated for use with EMOA.

3. Interventions must accommodate EMOA's specific and diverse understandings and expressions of mental health, which shape help-seeking behaviours, coping, and ultimately acceptance of treatment. These include cultural and spiritual beliefs as well as the psycho-somatic expression of mental distress.

4. Mental health services must provide a supportive environment in which cultural and spiritual beliefs and practices can be discussed. Services must be accessible in terms of location, available transportation options, and physical accessibility. The impact of mental distress or illness on physical mobility must be considered for service provision. For some older adults, home-based services may be preferred.

5. Public and internalized stigma associated with mental health must be addressed through community education. Social inclusion and activity for all EMOA must be promoted to minimize the risk for isolation and loneliness, as well as foster self-help and peer helping. Such initiatives might include voluntary activities and intergenerational programming, especially for EMOA who lack a supportive family network.[20] In parallel, mental health interventions should support development of mental health knowledge and supports for family caregivers of EMOA.

6. Treatment plans must be individualized and tailored to meet the specific needs of the older client. It is important for mental health professionals to address personal and familial background, immigration status and acculturation. Offers for support must be appropriate in terms of cultural and religious beliefs, norms and family involvement. Care plans must balance traditional and modern medicine in order to enhance effectiveness and compliance. Practitioners also require knowledge and understanding of how to accommodate family support in care planning and treatment intervention. This includes addressing potential challenges associated with family involvement such as privacy concerns when using family interpreters and the influence of family norms during offers and resistance.

7. Mental health services should include options for community supports, such as social groups and day programs provided through ethno-cultural agencies. Since many EMOA prefer to receive mental health support from their primary care physician, it is important that formal supports be integrated with primary care services.

8. Service models must be revised to better address the multiple health-related and socio-economic challenges that impede mental health treatment for EMOA. For example, immigration and settlement processes linked to levels of acculturation, ethno-cultural identity, length of residence in Canada, charter language ability, social isolation, sponsorship dynamics and financial insecurity, impact all dimensions of Candidacy. Ongoing case management and socio-emotional programs are key to address the broad range of factors that impact mental wellbeing over time for EMOA.[4] Accordingly, longer-term funding models are required to sustain the provision of continuous mental health supports.[13]

9. Mainstream mental health services should work to build connections and partnerships with trusted ethno-specific community organizations to facilitate service promotion and engage in a process of needs-based program development in the context of EMOA's own community.

Conclusion

A number of crosscutting factors influence multiple dimensions of Candidacy for EMOA requiring access to mental health treatment and support. These include cultural and religious beliefs and values, language and interpretation difficulties, the central role of family care and support, perceived cultural appropriateness of services, reliance on traditional or informal treatment and care, service accessibility, financial challenges, and local conditions. The findings from this review contribute to our understanding of EMOA's mental health experiences and provide insight for developing appropriate interventions for this population.

However, the current literature does not adequately respond to the guiding research question, namely, which mental health treatment interventions (particularly those at the levels of health care system and delivery) work well for EMOA in Canada. This reflects a significant need for intervention research in this topic area in order to support the development and provision of sensitive, appropriate, and effective interventions for increasingly diverse older adult populations. These interconnected and overlapping factors must be considered to promote appropriate and effective strategies for mental health treatment interventions for EMOA.

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Chapter Five: Intervention Strategies to Address Abuse of Ethnocultural Minority Older Adults from Different Communities

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Introduction

Ethnic minority older adults (EMOA) represent a significant proportion of older adults (65+) in Canada: whereas 30% of the older adults were immigrants in 2006, this proportion was nearly 70% in the metropolitan area of Toronto.[19] Immigration, settlement and family obligations are key issues affecting the health and wellbeing of immigrant older adults. In light of particular concerns surrounding elder abuse and neglect in the post-migration context,[15,16] the ability of EMOA to access support services is paramount.

This report discusses the capacious factors that influence the experience of elder abuse and neglect among EMOA and access to support services. We focus on the social, cultural, political and economic factors that impact older people, their caregivers, and service providers. Intervention strategies to address abuse and mistreatment are also discussed.

Research Question

As Director of the *Changing Lives and Family Violence Programs* at Family Service Toronto, our knowledge user partner Dr. Lisa Manuel was interested to ascertain: What types of intervention strategies address abuse of ethno-cultural minority older adults as it is defined and experienced in different communities, especially those coming from war-torn countries?

Methods

A literature search was undertaken to identify relevant studies for review. Search terms included: ethnic minority seniors; abuse and neglect; sponsorship; immigration; access to services; immigrant health; refugees. Emphasis was placed on older adults from war-torn counties. Twenty-six articles were reviewed for this report. The majority of studies emphasized the experience of Tamil, Punjabi, Chinese, Vietnamese, Japanese and African-Caribbean immigrants and refugees. The Candidacy lens[4] was used to review the literature. As highlighted below, each dimension of Candidacy is explored in relation to the unique experiences among visible minority communities living primarily in North America and the United Kingdom.

Findings

i) Identification of Candidacy

In situations of abuse and neglect, the identification dimension refers to the process in which EMOA recognize abuse and mistreatment and a need for intervention. A widespread lack of awareness of elder abuse and mistreatment undermines identification of Candidacy by EMOA[11] and service providers.[2] As there is no minimum standard of care for older adults, health professionals overlook warning signs of abuse, especially in cases of neglect.[2,28]

EMOA's conceptualization of abuse may not correspond to mainstream definitions.[1,2,5,7,15,16,18,21,22,24,27,28] The term 'abuse' can connote extreme violence when translated into certain languages.[7] Chinese older adults, for example, have indicated that they would be more likely to report elder abuse if the situation constituted a 'criminal case'.[5,28] 'Senior abuse' has been described by Punjabi older adults to include a lack of respect, being forced to baby-sit, social isolation, and loneliness.[18] Receiving the 'silent treatment' from children may also be seen as an abusive behaviour.[11] It is recommended that term 'mistreatment' be used to better address the spectrum of abuse and neglect experienced by EMOA.[1,7]

The multidimensional effects of elder abuse and mistreatment are compounded by emotional distress from adjustment factors, language barriers, and cultural isolation, all of which interfere with identification of candidacy to services.[12,13,21,22,25] Acculturation[2,11,12] and cultural norms of filial piety[12] impact perceptions and tolerance levels of abuse and mistreatment. Community expectations and ideals of familism are also underscored. Concerns for the welfare of children and grandchildren,[8,9] fear of shame,[1,7,21] and fear of 'losing face' in the community[5,12,28] negatively impact identification and help seeking. Factors related to immigration, such as fear of deportation or loss of sponsorship[3,6,7,8,17,18,24,26,27] and pre-migration experiences of trauma, especially among refugees,[8,9,11,12,13,17,29] hinder the ability of EMOA to recognize abuse and mistreatment and seek help.

ii) Navigation

After identifying their candidacy, EMOA must have knowledge of available support services and the ability to mobilize practical resources in order to use them.[4] Lack of knowledge[2,5,8,11,12,21,22,28,29] and low levels of social capital[6,7,8,9,18,17,25] negatively impact navigation by EMOA and their family caregivers. Navigation depends not only on literacy but also on an understanding of service configuration, which places newcomers at a disadvantage.[8,9,12,13,21,22,25] EMOA may view health professionals as primarily concerned with physical ailments and thus do not consider disclosing experiences of abuse and mistreatment, especially in cases of emotional or financial abuse.[2,5,13,28]

Navigation is constrained by a number of factors affecting EMOA. These include a lack of time due to paid and/or unpaid work, low income, unfamiliarity with Canadian living (weather, transportation, language), as well as social and geographic isolation.[6,7,8,9,12,1317,18,26,27,29] A lack of community support for new immigrants and refugees can lead to social isolation.[15,16,17] EMOA who have aged in Canada may share similar experiences of isolation.[26] As a service provider describes:

The seniors who are sponsored to come here are relegated to babysitting duties. They are very isolated, they don't have money for transportation, they're not able to link to other seniors in their community. Sometimes they have been here ten, fifteen years but they haven't been able to learn the language because they have been isolated and kept in the

home as babysitters (p.69).[26]

Limited social support, financial dependence, and fear of stigma impede navigation among immigrant women experiencing intimate partner violence.[6,8,9,18,27,29] Literature also underscores fear of deportation, fear of involvement by public authorities, and perceived racism and discrimination.[13] Indeed, citizenship and sense of belonging to the community impact EMOA's feelings of entitlement to receive services.[6,8,9,13]

iii) The permeability of services

This dimension of Candidacy refers to the manner in which services are organized and made available to service users. Service permeability is restricted by implicit and explicit gatekeeping such as referrals, multiple appointments, wait-lists, and the requirement for stable addresses and other qualification criteria.[1,3,7,24,27] Researchers report that service providers may be reluctant to accept new clients with multiple health issues, linguistic challenges, and complex insurance coverage in the United States.[17] EMOA who experience immigration and settlement issues (such as isolation associated with coming to a new country, learning new customs and increased dependence on adult children) or do not qualify for services are forced to endure situations of abuse.[2]

A lack of cultural alignment between services and clients contributes to low service permeability.[1,3,7,11,12,13,17,21,22,24,25,27] Incorporating cultural perspectives within service delivery is critical to increase permeability for members of immigrant communities.[1,7,16,24,27] For service providers working with EMOA in the UK, an overwhelming response to specialized services precluded the need for service promotion or advertisement.[7]

Service permeability is affected by the ageism apparent in the overall lack of services for older adults.[27] EMOA report feeling socially isolated due to the impact of institutional discrimination as evidenced by inadequate healthcare and social services for immigrant older adults and their exclusion from government programs.[1,11,12,13,17,21,22,25] In this way, formal institutions reinforce abusive situations rather than create solutions or provide intervention for EMOA.[27] Service providers note funding limitations and other systemic factors such as inadequate government assistance for seniors, inadequate safe housing and family poverty, stigmatization that undermine their ability to adequately respond to EMOA.[26,27]

iv) Appearances

EMOA are required to have a set of competencies in order to assert a convincing claim regarding their candidacy for support or intervention.[14] These competencies include "the ability to formulate and articulate the issue for which help is being sought, and the ability to present credibly" (p.13).[4] EMOA and their family caregivers are at peril when they are unable to clearly articulate their experience of abuse. EMOA have reported ambivalence, belittling or dismissive behaviour by medical professionals.[27] The narratives of older adults from disempowered, disenfranchised and marginalized groups suggest that interactions with health professionals are influenced by power differentials related to socio-demographic factors.[7,8,9,17] Gender, age, race and class mediate the disclosure of abuse and thus access to statutory support.[7,8,9,17] Conversely, successful appearances are more likely to result when EMOA can access culturally specific services and professionals with whom they can easily relate.[1,2,7,17,18]

During appearances at health services, EMOA may report symptoms of insomnia or back pain rather than disclose abuse or neglect.[11] Korean older adults in New Zealand expressed the effects of abuse in relation to 'Haw-byung', an anger syndrome known as "fire-illness".[21,22] The effect of stigma also comes into play during appearances. EMOA may be reluctant to

report abuse in order to preserve family harmony and honour[28] or to prevent "losing face" in their community.[5]

Language and communication issues negatively impact appearances of EMOA at health services and can extend beyond the initial consultation to subsequent appointments and follow-up support.[17] Service providers are often unable to provide interpretation services due to restricted budgets and limited resources.[1,3,7,8,9,18,24,27] Candidacy for care is clearly compromised when EMOA are unable to successfully present their need for support.

v) Adjudications

Following appearances at health or support services, adjudications or judgments made by professionals about an EMOA's claim for candidacy impacts access to intervention and support services. Inaccurate adjudications inhibit the progression of Candidacy. Racism and institutional abuse have been cited as causes of unequal access to state-sponsored care and support.[7] Ineffective assessment and referral processes are also underscored.[1,3,7,24,27] The failure of service providers to recognize abuse can be construed as complicity in maintaining abusive situations.[1,7]

These issues reinforce the notion of Candidacy as a process without a defined timeline.[4,14] Based on access inequities across public services, many older adults and their caregivers are often forced to wait for protracted periods of time for services.[7] EMOA risk further stigmatization when their situation is not accurately adjudicated. This scenario, which may be regarded as unresolved candidacy, captures the idea that one's candidacy journey may be incomplete. Structural forces resistant to individualized solutions present a significant barrier to accessing services,[14] even when EMOA may be able to engage with services.

vi) Offers and resistance

Offers for support services can be appropriately or inappropriately recommended by service providers and either accepted or refused by EMOA. Literature emphasizes the perceived appropriateness of offers, especially in terms of service language.[4,14] EMOA may have to choose between having their confidentiality compromised by the presence of a family or community member to provide interpretation or else remain on a waiting list for services in their own language.[7,17] Many EMOA are forced to remain in abusive relationships in order to avoid ostracism by family members, such as adult children, for accepting help.[8,9,25] For older Tamil women, pressures related to lack or loss of finances and fear of living alone played a significant role in the decision to leave an abusive situation.[8] These factors also contributed to stress and loss of self-esteem.[8]

EMOA often refuse offers for litigation or police involvement.[2,11,12,13,21,22] EMOA are typically marginalized and belong to groups that are located outside of mainstream cultures. Therefore, effective intervention strategies in cases of abuse and neglect may also lie outside of the mainstream. Restorative justice, for example, recognizes that traditional approaches may not provide justice for all ethno-cultural minority groups and also takes into account strengths of EMOA and definitional differences of abuse and neglect between groups.[15] Thus as an intervention strategy, restorative justice approaches may present an alternative to the traditional justice system.[15]

Despite an overall paucity of intervention strategies addressing elder abuse among EMOA, let alone their evaluation,[23] there is evidence that participatory action strategies hold significant potential. For example, participatory action theatre has been used by a multiservice organization in Toronto to engage EMOA through short plays and community development

projects.[20] This model can reduce linguistic and literacy barriers and promote opportunities for collective problem identification and solving. Researchers contend that a cross-sectorial approach involving policy makers, agency administrators, social and health professionals, community leaders, researchers, and older adults themselves is vital to elder abuse prevention and intervention.[9,10,16,23]

vii) Local operating conditions

Overall, the production of candidacy is considered to take place at the local level. Potential service provider responses (which are often discretionary) are an amalgamation of structural and localized perceptions, social values, and resources. Given that formal services for EMOA are funded municipally, provincially and federally and/or provided within a broader systemic framework of provincial and federal priorities, decisions taken at these levels invariably affect local operating conditions such as localized priorities and resource distribution. Time and resource constraints in clinical settings often restrict health professionals from providing sufficient support; for example they rarely have time to have the detailed discussions with EMOA that are needed to identify experiences of abuse.[2,5,11,12,13,21,22,24,25,28] Many families are bound together by a culture of collectivism, a family centred norm, familism, which raises the interests of the family above those of the individual. Government policies, funding priorities and societal expectations are often structured around the ideology of familism – the ideology that families should support and care for their elderly members or that the family unit is the best and most cost-effective provider of care.[8,9,12,16,18,29] This can pose a risk for older immigrant women for example, as they are often forced to remain in abusive relationships or face ostracism if they leave.[8,9,25] Without question, these policies restrict service configuration and reinforce dependence of vulnerable EMOA experiencing abusive situations. As McKeary and Newbold[17] assert, "the solution must be addressed at the policy/governmental level by acknowledging that accepting refugees (and immigrants) must be simultaneously recognized within health care budgets…." (p.530) and budgets for social services as well.

In the local context of Ontario, the provincial Strategy to Combat Elder Abuse exists to raise public awareness of elder abuse, training front-line service providers and coordinating existing community resources.[3] However, there are no specialized services for older adults in general and for EMOA in particular within the strategy. Government funded local services such as shelters and transition houses for survivors of family violence accept all ages; however, underlining assumptions are that they are victims of intimate partner violence (IPV) and come from a younger population. Most EMOA do not define abuse and neglect within the context of IPV and thus may not access related programs.[29] Incongruence between such local contexts and EMOA's identification limits EMOA's candidacy to services.

Discussion

The findings contextualized the ways in which elder abuse and neglect is defined and experienced within EMOA communities and highlights the unique ways in which they move through the stages of Candidacy. However, in considering our knowledge user's question, it is clear that the literature does not adequately address intervention strategies that concern abuse of ethno-cultural minority older adults as it is defined and experienced in different communities. Furthermore, research has yet to address the additional layer of trauma among certain groups such as older refugees from war-torn countries. Government policies, the experience of immigration in late life, and dependence on sponsoring families impact the risk of experiencing abuse. Structural factors, barriers to knowledge, and an overall lack of appropriate services reinforce dependence of EMOA on their families in the post-migration setting.

The definitions and experiences of elder abuse and neglect by EMOA are contextual and determined by a host of socio-economic and cultural factors. The subjective ways in which elder abuse and mistreatment has been examined in the literature is useful to inform the candidacy process in understanding access to support services for EMOA. The marginalized position of EMOA in relation to mainstream culture permeates their candidacy by impacting identification of abuse, help-seeking behaviour, availability of appropriate services, and eventual service uptake or resistance. The unique needs of diverse immigrant and refugee communities must be recognized in order to develop effective intervention strategies and ensure equity in access to health and social services. The following recommendations are important to this end.

Recommendations

1. Definitions of elder abuse and mistreatment should focus beyond extreme and overt forms of violence in order to capture the range of situations and inappropriate behaviours that EMOA experience. Public discourse and service providers must reach consensus regarding definitions of abuse, mistreatment and neglect as well as minimum expectations of care for older adults. Since EMOA may not necessarily identify their situation within the context of intimate partner violence, it is important for services and programs to be based on a wider framework.

2. Community education is paramount in the promotion of awareness among EMOA of elder abuse and mistreatment, their rights, available services and supports, and to reduce stigma related to help seeking and accepting offers for support. Information provision regarding how to assert a claim for candidacy should be included in the service delivery mechanism of agencies serving EMOA. Health and social service providers require education regarding the identification of elder abuse and mistreatment, options for support, as well as cultural responsiveness and the building of trust and rapport with EMOA.

3. National and provincial policies regarding immigration must be examined and revised in order to avoid reinforcing the dependence of EMOA in post-migration settings. Policy must attend to the isolation of EMOA, such as considering affordable transportation options and income security, in order to facilitate navigation and acceptance of offers. Policy considerations should include specific programs aimed at immigrant and refugee groups who face linguistic and/or material challenges.

4. Ethno-specific community organizations require additional resources to facilitate outreach and related supports (such as education, counselling, safe havens, case management etc.) for EMOA experiencing social isolation. Agencies may liaise between EMOA and the service system and work with community members to provide culturally congruent services.

5. Funding models and service configuration require continued assessment so that we can improve service permeability and service response by reducing waiting times and re-examining and removing stringent qualification criteria.

6. At the systemic level, policies and programs promoting restorative interventions may be more beneficial to EMOA than mainstream strategies. Alternative approaches such as restorative justice approaches and participatory action strategies should be considered and evaluated for their efficacy in addressing abuse and neglect among EMOA.

7. Increased research attention regarding the experience of abuse and neglect by EMOA in general and refugees in particular is required. The development and evaluation of intervention strategies is key in order to formulate guidelines for best practice in this complex domain.

Conclusion

There is a paucity of research on abuse of EMOA from war-torn countries and evaluating intervention strategies that organizations might use to support EMOA. Our review of current literature, using the Candidacy model, reveals the ways and processes in which EMOA, their family caregivers, and service provider organizations understand, define and address abuse and mistreatment. The analysis further highlights these processes are invariably linked to social, cultural, economic and political factors and the interplay of these complex factors must be considered in order to develop, maximize access to, and administer effective intervention strategies to address abuse and mistreatment of EMOA.

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Chapter Six: Exploring interventions that enhance the health and healthcare access of ethnocultural (racialized) older adults in rural, very small and/or geographically isolated communities.

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Introduction

Health has been conceptualized as not only the absence of disease or infirmity but also as a state of complete social, physical, and mental well-being[72] which is embedded in cultural expectations and meanings.[60] A lack of access to equitable healthcare services contributes to health disparities particularly given the unique barriers that some groups experience.[8] Although access to healthcare embodies the social value of equity in Canada,[3,41] an emerging body of literature indicates that ethnic minority older adults (EMOA) face significant challenges in accessing healthcare. The term EMOA is used to denote newcomers to the province as well as racialized[†] older adults who have aged in place. The challenges they face result from intersecting disadvantages along multiple axes of inequity including sociocultural characteristics, income, gender,[37] immigration status,[24] place of residence[10] and language.[54,73]

Residing in rural or remote and geographically isolated areas also compounds access barriers for EMOA.[43] According to Statistics Canada,[62] a rural area consists of fewer than 10,000 people and is located outside of large urban centres. Researchers conceptualize rural communities as geographically isolated areas and/or under-populated with inadequate infrastructural development.[19] Isolation and loneliness are major concerns among older cohorts in remote and rural Atlantic Canada due to small populations, non-existent community programs, limited facilities, high travel costs and severe weather conditions.[35]

In Newfoundland and Labrador (NL), a high percentage of the population is ageing: 16% of the population in 2011 was aged 65 and older (the national average was 14.8%); this population is projected to double to 36% by 2031.[65] Moreover, nearly half of the total population of NL resides in an isolated area.[65] Improving health services for older adults in the province is a priority for the government; considerations for racialized older adults must be included in that agenda.

Recent immigration strategies aimed at recruiting and retaining newcomers to the province are expected to help support labour market needs and replenish a declining population due to rapid out-migration and the ageing population.[26] The majority of new immigrants arrive from China, but they also come from East and South Asia, Africa, the Middle East and the Caribbean.[16] In 2006, the NL racialized population was approximately 5,720 and included South Asians (1,590), Chinese (1,325), Blacks (905) and Koreans (60).[64] Consistent

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† We use the term "racialized" rather than "visible minority" more commonly used by the Government of Canada[63] because it acknowledges the problems arising from discrimination based on essentializing generalisations that reference phenotypic characteristics rather than an assessment of the whole person.

with the healthy immigrant effect, the health status of recent immigrants may be adequate in comparison to Canadian-born individuals, but many experience significant health deterioration during their first ten years in Canada.[14,22] Compared to the general population, EMOA and recent immigrants experience slower rates of recovery after hospitalization;[55] and report lower satisfaction in accessing the Canadian healthcare system.[39] Equitable access to healthcare is therefore a concern for both newcomers and racialized older adults who have aged in place in NL.

Research Question

Although literature addressing healthcare access among EMOA in rural and remote areas is limited and fragmented, the trends discussed are useful to frame this report's research question: What types of interventions enhance the health and healthcare access of very small and/or geographically isolated, rural EMOA, who may lack larger community networks and the institutional completeness to ensure that they can access health and social service providers who speak their language?

Methods

A literature review was conducted to identify relevant studies on health and healthcare access among racialized older adults and rural populations. This search was primarily conducted in a database developed during a scoping review on the health and health care access and utilization of EMOA.[38] The Google Scholar database was also used to search for articles published between 1970 and 2014. Two searches were conducted: 1) a primary search was done using the following keywords: ethnic minority older adults, healthcare access, rural, and language barrier(s) and 2) a secondary search which included the following terms: ethnic minority AND healthcare access, health services utilization AND rural residence, ethnic minority AND rural residence. Academic peer-reviewed studies, published in English were selected in addition to documents from the grey literature (e.g., institutional and government reports or projects) were also included. The reference lists and citing articles for the selected publications were inspected for further studies. Fifty-three articles were reviewed, sixteen of which included a focus on ethnic minority populations. Emphasis here is placed on EMOA in Canada and specifically in NL; however, examples from the U.K. (which has a comparable health care system) and U.S.A are also included. The Candidacy lens was used to review the literature and findings from the publications have been highlighted relative to the seven dimensions of the framework.

Findings

i) Identification of Candidacy

The first dimension of Candidacy involves recognizing one's need and deservingness for healthcare.[17] Geographically isolated and marginalised groups often manage their health in response to crisis events and may not seek help related to disease prevention.[40] Older adults who live in rural areas, have fewer visits to general practitioners, specialists, and dentists compared to their urban dwelling counterparts.[2,45] They are also more likely to use emergency rooms.[32] A lack of healthcare services coupled with EMOA's reluctance to use available services creates dependency on familial relationships. Mair and Thivierge-Rikard[42] support this idea by suggesting that family relationships are particularly intense among traditionally marginalized and isolated communities. As such, EMOA residing in rural areas

are likely to turn to familial and community-based supports over formal assistance when they experience poor health.[10] In many cases, EMOA's perception of their health or illness contributes to how they access healthcare.

Constructions of health and illness by EMOA can influence their perceptions of whether or not consultation with a health professional is warranted or deserved. Rural culture, community context, and spirituality may all contribute to such constructions.[25] Carlton-Lenay[10] found that older Black farm women chose to ignore signs of illness in their efforts to avoid the stigmatization that goes with being 'weak' and unable to complete expected work duties. Illness thus challenged both their identities as independent, as well as their economic security. Land ownership among older women in rural areas is linked to increased wealth and power and seen as a form of old age security.[36] There is often a lack of understanding of work in relation to health and illness within the mainstream healthcare system.[10] Perceptions of formal healthcare access cannot be separated or isolated from the lived experiences of racialized individuals.

ii) Navigation

Navigation requires an awareness of healthcare services that are offered and the ability to access them. There are few healthcare facilities available in rural areas and those that exist are widely dispersed.[46] Members of rural communities must travel long distances to access healthcare, often to urban centres, and transportation options are infrequent and expensive.[35] Poverty among older adults in Canada is well documented (particularly among those living in small urban centres, isolated or rural areas[50] and this has a negative impact on their health.[59] Rural EMOA are disadvantaged by low socioeconomic status and inadequate community infrastructure.[68,71] A lack of viable transportation options significantly restricts and minimizes individuals' visits to healthcare facilities for regular health check-ups and consultations with specialists.[9,67]

Access to public transportation can have an important effect on how older adults interact with formal healthcare systems. For example, an intervention to address public transportation barriers increased mammogram participation rates among older racialized women.[56] In NL, transportation costs to attend medical appointments are subsidized by the provincial government;[11,33] however, individuals may face personal costs related to loss of income from missed work and living expenses while away from home. Decreased personal mobility due to age-related frailty can also hinder EMOA's ability to travel long distances.[23] Given these concerns, rural cohorts are more likely to rely on communications technology such as the Internet to obtain health information.[69] However, services such as the Internet and telephone are sometimes minimal or compromised, especially during inclement weather.[11,33]

iii) The permeability of services

This dimension of Candidacy describes the ease with which EMOA can access services.[17] Service access in isolated areas is a standard challenge. Restricted availability of healthcare resources is a common institutional barrier in geographically isolated settings.[29,31] Rural regions do not have the institutional completeness and resources required to support the needs of racialized individuals.[47] Limited access to family physicians and culturally sensitive practitioners is a significant barrier for rural and geographically isolated EMOA.[59] Of the estimated 15% of Newfoundlanders and Labradorians who do not have regular family doctors, most (75%) reside in rural areas.[44] Access to physicians is thus a concern for a large percentage of the rural NL population and these issues are compounded for many racialized older adults.[8]

Individuals want to be cared for by healthcare practitioners who are knowledgeable about

their cultural norms and values.[17] While it may be beneficial to have care providers from within one's culture, it is not always possible outside of the family setting, especially for EMOA living in rural and isolated communities.[28] Browne[8] notes that culturally inappropriate modes of healthcare delivery hinder service permeability for EMOA. Practitioners in health and long-term care services in small urban centers of NL are often culturally uninformed about best practice for maintaining health among racialized older adults.[47] Service permeability is reduced when linguistically appropriate information about health services is unavailable.[28] In addition, after being discharged from care facilities, EMOA report feeling ill-equipped to take care of their health at home.[28] Limited options for receiving health information further hinder service permeability. For example, Gray and colleagues[29] conducted a study of Canadian women residing in rural areas who were living with breast cancer. The study revealed that patients were concerned about having to rely on physicians as their only source of health information. Permeability is compromised when services are lacking and EMOA are forced to rely on a single information source, often in a language in which they are not fluent.

iv) Appearances

This dimension describes appearances of EMOA at healthcare services and how well they are able to articulate their candidacy for medical attention.[17] In the Canadian context, EMOA are expected to present medical problems proficiently and coherently in English or French and/or display symptoms that align with mainstream understandings of health and illness. Not surprisingly, EMOA are often aware that their racialization complicates the ways in which they engage with healthcare professionals.[6] EMOA may thus avoid making appearances due to the shame of their perceived linguistic illiteracy.[15] Appearances in rural areas are greatly hindered by a lack of culturally appropriate services, linguistically congruent professionals, and interpretation services.[61] In some cases, linguistic barriers may contribute to EMOA being stereotyped as passive and distant while receiving medical care.[58] However, the steady rotation of healthcare and social service personnel in rural areas also impacts appearances for EMOA, who find it difficult to establish a trusting relationship with each new professional.[24]

Health care providers in most rural and remote regions of NL do not typically share the religious and cultural values of racialized individuals. Such differences can result in discrimination against EMOA patients by healthcare providers.[52] Religious and cultural proscriptions among some racialized people further preclude women from seeing male health professionals.[1,18,20] EMOA have thus reported feelings of discomfort when interacting with practitioners in the formal healthcare system.[52] Factors related to immigration also thwart appearances by EMOA. New immigrants may believe that contact with healthcare providers will jeopardize their immigration status and avoid health services accordingly.[49]

v) Adjudications

The adjudications dimension describes professional perceptions of a patient's claim for Candidacy, such as perceiving the patient as either deserving or undeserving of healthcare.[17] Institutionalized healthcare is often designed in accordance with Eurocentric mainstream values and norms, which can initiate and perpetuate discrimination against racialized people[51] and hence limit EMOA's eligibility for healthcare. The biomedical or allopathic model of health, which underpins the Canadian healthcare system, separates the functioning of an individual's physical body from the mind. This model is at odds with the holistic notions of healthcare held by some groups of racialized people.[7] A holistic model of care proposes that the mind, body and spirit are linked to one's social environment, emotions, and health status; professionals in the mainstream system may undermine EMOA who express holistic health views and therefore impede their access to healthcare.[13]

As noted in the previous section, healthcare providers' assumptions about EMOA may also be informed by cultural and religious stereotypes.[52] Weerasinghe and Mitchell[70] found that racialized older women with professional qualifications were concerned about being treated as uneducated and ignorant about their personal and family health issues by healthcare professionals. Doubt cast over the EMOA patients' rights to access healthcare services by discriminatory or uninformed professionals deters them from seeking and accepting the healthcare services they need.

vi) Offers and resistance

This dimension describes the active participation of EMOA in accepting or rejecting services offered by health professionals.[17] Research suggests that EMOA may resist practitioners' offers of medication and health referrals[17] and a number of factors underpin their decisions. Stephenson's study[66] with Vietnamese residents in a midsize city in British Columbia highlights several important factors that facilitate understanding of racialized people's reluctance to accept formal healthcare directives: 1) EMOA may be motivated by cultural understandings of health that differ from biomedical notions, coupled with a mistrust of Western medicine; 2) EMOA may have a preference for traditional herbal remedies instead of allopathic medicine; and 3) EMOA (particularly men) may visit doctors rarely and seek attention only during emergency situations. Research has also found that immigrants may prefer spiritual or religious types of health treatment since certain types of health concerns and related symptoms can be associated with evil spirits.[21] Spiritual and religious prescriptions, such as prayers, are believed to help cure curses that are placed on individuals and/or their families.[21] Treatment offers, particularly for mental health concerns, may also be rejected based on a fear of community stigmatization[34] and conflicting perspectives between the patient and other family members of their efficacy relative to that of spiritual solutions.[21]

For some EMOA residing in rural areas, assistance from their families and immediate communities is preferred over options for formal support. Racialized persons report satisfaction with services provided through community groups that offer language and culturally specific services, such as settlement service organizations, local health centers, and faith-based organizations.[28] Among racialized communities in NL, family members are often responsible for older relatives' care.[24] Adult children may work together as a caregiving unit in order to support the health needs of an older relative.[24] However, familial support for older adults residing in rural areas is significantly compromised by the outmigration of young people to urban centers in search of employment[12] and the historically small number of racialized people in these locations.[24]

vii) Local operating conditions

This dimension describes multiple influences on Candidacy at a macro level, such as political, economic, and environmental factors.[17] Structural barriers, such as lack of infrastructure to provide culturally sensitive services, compromise access. Low rates of service utilization in rural settings are attributed to underdeveloped infrastructure and minimal success in recruiting and retaining health professionals.[8,32] Importantly, economic restructuring has resulted in the reduction and elimination of hospital services including access to family physicians, specialists, and pharmacists.[31,53] Restructuring has also downloaded state responsibilities to families and has created an over-dependency on informal supports from community groups, family members, and volunteers.[57] The province of NL does offer transportation and accommodation subsidies for residents who must travel in order to access specialized healthcare (e.g. cancer treatment).[27] Newfoundland and Labrador's Centre for Health Information has also developed a Telehealth Program that uses videoconferencing technology to connect clients to health care providers located in another community. An evaluation of

the program reports that Telehealth was associated with high levels of satisfaction among patients and providers and also improved access to patient information, continuity among providers, and frequency of patient-follow-ups.[11] However, the applicability of the program to the health and access needs of EMOA was not examined.

Research suggests that most Canadian provinces, including NL, offer culturally responsive strategies and incentives for training, recruiting and retaining healthcare professionals.[30] However, current strategies are insufficient.[47] In an attempt to provide voluntary culturally sensitive support to patients, nurses in NL unwittingly broke confidentiality by contacting community leaders to alert them of EMOA who were admitted to hospitals.[47] In many cases, patients were reluctant to share personal matters with members of their community and felt betrayed by the nurses' actions.[47]

The immigration process is a significant barrier to EMOA's eligibility for healthcare services. Individuals born outside of Canada spend considerable time visiting government offices and agencies in order to seek clarification and obtain approval for their citizenship entitlement before becoming eligible for healthcare services.[5] These costly and exhausting bureaucratic procedures are systemic barriers that are challenging for recent immigrants to understand and navigate.[61] In addition, EMOA with limited public and/or private pension benefits or personal assets are likely to live in poverty.[10] Lack of financial resources therefore undermines EMOA's ability to access and accept offers for healthcare that are not state funded.

Discussion

This report highlights a number of issues that must be attended to when developing interventions to enhance the health and healthcare access of geographically isolated and rural EMOA, such as those residing in the province of NL. Access to healthcare in rural and isolated settings is greatly complicated by geographic location. Rural communities face challenges related to limited economic and employment opportunities, lack of service infrastructure, underdeveloped transportation services, limited availability of healthcare professionals, and out-migration of younger community members. In addition, the healthcare system is poorly structured to accommodate racialized people's needs due to a lack of culturally congruent services and the persistency of institutional discrimination. These factors often lead EMOA to rely on informal sources for healthcare support.

Families, friends and neighbours commonly provide informal support for EMOA residing in rural or geographically isolated communities. Older adults seek support from family members and cultural groups when they are unable to self-manage their care. However, access to family members and cultural communities may be very limited due to the small numbers of racialized people who reside in rural and geographically isolated regions. To compound the situation, discrimination based on multiple and intersecting social identities such as class, language, religion, gender, culture, sexual orientation, age, health status and race significantly impact EMOA's access to healthcare services. The literature fails to account for EMOA's intersecting realities, instead discussing EMOA mostly in a two-dimensional manner wherein age is viewed as the independent variable relative to which all other variables such as gender roles, health status, language, culture, or religion are dependent. In addition, there are serious gaps in the literature relative to explicit discussions of racism, sexual orientation and gender identities. Future work must consider these intersecting identities in order to fully address the experience of EMOA in accessing health and social services in rural and geographically isolated communities.

Recommendations

Interventions to enhance the health and healthcare access of geographically isolated, rural EMOA are important, especially given that they may lack larger cultural community networks and experience institutional discrimination. The individual, community and institutional health system factors impacting Candidacy must be addressed to ensure that EMOA have equitable access to culturally relevant healthcare services and culturally sensitive service providers. In particular, strategies that lie outside the formal healthcare system are necessary to address the healthcare service needs of rural EMOA. The following recommendations are offered:

Accept alternative interpretations of health and healthcare

EMOA's interpretations of health and healthcare may differ from the mainstream biomedical model to which healthcare practitioners in NL subscribe. Therefore, healthcare strategies and interventions must integrate EMOA's understandings of health, diagnosis and treatment modalities in order to facilitate identification of the need for candidacy, appearances and adjudications at health services, and acceptance of offers for treatment.

Initiate and strengthen community partnerships and networks

The strengths of rural and marginalized communities are grounded in the premise of community solidarity and close-knit relationships.[36,48] Policy makers and practitioners must therefore acknowledge and partner with community stakeholders and family networks to design effective healthcare interventions and services. Collaboration with community-based networks is essential to delivering equitable, accessible, and culturally appropriate healthcare services for EMOA in rural regions.

Schedule ongoing and integrated professional training

Cultural sensitivity training promotes respect of ethnocultural customs and traditions.[70] Providing culturally sensitivity services is key to ensuring patient satisfaction with the healthcare system.[5] Medical training must integrate complimentary and/or alternative education within the biomedical model to promote a better understanding of holistic healthcare. Ongoing training and development for healthcare professionals must include collaboration between community members, healthcare providers and EMOA themselves in a process of continual recruitment and training.[47]

Address transportation challenges

Interventions to improve access to appropriate healthcare services in rural settings must consider challenges related to transportation. Mobility limitations can impede EMOA's ability to travel long distances to and from health facilities and may be compounded by limited finances. Options for subsidized transportation services as well as in-home and/or mobile health support are necessary. Nurse practitioners and social workers may play a key role in the provision of services in rural communities by travelling to clients to deliver healthcare services in their homes or communities.[4]

Revise discriminatory and inflexible policies

Limited financial means translates into limited access to healthcare, since many of the costs associated with access are collateral to the cost of the care itself. Policy makers must be

attentive to financial challenges concerning under-employment, stringent and discriminatory eligibility criteria, and personal expenses that place financial pressure on EMOA, many of whom are economically disadvantaged. In this regard, eligibility criteria and income testing policies need revision in order to accommodate the financial needs of EMOA.

Develop and promote telemedicine

The development of healthcare service infrastructure is a necessary long-term solution to address healthcare disparities in Atlantic Canada. Telemedicine is a viable option with the potential to confer immediate gains in the delivery of healthcare services in remote and rural areas. Telemedicine services may be used to link individuals located in isolated settings to larger health centres that are better equipped, for example, in terms of bilingual/bicultural staff and related health resources. Telemedicine can also offer options for health information, screening, and management that can be tailored to the unique needs and circumstances of EMOA. NL's Telehealth program, which focuses on chronic disease management, must be expanded to meet the growing needs of EMOA who are unable to access healthcare services by more traditional means.

Conclusion

Access barriers to health care are compounded for EMOA who reside in rural or remote and geographically isolated areas, such as NL. This report has highlighted a number of multilevel and intersecting issues that must be attended to in order to address the health needs of isolated and rural EMOA. In efforts to improve the infrastructure and delivery of health care services for older adults in NL, the government must make considerations to ensure that rural EMOA have equitable access to culturally relevant healthcare services. It is crucial for healthcare organizations to recognize alternative interpretations of health, maintain community partnerships, and provide integrated cultural sensitivity training for health professionals. Transportation challenges must also be addressed, as well as discriminatory and inflexible policies that disadvantage EMOA in multiple and intersecting ways. Finally, telemedicine must continue to be pursued as a long-term solution to promote health equity in Atlantic Canada.

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Chapter Seven: Unpacking Access to Health Services and Health Promotion Programs and Information for Ethnocultural Minority Older Adults

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Introduction

In chapter one, we outlined the process of producing five topical reports in preparation for our Planning Meeting in June, 2014. All topical reports were submitted to the project coordinator (M. Badger) who imported them into NVivo 10 (2012) to allow for consistent coding. Text segments from each report were coded deductively relative to the seven dimensions of Candidacy. Inductive codes were also assigned to illustrate the types of negotiations for care defined by each dimension, as well as any outliers not accommodated by the framework. Comparisons were made across the five topics to extract patterns related to cross-cutting and topic-specific themes. In this way we identified all instances of each of the seven dimensions of Candidacy (access) across the different topics. Our cross-cutting analysis is presented in this final chapter.

In addition to shedding light on the topic of access to health care services and information and health promotion programs for ethnocultural minority older adults (EMOA), our analysis will contribute to an understanding of the relevance of the Candidacy framework to the different health and social care contexts that our knowledge users represent. It will also contribute to the development of the framework by illustrating the types of negotiations for care that define each dimension, as well as any outliers that are not accommodated by the framework.

Cross-cutting Findings: Dimensions of Candidacy

I) Identification of Candidacy

The first dimension of Candidacy, identification, describes how symptoms are recognized as requiring and deserving of medical attention or intervention.[34] Here, a desire to protect individual and cultural identity may play a role in one's decision to seek health and/or social services.[35] Negotiations during this stage take place mainly with oneself but family members may also be involved. Delayed identification of candidacy among disadvantaged populations, including EMOA, is common and can precipitate a crisis event.[34,87] Common issues that emerged across all topical reports to affect identification include:

- Alternative understandings of health and illness;
- Awareness of the health issue;
- The role of stigma;
- Family factors;
- Maintaining agency;
- Immigration factors; and
- Identification in health settings.

Alternative understandings of health and illness

The literature has emphasized that ethnic minority populations are disadvantaged by alternative understandings of health and illness: individuals may not identify themselves as potential service users and such alternative understandings are often not incorporated into existing service models.[85] Cultural norms significantly influence the ways in which people understand their health and thus perceive their candidacy. For example, ambivalent attitudes among widowed South Asian women toward participation in leisure-time activities are influenced by cultural and tradition-based gender norms constructed during early life experiences in their country of origin.[145] Such attitudes thus prevent them from participating in exercise and other health promotion activities.

There is considerable diversity in the ways in which symptoms are experienced and identified (or misidentified) by EMOA. The symptoms of dementia and mental illness, as well as inactivity in later life, are commonly normalized.[16,29,56,75,137] Also common is the attribution of these symptoms to social isolation and poor physical health.[139] Although symptom normalization may in part be due to socioeconomic status and education,[12] such normalization of symptoms can be found among EMOA with dementia and their family caregivers across diverse educational and professional backgrounds and can be related as well to the preservation of identity.[69]

Within certain ethnic minority communities, discourses of collectivism and divinity are common and may not align with Western representations of health and illness.[12] For example, family caregivers of South Asians with dementia in the U.K.[84] interpreted the disease through a traditional religious and spiritual lens: it was thought to be a mental illness caused by 'spirit possession' or 'the evil eye'. In other studies, EMOA have referred to mental health issues as spiritual weakness, an emotional imbalance or a lack of control,[75,86,141] or as punishment for sins.[86] The fatalistic belief that symptoms are beyond individual control may also result in the acceptance of health problems, precluding identification of the need for care or preventive measures.[56]

EMOA who experience depressive symptoms may identify their mental health issue as 'stress' or a 'spiritual crisis' since terms such as depression and anxiety may not be customary in their first language;[65] there is no set terminology for dementia within South Asian languages.[122] Despite having varying levels of impaired memory, South Asian older adults in a U.K. study were not familiar with the words 'dementia' or 'Alzheimer's disease'.[79] In parallel, mainstream definitions of elder abuse have been criticized for focusing on extreme or overt forms of violence (particularly when translated into some languages). Some abusive behaviours, such as disrespect and government or systemic abuse, are thus not recognized as such by immigrant seniors or by social service agencies that aim to protect their wellbeing, until there is a crisis event.[113]

Chinese older adults in several studies preferred to "wait and see" rather than seek support or treatment from mental health services.[70,136,147] This can result in help-seeking only when problems become severe.[28,86] Immigrant seniors and their families may believe that medical attention is not warranted until physical or somatic symptoms present.[121] Mental distress in particular may not be considered harmful until it manifests as a physical pathology or hinders one's daily activities.[2]

Awareness of the health issue

EMOA were commonly described as having low levels of general awareness and knowledge regarding the various health issues under investigation. This was especially pertinent

in the literature on elder abuse and mistreatment. Poor knowledge of what constitutes an abusive behaviour and to the sources of help available contribute to the underreporting of abuse among Asian communities in Western countries.[80,146] Similarly, lack of exposure to dementia and mental illness make it difficult for anyone to connect their own suffering to such conditions. EMOA are less likely to be familiar with such diagnoses due in part to the rise in incidences of dementia and depression now that people are living longer in combination with the alternative aetiological attributions of such diseases and their limited communication to the general public in their countries of origin.[16,72] While younger caregivers and other family members are more likely to be familiar with such diseases, and are often crucial in their identification, recent immigrants and those with lower socioeconomic status sometimes lack the knowledge and awareness to recognize their symptoms.[59,69]

Stigma

Negative perceptions and stigma surrounding health issues, especially concerning mental illness, also have a profound influence on the identification of candidacy for health and social services among EMOA. Numerous studies of EMOA speak to denial of health problems such as cancer, which is viewed as incurable, due to the stigma associated with them.[50,77,98,] The need for help thus goes unrecognized. The expectation within a community that victims not speak out about the abuse they experience, which is deemed to be shameful to the entire family can similarly mute cries for assistance.[53]

Stigmatization may stem from factors such as fear, shame, and social exclusion.[15,40] For example, a reluctance among Asian immigrants to report elder abuse has been attributed to 'shame culture', which can also lead older adults to believe that the abuse was deserved and should remain private.[108] EMOA may be more likely to report elder mistreatment if they believe an abusive situation constitutes a criminal case, however the fear of 'losing face' in the community may prevail.[36,146]

For families, concealing a mental health issue, such as dementia of an elderly relative, from the rest of the community may be a coping mechanism to preserve family dignity and avoid problems during arranged marriages.[16,29,84] One example is the common belief found among people of Punjabi Indian origin that dementia symptoms are caused by a lack of care, either by one's self or one's family.[73] Similarly, mental illness or distress has been attributed to interpersonal stress, failure of family members to fulfill filial duties, or a lack of family support.[75,86,141] As EMOA internally negotiate their candidacy for care, the extent to which they are respected by the family and community may impact whether or not mental health issues are expressed.[2] Men in particular may view memory impairment as a threat to their position in the community.[79]

Family factors

EMOA often exhibit cultural ideals of familism, whereby "solidarity of the family as a group supersedes the interests of individual members of the family."[94] In this context, members of both the immediate and extended family can play a key role in identification of candidacy.[69,96] While family members may misidentify symptoms of dementia for normal aging or as personality traits, they often make important observations regarding changes to personality and usual behaviour, and recommend help-seeking especially upon noting safety risks to the older adult.[69,96] Families may be more likely to facilitate identification when household life is disrupted by the older adult's symptoms. For example, the incontinence of an EMOA with dementia left one family feeing they could no longer pray at home, which they considered 'dirty' as a result.[16] This case was compounded by the family's avoidance of the temple based on their fear of shame or stigmatization by their community. Such feelings can lead EMOA to hide symptoms from family members.[139]

Ideals of familism combine with culturally-informed gendered household roles (e.g. completion of expected daily tasks), that are reinforced by structural factors such as the high cost of childcare.[3,51,71,121] EMOA, particularly women, are thus encouraged to downplay their own health needs relative to their familial responsibilities; thus immigrant older women do not necessarily share their health problems with family.[51,86] The sense of indebtedness felt by sponsored family class immigrants who co-reside with adult children, can also contribute to this tendency to minimize their apparent need for medical or social supports or access to health promotion activities.[65] The "double barreled social debilitation" (p.1772)[10] that arises from the financial, physical, and emotional dependence of sponsored immigrant seniors on family members can have far-reaching implications for identification.

Family dynamics strongly influence an older adult's decision to leave or endure an abusive situation. Among older Tamil women, for example, lack or loss of finances, fear of poverty, loss of social status in the home and community, and loss of self-esteem may deter identification of candidacy.[52] Ideals of familism may thus perpetuate mistreatment of EMOA.[53,82,107] Abuse inflicted by family members on older adults is typically under-reported due to their feelings that reporting the abuse is disloyal, their desire to protect the abusive family member and the family's standing in the community, and/or fear of reprisal, abandonment by family, and institutionalization. For EMOA these feelings are magnified by ideals of familism as well as their higher propensity to co-reside with adult children and to be financially dependent upon them, particularly if they are sponsored immigrants.[23,40,71,94,131,143]

Maintaining agency

Research has identified 'mastery'—control over one's life and the ability to deal with life's difficulties—as a personal coping resource against sadness, depression and loneliness among older Asian Indian immigrants.[33] Unfortunately, this strong desire among EMOA to address mental health challenges on their own in order to maintain personal agency[38,1,70] can inhibit help-seeking. This preference may partially result from the fear that service use will lead to a loss of independence.[38] Correspondingly, stoicism and an emphasis on endurance in Asian families may contribute to misidentification of abusive behaviours and thus the need for care and deservingness of candidacy.[81,82,109]

Personal characteristics of hardiness and independence may be valued to the detriment of identification and help-seeking, especially among EMOA living in rural settings.[87] Older rural women who have achieved some level of security and independence through landowner-ship , have been found to ignore or self-treat symptoms of illness that threaten their hard-won identities as self-sufficient.[22,62] Such perceptions of health have been linked to rural culture, community context, and spirituality, and in combination reduce the likelihood that rural older adults will seek professional health care.[47] In parallel, older adults in the workforce may put health issues 'on hold' due to concerns about employment and finances.[3]

Immigration factors

Factors related to immigration and settlement can also profoundly affect identification of candidacy among EMOA. For example, the ability of Vietnamese, Cambodian and Tamil older adults to recognize and seek help is strongly influenced by their pre-migration experiences of trauma, which can be compounded by post migration issues related to economic security, such as ineligibility for pensions and old age benefits in their new country.[52,53,80,81,82,97,148] For some immigrant seniors, fear of authorities and of jeopardizing immigration applications may impede their identification of the need for care.[45] Finally, tolerance levels of abuse and neglect are strongly influenced by fear of deportation and loss of sponsorship.[71,52,82,94]

Immigration and settlement can also influence perception of symptoms. In some cases, EMOA have interpreted their illness symptoms as resulting from loss and powerlessness or the suppressed emotions of anger and hopelessness associated with migration,[75,88,108,109] Levels of acculturation have also been shown to influence EMOA's identification and perception of elder mistreatment.[21,80,82] Among older Korean immigrants to New Zealand, researchers suggest that the multidimensional effects of elder abuse are compounded by emotional distress from adjustment factors, language barriers, and cultural isolation, all of which interfere with the process of identification of the need for care or support.[81,82,109,131]

Identification in health settings

When help is not sought by EMOA or their family members, identification may still take place within health care settings or by a health provider. In the case of dementia, this may occur when the older adult is being treated for other medical conditions,[16,69,96,103] or in response to a tipping point such as bereavement,[19] leading to referrals to memory specialists. Service providers often play a key role in the identification of elder abuse and mistreatment by noting situations in which seniors' needs are sustained at minimal or sub-minimal levels.[97] While EMOA may be reticent to report abuse or simply not perceive the mistreatment as such, health care professionals are crucial in noticing physical signs of abuse.[21,36,81,146] However, neglect is less readily detected by healthcare workers. Researchers note a lack of consensus surrounding minimum standards of care for older adults, which can cause possible warning signs of abuse and neglect to be overlooked.[146]

II) Navigation

Having established that they need and deserve health or social care and support, EMOA must locate and make their way to relevant services. These tasks require both awareness of the services available and mobilization of the necessary practical resources.[34] Findings from the topical reports suggest that the navigation dimension of Candidacy is commonly affected by the following:

- Attitude and trust;

- Knowledge;

- Language;

- Informal support;

- Stigma;

- Geographical location;

- Service level factors; and

- Intersecting determinants

Attitude and trust

Although older persons may recognize their need for health care or social supports, our review suggests that EMOA may hold negative or ambivalent attitudes towards care providers. For instance, caregivers may delay seeking a diagnosis for their family member once symptoms are recognized in order to avoid causing anguish or 'betraying' the person with dementia.[102] Delays may be exacerbated when EMOA have little confidence that the service will provide any relief. For example, Punjabi immigrants in the U.K. have expressed the belief that "there was nothing that could be done" about their dementia symptoms, and thus there was little point in seeking help from professionals.[73]

Similarly, a reluctance to seek assistance from health and social services has been noted among Korean American immigrants experiencing abuse[74] and among EMOA experiencing mental health symptoms.[28,92,136] Certain EMOA may perceive service providers as not sufficiently knowledgeable or able to understand their problems, too busy, or not wanting to treat them.[11,28,72] Delays in help-seeking are further compounded when EMOA reside in geographically isolated areas; the perceived limited benefit is outweighed by the considerable effort required to mobilize the necessary resources.[20,60]

Negative attitudes toward help-seeking by EMOA may result from a lack of trust in formal systems of health or social services due to historical maltreatment,[86,99] perceived racism and discrimination,[40,81] or for personal reasons such as negative experiences during past treatments or hospitalizations.[11] Therefore, information provision may better facilitate navigation if delivered by an independent source.[59,104]

Lack of knowledge

Parallel to the process of identification, common barriers to navigation among EMOA include a lack of knowledge of the services available. For specific health conditions such as dementia, this may include a limited understanding about the cause and benefits of obtaining a diagnosis.[104] The mental health literature is replete with examples of the inability of EMOA to navigate the complex system of services; not knowing which services to access, how to obtain a referral or schedule an appointment impeded their ability to establish candidacy for care.[3,11,33,38,59,72,86,116,121,125,141,147] The same can be said of immigrant older adults experiencing elder abuse and neglect.[21,36,52, 80,108,146,148]

Older adults who immigrate later in life may experience particular difficulties navigating health and social systems due to a history of reliance on informal means of information gathering in their country of origin;[4,149] low social capital can hinder navigation, especially for new immigrants.[69] This in turn can result in low levels of service uptake among EMOA.[4] Research suggests that previous interactions with mental health professionals are associated with a better understanding of health services.[86] Family and friends of immigrant seniors may also lack knowledge of services.[69,88] The literature describes family caregivers as being unable to identify appropriate services for EMOA, in part due to their limited ability to mobilize the social capital required to successfully seek them out.[37,40, 52,53,97,107,131] For example, a female caregiver who had been living in Vancouver for three years experienced significant isolation as she spent the majority of her time at home caring for her child and aging mother with dementia and did not know how to access the services she needed.[69]

Language

EMOA may also encounter challenges in navigating their way to services due to language and communication difficulties.[61] Language and literacy barriers to navigation have been underscored in the literature on chronic conditions,[114] falls risk and prevention,[43] and mental health.[3,59,38,88,125,147] A lack of linguistic proficiency in Charter languages may also result in social isolation, cultural alienation, and emotional distress among EMOA.[81,82,131]

Language barriers may be especially pertinent for ethnic minority women. Gender can have a far-reaching impact on older immigrant women who are kept in the home (for child-minding duties, for example) thus precluding any opportunity to learn and practice the mainstream language.[32,75,88,89,138] Older women, such as those from the Punjabi community living in British Columbia, are often heavily dependent on family members for transportation to and from health services since they may not drive, be able to afford a taxi, and may avoid public transit due to a lack of English language skills.[51] This combination of language

and transportation barriers prevented diverse EMOA from participating in a state-sponsored elderly nutrition program.[26]

Role of social networks

Support from family and friends, can be crucial for successful navigation.[32,69,75,88,96] Adult children may be an especially important resource for information and assistance in accessing the western health care system, and for emotional and instrumental support.[51,86] This may be especially salient for rural elders due to a lack of service infrastructure in outlying regions, but family members do not always live nearby.[91,130] Recent and sponsored immigrants may be especially dependent on family and others for transportation, finances, and interpretation.[11,71,141] Among older Chinese immigrants, greater perceived social support was associated with more positive mental health help-seeking attitudes.[136] Peer support in particular may be important to encourage service uptake, as older adults may be more likely to listen to other older adults with regard to help-seeking.[141]

On the other hand, instances of delayed navigation due to family support have been described. Out of respect for family hierarchy, family members may choose to discuss dementia related issues amongst themselves or with a religious leader before mobilizing practical support.[102] The importance of not assuming that support is always available to EMOA has nonetheless been underscored by several studies that found that the social networks of recent immigrants were often fragmented.[61,88,141] The absence of an established supportive community is especially acute for recent refugee arrivals.[94,97] Church groups sometimes fill this void for some older adults in rural communities; however differences in religious affiliation may cause a reluctance to seek help from such groups among EMOA.[124] For older immigrant women experiencing intimate partner violence, limited social support and financial dependence on the abuser can greatly impede the navigation stage of establishing Candidacy.[37,52,53,107,141,148]

Stigma

As seen with identification, stigma also influences navigation. EMOA have expressed concerns that "people would gossip about you if something went wrong."[73] Confidentiality presents a major issue for EMOA experiencing abuse, where factors such as fear, shame, and social exclusion can influence their willingness and ability to seek help.[15] People needing mental health services are deterred from seeking care by both "public stigma (negative attitudes held by the public) and internalized stigma (negative attitudes held by stigmatized individuals about themselves)," and the latter mediates the response to the former.[28] Bilingual/bicultural workers can be invaluable in helping EMOA and their family members to move beyond the internalized stigma; the option for those seeking care to enquire as though "on a friend's behalf" is an important strategy.[14] Such workers must be sensitive to the confidentiality of such enquiries. Awareness campaigns can be helpful in reducing public stigma, but more evidence is needed to ascertain their effect on actual help-seeking behaviour.[104]

Geographic location

Not surprisingly, factors related to geography challenge navigation. For example, many EMOA live in suburban areas while culturally sensitive services are located in city centres.[121] This issue is arguably most salient in rural communities, where there are not only large geographic distances between health clinics and clients but also shortages in practitioners and services.[54] A lack of viable transportation options significantly restricts visits to health care facilities, such as for regular check-ups and consultations with specialists[18,133] and harsh weather conditions frequently add to transportation difficulties.[17,77] These differences can impede access to service. For example, rural women who must travel between one and

three hours to screening centres are only half as likely to receive a mammogram as their urban counterparts.[56] To offset transportation challenges, rural cohorts are likely to rely on communications technology such as the Internet to obtain health information.[144] However, both the Internet and telephone are sometimes minimal or compromised, especially during inclement weather.

Navigation and service access may also be hindered when older adults live in deprived or unsafe areas,[11] or experience home insecurity or poor housing conditions.[125] Rural EMOA in particular are often doubly disadvantaged by their low socioeconomic status and inadequate infrastructure development.[134]

Service level factors

Service organization and publicity play a large role in navigation. To promote navigation to services and information among EMOA, organizations are advised to produce multipurpose leaflets outlining symptoms and the help available, as well as using neutral terms (e.g., 'memory problems' in lieu of 'dementia'; 'looking after' instead of being a 'caregiver').[101] Information provision via video or TV may be especially critical for individuals who are not literate in either English or their mother tongue.[66,91,101] Depending on the group, radio broadcasting, websites, and telephone help lines may connect most effectively with people in their own homes.[66,117] Many immigrant older adults, particularly women, are more comfortable and familiar with sources of health information generated within their own ethnocultural community.[6]

Linking agencies, such as the Alzheimer's Society and ethnocultural or immigrant settlement organizations, are important to facilitate service awareness and uptake among EMOA.[19,69] Community outreach activities such as health information 'roadshows' held at community centres and religious establishments are key to establishing links with EMOA and their families.[101] Similarly, offering health screenings and cognitive assessments in non-institutional settings can facilitate dialogue and community engagement in the uptake of health services and interventions.[50,121] In their liaison roles within linking organizations, bilingual/bicultural workers are instrumental in helping EMOA and their families to navigate mainstream services.[14,59] In geographically isolated areas, the closest proxy for this role is often the nurse practitioner.[7]

Intersecting determinants

Successful navigation requires the mobilization and coordination of diverse resources such as income, language, social support, time, and transportation, each of which influences the other. The availability of these resources depends on the intersection of social determinants of health which are influenced in turn by systemic issues such as immigration policy. For example, many Family Class immigrants are sponsored by their adult children so that they can assist in the care of their young grandchildren. Often wholly dependent on their sponsors, many also engage in low-wage labour (e.g. temporary farm work).[48,71,107,141] In combination with a lack of income and poor social support, restricted free time can constrain an older immigrant's ability to seek help.[2,68,82,97,121,139] Assisting an older family member with navigation can also be a financial burden for families, as it may mean loss of wages for missed work.[17,59]

III) The permeability of services

Service permeability speaks to the accessibility of services relative to the qualifications one needs in order to use them.[34] Factors that commonly affect service permeability include

the location of clinics, hours and language of operation, and funding models that limit the time health practitioners have per patient.[66] Relevant factors that emerged from our topical reports include:

- Service availability;

- Organization of services; and

- Ethnocultural congruence between clients and services.

Service availability

The paucity of suitable resources and services for EMOA and their families influences their permeability, because the demand always outpaces the supply and long waitlists are the norm.[59,72,115,141] In addition to funding shortages, the recruitment and retention of health and social workers into services targeting older adults presents a significant challenge, especially in rural regions.[31] Many rural hospitals have reduced or eliminated specific services including mental health services, palliative care, as well as cancer screening and treatment, thus limiting the care available to all older adults.[119] Moreover, rural regions do not have the institutional completeness and resources required to support the needs of racialized individuals. For example, health and long-term care services in small urban centers of Newfoundland and Labrador are culturally uninformed regarding best practice for maintaining health among racialized older adults.[106]

For older immigrants with mental health conditions, services that combine mental health, psychiatric, or geriatric care with ethno-specific social services are needed,[59,121,126,141] as are age-appropriate services and programs for mental health education and rehabilitation.[29,86,141] Low service availability leaves many EMOA without adequate care and burdens more permeable health services such as walk-in clinics, hospital emergency departments, and community health centres.[97] In addition, some health providers may be reluctant to accept new clients due not only to their complex health needs but to linguistic challenges and limited insurance coverage.[97]

Organization of services

Partnerships between mainstream services and those offered by the community sector can have a significant and positive impact on service permeability.[16,66] However, divergent views surrounding who should deliver what kinds of services as well as poorly integrated care may significantly minimize service access.[16] This is evident in descriptions of the lack of coordination across service delivery networks between mental health and protective (elder abuse) services.[29] High service demand, inefficient referral processes, and thus long waiting periods further decrease service permeability.[3,16,117] In some cases, there may be delays surrounding confidentiality when doctors opt to withhold information about older patients from their caregivers.[19] Some caregivers and older immigrants have had to wait decades after asserting their candidacy before they could access certain services such as seniors housing, statutory services for elder mistreatment, and specialized health practitioners.[15,21,40,97,107,112,141]

Candidacy for care for EMOA is complicated by the eligibility criteria required to receive services. In both the UK and Canada, EMOA have been aware of services but unable to obtain support for many years due to complex referral and qualification processes.[15,23,40,71,78,141] Ineligibility for services or delays have been attributed to immigration status, racialization, income inequity and other social determinants of health. The constellation of structural barriers that racialized and immigrant older adults confront are often more important than the cultural barriers to which reduced access is most often attributed.[78]

Flexibility is the key to maximizing service permeability. Services must accommodate both EMOA and their families, and offer multifaceted support such as regular phone calls and home visits. As with navigation, outreach programs are essential to connect services and service users.[13,115] Research suggests that bicultural workers with medical training, who have an understanding of cultural norms, are proficient in community languages, and are knowledgeable about the healthcare system as well as the principles of health equity and access are indispensable.[13,83,90,135] Alternatively, 'mainstream' services might consider partnering with linking agencies that possess many of the resources they need to increase permeability such as appropriate language skills and knowledge about the trust of specific groups of EMOA.[59,67]

Service permeability can also be affected by the physical and social environments in which services are offered (e.g. the creation of a welcoming atmosphere, the set-up of a clinic, the location of a program within a facility) as well as the location of a program (e.g. offered in a familiar community setting versus an institution). Both can affect levels of comfort, a sense of privacy, and/or the extent to which clients are distracted.[19,141] EMOA have also reported feeling restricted by short appointment times that do not allow for detailed discussions with health care professionals about their complex conditions, particularly when language is a barrier.[35,65] Social service providers echo this concern with time and resource constraints in delivering services to EMOA experiencing abuse.[21,36,82]

Ethnocultural congruence

The degree of ethnocultural congruence between health services and clients and its effect on service permeability is greatly emphasized in the literature on EMOA. Many health services are provided in ways that are culturally incongruent and hence unfamiliar to EMOA, particularly immigrant seniors. Such incongruences are often associated with religious practices.[15,41,64,68,76,86,113,141] For example, the availability of appropriate food has been seen to impact participation in elderly nutrition programs[26] as well as the uptake of mental health services[11] and long-term care.[38,41,66] A low degree of cultural alignment has been associated with a lack of confidence, trust, and compliance among ethnic minority seniors.[76] Mainstream services that overlook the unique needs and past experiences of older immigrants and refugees experiencing abuse can place them at further risk for institutional abuse.[15,40]

Based on their research with older immigrant women from China and India, Ahmad et al.[3,6] maintain that 'tailoring' health promotion interventions according to cultural and religious preferences should be understood as distinct from merely 'targeting' a population for intervention. Tailored services must consider intersections of health, cultural and geographic needs that can best be met when developed with local communities.[119] Pre-migration life experiences such as gender segregation, patriarchal protection, and preparation for marriage and family life may prevent older women from participating in health promotion programs that do not align with internalized traditional and cultural norms.[145] For example, older Punjabi women were encouraged to participate in an exercise program for the first time in their lives when they were permitted to wear traditional clothing and instructions were provided in Punjabi.[66] Adapting an exercise program to include culturally congruent activities such as yoga, tai-chi, and Bollywood-style aerobics were also key to engaging EMOA in a U.K. health and fitness program.[95]

Service permeability is greatly restricted when there is a lack of translated health material and related documentation, or limited interpretation services.[66,141] Moreover, language discrepancies between clients and services often persist beyond initial consultations to impact subsequent appointments and patient adherence.[97] Accommodating language barriers is necessary, but not sufficient; an understanding of the EMOA client's culture and past life experiences are also necessary to ensure that services are fully accessible.[141]

IV & V) Appearances and Adjudications

Although an older adult may gain access to a health professional, there is no guarantee that they will be able to successfully assert their claim for candidacy. The `appearances' dimension of Candidacy describes the presentation of a patient at a health or social service to articulate their need and make a credible claim for care.[34] This dimension relates specifically to the interaction between a client and health professional, and may be influenced by the client's language skills, cognitive functioning, socioeconomic status, gender, and age for example. The care provider's or gatekeeper's role in this interaction is captured by the `adjudications' dimension of Candidacy. After a client presents their need for care, practitioners must make judgment calls based on their own knowledge and biases.[34] We present these two dimensions together since they most often coincide in practice and in the literature. Increasingly, we see publications on critical health literacy that addresses both dimensions.[25,126] Factors described in the topical reports that commonly affect these dimensions include:

- Client factors;

- Practitioner factors;

- Communication issues;

- Family support; and

- The diagnostic context.

Client factors

The claim to candidacy is influenced by the ways in which EMOA present their claim. Cultural differences in the expression of mental health symptoms may complicate diagnosis.[125] The somatic presentation of mental health symptoms (such as headaches, back or joint pain, and fatigue) commonly found among Asian patients can result in their attribution to a physical cause.[5,72,75,86,88] In parallel, Vietnamese elders experiencing elder mistreatment have presented with insomnia or back pain.[80]

EMOA with depression or anxiety interpret and hence present their symptoms as `being tired', `thinking too much' or `negative thinking.'[2,72] EMOA and their families have misidentified the symptoms of dementia as `absent-mindedness,'[139] and have attributed them to pre-existing personality traits (e.g., anger), mental illness (e.g., depression), physical illness (e.g., diabetes, heart disease), and life transitions (e.g., retirement).[69,96,102]

A perceived sense of inferiority relative to the more highly educated care provider can also affect how EMOA articulate their need for treatment.[72] More broadly, they can be overwhelmed by the service system, which can affect their understanding of what is expected of them during consultations.[38] For example, Asian older adults may believe that health professionals only treat physical illness and thus do not perceive any reason to disclose their experiences of abuse and neglect.[36,81,82,108,131,146] Some EMOA may feel too ashamed of a stigmatized condition (e.g. abuse, mental illness, cancer) to disclose the problem,[11] or they may be reluctant to present their concerns as deserving of medical attention according to clinical criteria.[72] They may also be wary of statutory services due to past experiences of racism, discrimination, and dismissive behaviour by practitioners.[11,103,125,141]

Cultural norms regarding communication are also significant; EMOA may not be accustomed to disclosing personal feelings with unfamiliar persons,[80] and asking intrusive questions may be culturally tabooed.[105] The influence of gender can also be seen, wherein interactions

between men and women affect whether and how personal health issues are discussed.[141,144] EMOA may feel uncomfortable, though not necessarily unwilling, to see a health professional of a different ethnocultural background or younger age.[28] However, once trust has been established between a client and health professional, EMOA and their families may ask for advice more readily, confide fears, and recommend services to friends.[13]

Practitioner factors

Appearances commonly begin with the general practitioner or family physician as the first point of contact;[19,29,69,91,96,102,114] EMOA are less likely to use specialist health services.[8,9,24,86] Thus, the importance of a sympathetic and supportive general practitioner must be empha- sized.[102] Just as EMOA may have difficulty articulating their needs to practitioners with whom they cannot relate, health practitioners likewise report a lack of experience and confidence in working with persons from diverse ethnic backgrounds.[16,91] Importantly, a practitioner's values, prejudices, and fears can compromise the support offered to older immigrants.[72] These may include cultural assumptions about patient attitudes and behaviours (essential- izing) as well as 'statistical discrimination' whereby decisions are based on the morbidity of certain conditions among different ethnocultural populations.[86,88,141] For example, health practitioners have avoided introducing sensitive issues such as Pap testing to older immigrant women for fear of embarrassing the patient.[50] There is a clear need for specialized medical training that extends beyond culture to the provision of individually responsive care.[16,63,91] Among older immigrants, important facets of one's life history to consider include country of origin, age at immigration, migration route and reasons for migrating.[57]

Assumptions and stereotypes about EMOA are found in multiple domains. In the health promotion field, for example, health practitioners incorrectly assumed that immigrant women would be too pre-occupied with settlement issues to consider exercising.[42] Research also points to ageist attitudes among mental health providers; perceptions of older adults as non-compliant or uninterested in treatment have lead to insufficient offers of care.[29] Likewise, delays in receiving a dementia diagnosis have been attributed to practitioner attitudes such as dismissing the concerns of caregivers and ascribing memory complaints to old age.[69,174,102] These issues may speak to gender, age, and status-based power imbalances between health professionals and EMOA.[69] Similarly, intersecting dimensions of social difference also mediate access to statutory support and the expression of abuse among marginalized groups.[40,52,53,97]

Communication

At the most basic level, appearances of EMOA are constrained when no culturally or linguis- tically congruent professionals and/or interpretation services are available.[127,129] Consistent service from linguistically and culturally congruent practitioners is especially difficult to estab- lish in rural areas where the steady rotation of health and social service personnel through the region is the norm. Perhaps even more important than a shared language per se is the lost opportunity that inconsistency presents for establishing trust between rural and remote EMOA patients and health and social service providers.[46]

Even though a practitioner speaks the same language as his or her client, they may do so in a manner which is overly professional or does not reflect the client's dialect, particularly when working with older adults.[13] Cultural conventions, such as how to address someone, and non-verbal communication including eye contact and gestures, are important for building trust with clients.[101] In working with older immigrants, ethnocultural alignment goes beyond addressing language barriers.[122] Effective communication must accommodate family members and address age differences, limits in vocabulary (especially when discussing

Western notions of health), and varying levels of comfort with medical environments and testing.[123] Additionally, it is important to investigate how cultural differences impact patient-practitioner dynamics, such as the ways in which these differences can contribute to misunderstandings around chronic disease management and levels of compliance and patient adherence.[123]

The type of language and terminology used during consultations is crucial to facilitate access to appropriate care. Practitioners must be careful to avoid alarming or stigmatizing terms that may discourage EMOA from using particular services.[90] For example, researchers advocate that health providers reframe dementia as a medical condition rather than a mental illness with the goal of reducing the stigma associated with it.[16] Use of the term 'elder mistreatment' is also recommended in order to move conversations beyond violence toward a wider spectrum of abuse (interpersonal and institutional), neglect, and disrespect.[15,40]

Communication difficulties with older adults, regardless of ethnic background, are often exacerbated by the nature of the health issue or disease.[57] Certain illnesses may be associated with functional impairment including limitations in sight, hearing, or speech and thus compromise one's ability to effectively self-advocate.[29,88] This can complicate diagnostic processes, such as establishing patient histories and conducting assessments based on language recognition.[88] In the case of dementia, older adults may not be able to remember details from consultations, thus excluding caregivers from client-practitioner interactions can cause significant delays in obtaining dementia care.[102] Likewise, communication difficulties may prevent older immigrants from coherently articulating their needs over the telephone.[10] In some cases, lack of language comprehension during appearances with care professionals has resulted in allergic and/or adverse drug reactions.[69,135]

Family support

Appearances of older immigrants at health services are commonly supported by family members. In a Punjabi study, daughters played a key role in communicating with physicians, providing translation, and explaining treatments to their parents.[51] While older people may have confidence in their family to represent them during appearances, adult children may have competing family and work commitments preventing them from assisting the older adult.[51,59,121] Moreover, the presence of a third party during consultations can compromise the building of trust between a client and health professional,[97] and practitioners may lack the training and experience to support family relationships.[91]

When adequate interpretation services are unavailable, EMOA often rely on family members for communication during meetings and appointments.[11,38,97,121] While this support may be key to facilitating access, using a family member for interpretation, especially a younger person, can compromise confidentiality and lead to inaccuracies, embarrassment, and withholding of information.[57,66,121] For instance, older adults may refrain from expressing their views or discussing certain problems such as addiction issues.[59] Use of family for interpretation is also counter indicated when older immigrants are susceptible to abuse and neglect within the family due to the dependency that their sponsorship status engenders.[71,94]

The diagnostic context

Adjudications are frequently complicated by a lack of culturally sensitive assessment tools for screening and diagnosis.[12] For example, cultural biases in instruments can skew estimates of dementia severity since instruments are typically developed using samples from the general population.[101] Screening and assessment tools must be adapted to ensure that their meaning and content reflects the language and cultural context of the client.[16,74,75,116,147] Uptake of

mental health treatment among ethnocultural minority patients has been positively associated with the use of a culturally sensitive psychiatric evaluation (the Engagement Interview Protocol (EIP)).[147]

A timely and accurate diagnosis of dementia is critical as it expedites access to dementia-specific services, such as particular treatment plans according to dementia type, homecare and respite, and also facilitates future planning with regard to care preferences and representation agreements, for example.[101] Missed and delayed diagnoses by primary care practitioners are nonetheless widely reported.[19,69,96] Such errors can have far-reaching implications for EMOA in abusive situations, where the ability of the service provider to recognize candidacy is crucial: many older adults will not volunteer such information.[21] If certain signs and symptoms are missed, then it may take a crisis event before the older adult receives proper diagnosis and care.[102] The World Alzheimer Report[162] has described a waiting period between 3 and 6 years for individuals with memory impairment to receive an accurate diagnosis. This may speak not only to diagnostic difficulties but also issues among the professional community regarding awareness of the disease and treatment options. Recent research suggests that technology innovations such as decision support software for primary care physicians may improve the diagnostic process in health settings.[104]

VI) Offers and resistance

The offers and resistance dimension of Candidacy refers to the acceptance and resistance among patients or clients to offers made by health or social service professionals for referrals, medication, and additional health and social support. Common issues that emerged across all topical reports within this dimension include:

- Suitability of offers;
- Knowledge and understanding;
- Informal support; and
- Stigma and self-maintenance.

Suitability of offers

Not surprisingly, EMOA resist offers for care that are deemed unsuitable.[88] Mental health services are much more readily accepted by EMOA when they are integrated with primary care services.[8,9] Similarly, mental health supports and health promotion programs that simultaneously address the social and emotional needs of the client are more appealing to EMOA.[29,66] Accordingly, older immigrants and their families are often more likely to accept support offered by ethno-specific agencies over formal services.[11] In parallel, effective interventions for vulnerable populations often lie outside of mainstream services.[93] For example, EMOA are cited as being resistant to police involvement or litigation in addressing situations of elder mistreatment.[21,80,81,82,109] Restorative justice strategies have been proposed as a more suitable approach, especially for immigrant seniors who are dependent on their abuser for support.[93] Furthermore, lack of suitability has been noted with regard to the province of Ontario's Violence Against Women (VAW) framework concerning intimate partner violence. Many EMOA may not define abuse and neglect within the context of intimate partner violence and thus may not perceive the suitability of programs and services offered.[37]

The acceptance of offers may also be predicated on cultural, spiritual and religious factors;[38,75] for example, EMOA may prefer traditional remedies or spiritual healing practices to Western medicine, particularly for mental health concerns.[3,11,74,86,132] In particular, research emphasizes strong resistance among South Asians to accepting residential care,[79] which

has been deemed "ideologically unacceptable and culturally inappropriate." (p.390)[16] It is difficult for families to choose and accept long-term care when no suitable options exist.[110] Incorporating patient beliefs into treatment and care plans is one strategy that can promote acceptance of and adherence to offers.[38] Offers of support should also be sensitive to clients' personal and familial cultural history, including immigrant status and levels of integration.[88] To this end, EMOA may prefer bilingual/bicultural health workers.[86,121]

Knowledge and understanding

Culturally informed understandings of health and illness can also impact one's interpretation of offers for treatment and referral, as well as the ability to act on a health professional's instructions.[123] For example, the literature on dementia suggests that diagnoses are more likely to be accepted when families have previous experience with the disease, either personally or professionally.[19,69] When families lack knowledge, they may feel hopeless about options for care beyond family support.[16] Similarly, negative attitudes toward mental health services may cause EMOA to believe that medical treatments are not the most effective strategy for managing symptoms.[28,136]

Although EMOA may face challenges understanding their diagnosis and options for treatment, they may still pretend to understand practitioners in order to appear compliant or prevent embarrassment.[38] This in turn can lead to intentional or unwilling noncompliance (e.g. accepting prescriptions but discarding medications) and poor health outcomes.[38,72,88] A lack of understanding may also arise due to disease related cognitive deficits,[29] as well as literacy and language barriers.[88]

Norms of filial piety and gender roles

A significant portion of the literature focuses on the preference for ethnic minorities to `care for their own' due to cultural norms and religious obligations surrounding filial responsibility.[4,12,59,79,84,86,103] Accordingly, EMOA and their families may be resistant to offers from services and agencies since acceptance could imply that families need supplemental support and are incapable of fulfilling their duty to care.[84,117] Thus, remaining in the family home may be viewed as an emotional and practical imperative by EMOA.[79] Offers for caregiver respite such as day care (versus home-based respite or short-stays in care homes) are likely to be the most acceptable option for EMOA and families who are reluctant to allow strangers, including health providers, into their home.[16,101] Service use can be intermittent since acceptance is likely to fluctuate over time as health providers build trust with clients and their families.[13]

Gender norms can also influence acceptance and resistance to offers. For example, In South Asian immigrant households, men play a stronger role in decision-making and compensatory support, whereas women are more likely to provide more `hands-on' care.[61] Thus, husbands, fathers, and grandfathers will often have the final say as to whether medical treatments and participation in health promotion activities are deemed acceptable or not.[51,70,117] The ability of some EMOA to communicate their needs and preferences to care providers, can thus be compromised.[43] This is especially true for older women with language barriers. For older adults with traditional values, the issue of cross-gender caring, especially from persons outside the family, may be unacceptable.[61]

Although family may care for EMOA into late stages of illness and disease, researchers caution that this may not always be the case.[16] It cannot be assumed that all EMOA have supportive extended families since there a number of factors related to migration and acculturation at play.[57,61] Support from family may be restricted by immigration laws, fragmented

family networks, the growing preference for nuclear households, financial pressures, and the changing social practices of marriage, divorce, and women in the workforce.[61,71,101] In rural areas, familial support for older adults is significantly compromised by the outmigration of young people to urban centers in search of employment.[27] Consequently, government policies based on the ideology of familism may actually leave EMOA without adequate care.[53,82,94,107]

Stigma and self-maintenance

As seen in the identification and navigation dimensions of Candidacy, acceptance and resistance of offers can be influenced by stigma. For example, fear of stigma can dissuade EMOA from following up on referrals or partaking in health screening.[29,44,50,59,75,121,141,147] Feelings of shame and embarrassment have been noted among older persons receiving mental health services.[11] Fear of stigmatization may be especially salient in small and isolated communities.[58] Treatment may also be resisted due to fear of the medication itself and potential side effects, or from past negative experiences with health services.[28,69]

Readiness to accept treatment can vary among EMOA. For example, persons with dementia may aim to "preserve identity and autonomy in the face of increasing symptoms."(p.7)[19] Thus, resistance to offers may be less a form of denial than a strategy for self-maintenance.[19] The desire to maintain freedom and self-control is also evident in accounts of EMOA who seek to address mental health challenges on their own and hence resist treatment.[2,11,33,72] Acceptance of services or treatment is equated with a loss of independence.[38,65]

VII) Local operating conditions

The final dimension of Candidacy, local operating conditions, pertains to local and specific factors that affect interactions between clients and health professionals, such as the availability and suitability of resources and services.[34] Findings from the topical reports suggest that Candidacy can be affected by local operating conditions including:

- Service factors (such as service availability and organization); and

- Structural factors (such as policies surrounding immigration and health insurance).

Service factors

Local operating conditions are greatly impacted by the services available for EMOA, with significant differences between regions. In rural areas, the regionalization of health services is a major challenge to the delivery of health care, as there are often long distances between services and clients due to low user densities.[31] In addition to geographical challenges, researchers have called attention to market forces (e.g., staffing shortages, fiscal constraints), and programming issues (e.g., low uptake of services, even during advanced stages of illness) that influence access in rural and remote regions.[17,31,54,55,120,142] This may prevent older adults with more specialized needs, such as those with Alzheimer's disease or in need of palliative care, from being accommodated in or near their home community.[31,119] Economic restructuring in rural and remote regions of the country have resulted in the reduction and elimination of hospital services including access to physicians, specialists, and pharmacies.[54,118,119] Restructuring has also created an over-dependency on informal supports from community groups, family members, and individual volunteers, all of whom may be in short supply.[128]

Local conditions can also influence physical activity levels and healthy eating. For example, although traditional diets of Indian immigrant families in Newfoundland aligned closely with

recommendations from Canada's Food Guide to Healthy Eating, the relative non-availability of reasonably priced ethnic foods in local markets was seen to contribute to poor nutritional practices among them.[140]

Service success and sustainability is compromised when funding for programs is short-term[59,101]; it takes time to build trust and establish relationships with EMOA and local communities in general, hence the deliverables required by funders may not be possible within the short period for which funding is provided.[59,101] Other immediate pressures affecting service availability for EMOA include workplace culture (such as support from management), competing clinical priorities, and the capacity to integrate multiple aspects of care both within and across organizations.[29,59,72,141]

There is a clear need for further service development for EMOA and their families. Needs-led service development, whereby stakeholders are engaged in ongoing dialogue in order to address the specific circumstances of the local population, is essential.[85,106] Education and training for health service employees regarding culturally appropriate practice, ideally in the form of province-wide programs with ongoing financial support, has also been recommended.[106] In rural communities, nurses and nurse practitioners[7,106] as well as interdisciplinary 'one-stop' clinics[171] can potentially make a positive impact on the lives of immigrant seniors. Improved service development is an area where more research is required, especially for systematic evidence and evaluations of effective solutions and approaches to service design and delivery.[85]

Structural level factors

Many EMOA report feeling underserviced due to the impact of institutional discrimination, as evidenced by their exclusion from specific government programs, inadequate health care and social services, and lack of recognition in healthcare budgets.[10,80,81,82,97,108,109,131] Indeed, there are cumulative effects of health and material disadvantage resulting from discrimination at a variety of institutional and organizational levels.[100] These include linguistic discrimination, duration of residence since immigration, formal labour force participation (including promotion prospects), reduced income in retirement, and living in areas with a high rates of harassment and crimes based on race and language.[100] Institutional barriers to healthcare for EMOA must be addressed at the policy and governmental level.[97] A focus on linguistic and cultural competence, and careful consideration of what this training may look like and who it should serve, is needed across all healthcare contexts.[4,135]

A number of additional government policies impact Candidacy in terms of the contextual conditions that they generate. For example, failure to recognize the credentials of newly immigrated health professionals can minimize the opportunities to provide services to EMOA in their mother tongue.[111] As previously discussed, policies concerning sponsorship of Family Class immigrants[79] and regionalization or amalgamation in rural and isolated communities[134] can leave many EMOA without access to adequate care. The cost for medication, treatment, and services differ from one province to the next based on their medical service plans. This is often the only health care available to immigrant older adults who are typically not eligible for extended services and do not have employment-based extended care. Hence these interprovincial variations may exert a greater impact on them than the general populace.[71] EMOA are thus susceptible to financial hardship based on their inadequate health and retirement benefits, ineligibility for health insurance, and delays in receiving health care reimbursements.[38,59,71,141] Accordingly, service access is more likely to be restricted among EMOA when personal financial resources are limited.[3,13,38,59]

Discussion

From this consolidated review of access to health and social care by EMOA, we can see that the experiences of EMOA vary in form and emphasis across the diverse topics relative to the seven dimensions of Candidacy. For example, issues of geography and service amalgamation are salient for EMOA living in rural and remote communities, while a widespread lack of awareness of elder abuse and mistreatment greatly hinders access for older adults in vulnerable situations. The role of primary care practitioners in facilitating early diagnosis and access to appropriate options for treatment and care is especially salient to in the domains of mental health and dementia care.

Yet, it is clear that there are more similarities than differences when considering the negotiations and mechanisms underlying Candidacy for EMOA. Accordingly, a number of considerations may be outlined in order to improve equity in access. These are presented relative to actions that may be targeted to specific groups, as follows.

Clients and families

A lack of awareness and understanding of health issues and associated stigma are significant barriers to identifying EMOA's need and deservingness for care. Older adults and their families require appropriate information about the cause, signs and symptoms of health issues, assessment processes, as well as options for treatment and referrals. It is imperative to reach out to family members of older immigrants, who often play a large role in most dimensions of Candidacy such as identification, providing support (e.g. with interpretation, information-seeking, transportation) during navigation and appearances, as well as information and decision-making assistance to help clients understand offers of assistance so as to reduce resistance.

Actions should also target family caregivers, who may not identify their need or deservingness for self-care or respite. In order for statutory services to be accepted, health and social services must not only provide flexible and appropriate options for individuals, but clients and their families must also understand how these services compliment (rather than displace) family support. However, it cannot be assumed that all EMOA have access to a supportive family network. Clients who lack activated social networks require different types of material and assistance in order to facilitate access to appropriate care. It is important to also facilitate self-efficacy and autonomy among EMOA so that they may best self-advocate for their health care needs.

Communities

Community health education and outreach is crucial to reduce stigma surrounding health issues and accepting help (especially for mental illness and elder abuse), to improve knowledge and understanding of health and illness (i.e., health literacy), and to promote awareness of available services and supports. Health campaigns tailored to specific communities that use innovative forms of media (such as ethnocultural newspapers, radio programs, and television channels) and provide signposts for services are important to this end. Furthermore, partnerships with community organizations and local leaders are critical to build trust of health services among communities. While the community solidarity and close-knit relationships of rural and marginalized communities can be a strength, it is also crucial to recognize the greater potential for stigmatization within such communities as well as the potential for ostracization for those who don't 'fit in.'

Service providers and primary care practitioners

Family plays a very significant role in accessing health care for EMOA. Service providers must understand that health conditions may be seen as a 'family issue' and consider the needs of the family accordingly. Further, health professionals should consider nuances surrounding gender roles, intergenerational tensions, and issues related to sponsorship and migration that can affect the types of support an older adult may or may not receive from family. It is important for service providers and general practitioners to be aware of the preference for family care yet avoid assumptions regarding the nature and extent of family involvement.

In order to improve ethnocultural alignment between health service providers and clients, education and training for health professionals is crucial. Professionals should understand how certain health issues might be conceptualized by clients in light of cultural understandings of health and well-being, which could affect how older adults present symptoms and adapt to their experience of illness. Ultimately, it is important for health providers to look beyond cultural differences to promote person-centred care.

Primary care practitioners are often the gatekeepers to appropriate care and supports. Training regarding symptoms, diagnosis, and options for treatment and referral is thus imperative. In addition, training should highlight best practice for medical communication, use of appropriate terminology, and call attention to the potential for power dynamics to influence interactions with clients and their families. This may also be applicable to acute care workers, who attend to older immigrants in crisis or for another health issue. Health providers should have up-to-date knowledge regarding options for post-diagnostic support including respite, home services, social and psychological support, as well as programs offered by local community centres and agencies.

Service providers and general practitioners must aim to build rapport and trust with clients. Sympathetic health workers and supportive non-threatening environments are key. Assessments and screenings should be offered in non-institutional settings, such as community centres and places of worship. Bicultural and linking workers as well as case management may be essential to establish trust over time with clients and families, and further maximize ethnocultural alignment. This aspect is also important when considering interpretation services, where older immigrants should have access to an independent yet trusted and reliable interpreter.

Health care organizations

Health care organizations may benefit from an expanded view of health in order to reach a wider array of potential service users. This may be done by incorporating community beliefs and alternative representations of health and illness within existing service directives. Shifting toward a more holistic view of health and illness would also benefit service promotion and outreach programs, where health messaging should be tailored to communities in order to motivate help-seeking and facilitate navigation. To this end, inter-organizational cooperation between health authorities and community agencies would potentially benefit both parties. Furthermore, organizations should integrate informal supports and the ties among them (e.g., EMOA, family, and community volunteers) into their planning services, programs, and policies to facilitate the development of social capital.

To maximize ethnocultural alignment between services and clients, organizations must provide access to bicultural/bilingual workers and create comfortable health settings for clinics and programs. Training materials for professionals should be developed to promote best practice for person-centred care in supporting clients from diverse backgrounds.

Ultimately, health care providers should be empowered to develop their own strategies for working with EMOA.

The importance of flexibility in services must be emphasized. The location and environment of health services should be welcoming, central, and familiar to service users, including adequate hours and language of operation and attention to physical accessibility. Services and programs should take into account logistical factors that may hinder navigation and appearances for some older adults and their families, such as work, child-care, and transportation arrangements. In certain cases such as in rural communities, home visits and assessments may be preferable. Health care organizations should consult with local communities to engage in needs-led service development and create programs that reflect the diverse individuals they aim to serve. In a continuous process of service development and refinement, research should be conducted in order to evaluate the implementation and reach of existing services and programs. Knowledge dissemination activities are also essential to promote awareness of access-related issues.

Policymakers

In the current context of population aging, an increased societal awareness of the health issues affecting older adults is warranted. All health strategies should be reviewed through a 'seniors lens' which: (1) is attentive to age-related inequalities in health; (2) provides programs that work towards reducing age-related inequalities in health; (3) provides accessible and accountable information on policies for seniors and stakeholders; (4) ensures a wide publication of programs; (5) develops research to solve current barriers in access; and (6) is attentive to senior diversity, including across intersections of gender, ethnicity and sexual orientation.[30]

Policy surrounding an information and communication strategy is needed to increase awareness and promote public discourse of issues such as mental health, dementia, elder abuse and mistreatment, and health promotion. Policy regarding service development should call for multifaceted supports including home care, caregiver respite, daycare, innovative housing models, and appropriate options for long-term care. There is also a need for further research and technology development (e.g., creating valid and reliable diagnostic tools and decision support software for health professionals).

In addition, funding models must be revised in order to reduce waiting times and facilitate the long-term sustainability of services. For example, the patient-practitioner communication dynamic discussed under 'appearances and adjudications' would benefit from increased time per patient with primary care practitioners, and services offered by the community sector would be strengthened by funding schemes that allow for a longer period of development and operation. Policy makers must also be attentive to financial challenges that arise from under-employment, stringent eligibility criteria, and out-of-pocket expenses, which contribute to the low-income status of many EMOA. Greater financial support to reduce the cost of medications and out of pocket expenses, such as transportation and in-home and/or mobile health support, for low-income older adults is thus required.

In rural and remote areas, access to all types of service is closely linked to the availability of affordable and timely transportation options. Telehealth services may offset the need to travel to services in many instances, but these services will only be helpful to EMOA if they are both age-friendly and culturally and linguistically competent.

Policy should further endeavor to address issues of power, structure, and culture, and their intersections in order to improve access to social and health services. Such policy-

level revisions include: universality and diversity; reducing material disadvantages; fighting discrimination; and providing gender and context sensitive policies, programs, and services. McDonough and colleagues[175] have outlined eight key areas for policymakers to consider in meeting these goals for EMOA: (1) consistent racial/ethnic data collection on communities so that adequate interventions can be made, including at time of immigration; (2) effective evaluation of disparity-reduction programs; (3) minimum standards for culturally and linguistically competent health services; (4) greater minority representation within the health care workforce; (5) expanded health screening through improved insurance coverage; (6) establishment or enhancement of regional or provincial offices of minority health; (7) involvement of all health system stakeholders in minority health improvement efforts; and (8) creation of a national coordinating body to promote continuing state-based activities to eliminate racial and ethnic health disparities.

Conclusion

The Candidacy framework has proved invaluable as a means of exploring the different questions posed by our knowledge user partners, each of which has been addressed in greater depth in the topical reports prepared for each site. We acknowledge that the literature needed to fully answer the questions posed in Newfoundland (rural and remote EMOA) and Toronto (elder abuse interventions for EMOA from war-torn countries) was relatively sparse. These deficits in evidence point to opportunities for research. Information gleaned across the enquiries into the different topics further identifies factors that can increase access that are worthy of consideration in the design of potential strategies and evaluation of their uptake.

Paying heed to the influence of each dimension of Candidacy on the ability of EMOA to access the health and social care that they need, encourages us to recognize the richness of data in specific studies that is too easily overlooked when we seek to summarize its contribution. At the same time, the breadth of the different dimensions of Candidacy, which take into consideration each of the micro, meso, and macro levels of analysis, unites diverse bodies of literature focusing on community networks, capacity building, community development, health literacy, patient-centred care and communications, cultural competence and responsiveness at the provider and organizational levels, and health care, cultural, housing and immigration policies.

Using the Candidacy lens to consider access issues across the different topical domains of interest to our knowledge user partners, which are typically considered by distinct groups of researchers, also proved to be of considerable importance. Funders of research and health and social services are often reluctant to invest in projects focusing on EMOA, based on the argument that their size does not warrant the cost. The focus of one our teams on the influence of social determinants on the health outcomes of EMOA clearly establishes the need to invest the most in those EMOA with the greatest need. By looking at the different mechanisms that facilitate and impede access to services across different contexts (health promotion, mental health, dementia care, elder mistreatment interventions and prevention) and in different settings (rural versus urban), we begin to see patterns that identify the most underserved EMOA and the ways in which the barriers they face can be overcome. Funders can be assured that addressing barriers in one domain will have a ripple effect that has the potential to improve access to a range of services.

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Appendix: Team Members and Knowledge User Questions

Academic team & institutions	Knowledge user partner & affiliations	Geographic Scope	Questions of interest	Search terms and number of articles reviewed
Chappell, Neena (Sociology, UVic) Browning, Sean (RA)	Powell, Simone (Public Health Agency of Canada)	National; Victoria, BC & Ottawa, ON	What elements of health and social service interventions aimed at addressing determinants of health for EMOA in Canada positively influence their health status?	ethnic minority seniors; determinants of health; access to services; immigrant health; immigration; health utilization; cultural beliefs and attitudes; ethnic health # of articles: 40
Matsuoka, Atsuko (SW, York) Guruge, Sepali (Nursing, Ryerson) Hepburn, Shamette (RA)	Manuel, Lisa (Family Services Toronto)	Toronto, ON	What types of intervention strategies address abuse of EMOA as it is defined and experienced in different communities (especially those coming from war-torn countries)?	ethnic minority seniors; abuse and neglect; sponsorship; immigration; access to services; immigrant health; refugees # of articles: 26
Kobayashi, Karen (Sociology, UVic) Khan, Mushira (RA)	Eve, Doni (Health Engagement Unit, Population and Public Health Division, BC MoH)	Victoria, BC	What health promotion interventions optimize uptake of available health promotion materials/services/amenities by EMOA?	ethnic minority seniors; intervention; health promotion; health promotion strategies; health promotion and ethnicity; chronic disease; access # of articles: 32
Koehn, Sharon (Gerontology, SFU) Badger, Melissa (RA)	Friesen, Kathleen (Clinical Programs and Population Health, Fraser Health Authority)	Vancouver, BC & Fraser Valley, BC	How can the health authority improve dementia care services for minority older adults (particularly South Asians)?	ethnic minority seniors; dementia; South Asian; patient centred care # of articles: 27
Lai, Daniel (SW, UCalgary) Tong, Hongmei (RA) Daoust, Gabrielle (RA)	Schroeder, Bonnie (Canadian Coalition for Seniors' Mental Health)	National; Calgary, AB & Toronto, ON	Which mental health treatment interventions (particularly those at the health care delivery and systems levels) work well for EMOA in Canada?	ethnic minority seniors; mental health; depression; access to services; ethnopsychiatry; immigrant health # of articles: 32
Mullings, Delores (SW, Memorial) Flood, Katie (RA) Sedziafa, Alice Pearl (RA)	Yamuna Kutty (Multicultural Women's Organization of Newfoundland and Labrador)	St John's, NL	What types of interventions enhance the health and health care access of very small groups and/or geographically isolated/rural EMOA, who may lack large community networks and the institutional completeness to ensure that they can access health and social service providers who speak their language?	ethnic minority seniors; healthcare access; rural; language barrier(s); health services utilization; rural residence # of articles: 53