Cultural Competency with Older Adults

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Introduction

- As the general population ages, it is imperative that service providers from health, mental health and other service sectors understand and recognize how to work with older adults, from various backgrounds—age group, gender, ethnicity, physical ability, gender identity, sexual identity, and other cultural considerations. Failure to do so could result in unintended negative health and mental health outcomes, and perpetuate the disparities in care.
Introduction

- Older Adults—who are we/they?
  - American Association of Retired Persons (AARP): 50+
  - US Census Bureau: 65+
  - World Health Organization (WHO): 60+
- Culture—definition
- Competency--definition
Demographics

US Census Data (2010):

- Between 2000 and 2010, the population 65 years and over increased at a faster rate (15.1 percent) than the total U.S population (9.7 percent)
- Up from 35.0 million in 2000 to 40.3 million in 2010
- Represented 12.4% of total population in 2000, and 13.0% of total US population in 2010
Demographics

- Despite a higher population growth in ten-year age groups beyond age 75, the largest percentage growth in five-year groups, at 30.4%, is in the 65-69 years group
  - Lowers the median age of the population 65 and older
- Males experienced more rapid growth than females in the older ages
- The West had the fastest growth in the population 65 years and over, increasing from 6.9 million in 2000 to 8.5 million in 2010, or 23.5%.
- The West also had the fastest growth in the population 85 years and over (42.8 percent), increasing from 806,000 in 2000 to 1.2 million in 2010
Santa Clara County Demographics

US Census Bureau County Quickfacts:

- 12.0% are over the age of 65 (2013)
- 37.1% are foreign-born persons (2009-2013, all ages)
- 51.2% speak a language other than English at home, aged 5+ (2009-2013, all ages)
Older Adults and Mental Health

From WHO (2013):

- Between 2000 and 2050, the proportion of the world's older adults is estimated to double from about 11% to 22%.
- Neuropsychiatric disorders among the older adults account for 6.6% of the total disability for this age group.
- Approximately 15% of adults aged 60 and over suffer from a mental disorder.
Older Adults and Mental Health

From WHO (2013):

- Dementia and depression are the two most common neuropsychiatric disorders in the 60+ age groups
- ¼ of deaths from self-harm are from this age group
- Mental health problems are under-identified by health-care professionals and older people themselves, and the stigma surrounding mental illness makes people reluctant to seek help
Cultures

Diversity in the aging population:
- Race & ethnicity
- age group
- gender
- language
- sexual orientation
- disability
- class/socioeconomic status
- education
- religious/spiritual affiliation
Culture & Competency

Culture: “the integrated pattern of human behavior that includes thought, speech, action, and artifacts and depends upon the human capacity for learning and transmitting knowledge to succeeding generations” (Merriam-Webster Dictionary on medical definition)
Cultural Competency

- Cultural competency: “the ability to relate effectively to individuals from various groups and backgrounds. Culturally competent services respond to the unique needs of members of minority populations and are also sensitive to the ways in which people with disabilities experience the world. Within the behavioral health system (which addresses both mental illnesses and substance abuse), cultural competence must be a guiding principle, so that services are culturally sensitive and provide culturally appropriate prevention, outreach, assessment and intervention.” (UPenn Collaborative on Community Integration)
Why is cultural competency important?

- Patients are at higher risk of receiving poor quality care and experiencing negative health consequences when healthcare professionals, medical institutions and systems do not promote and provide culturally competent care.

- Provision of culturally competent care can increase quality and effectiveness, increase patient satisfaction, improve patient compliance, and reduce racial and ethnic health disparities.

(Leon, National Center for Health and the Aging)
Cultural Competency in Santa Clara County

- Very diverse County
- Threshold languages:
  - Spanish
  - Vietnamese
  - Mandarin
  - Tagalog
  - Cantonese
Focus on age groups and most served ethnic groups at AACI

- **Age groups:**
  - Younger old
  - 65-80 age group
  - Older old

- **Ethnic groups:**
  - Cambodian
  - Chinese
  - Vietnamese
Common myths about aging (or how to avoid age stereotypes)

- **Myth:** Dementia is an inevitable part of aging.
  - Fact: Most older adults are cognitively intact.

- **Myth:** Older adults have higher rates of mental illness than younger adults, especially depression.
  - Fact: Older adults tend to have lower rates of depression than younger adults.

- **Myth:** Older adults are a homogeneous group.
  - Fact: The aging population is a highly heterogeneous group.

- **Myth:** Most older adults are frail and ill.
  - Fact: Most older adults have good functional health.

- **Myth:** Older adults have no interest in sex or intimacy.
  - Fact: Most older adults have meaningful interpersonal and sexual relationships.

- **Myth:** Older adults are inflexible and stubborn.
  - Fact: Most older adults have the same personality traits as at a younger age.
Younger old

- Aged 50-64
- Commonly served in the Senior Wellness Program
  - Services are primarily preventative
  - Engagement in physical and social activities, and discussions about maintaining mental and cognitive health
  - Referral to resources as necessary
- Those in MH program may have multiple health & mental health issues
  - More intensive engagement process
  - Collaboration with family and multiple systems
  - Housing and other fundamentals may be priority foci with case management services
  - Substance abuse is possibly underdiagnosed
General considerations for working with Younger Old OAs

- **Prevention** -- Activities or services geared towards prevention and early intervention for healthy (physical, mental & social) individuals, such as dancing, computer classes, writing, art, tai chi, etc.

- **Outreach at Senior Centers**, with primary care providers, possibly senior apartments

- **Assessment** — allow longer time for longer history-taking; due diligence asking about substance use, sexual practices (for some cultures, proceed with caution); assess for changes in lifestyle (e.g. retirement, reduced work or income)

- **Interventions** — understand any psychosocial impediments in compliance (lack of housing, transportation, etc.), collaborations with treatment teams to learn of any treatment/medication interactions
65-80 age group

- Majority of Senior Wellness Program participants
  - Diversity in health status
  - Most are active with family or community
  - Can engage in a variety of service offerings at SWP

- In MH program
  - Usually have multiple stressors as well as health and mental health issues
  - Longer engagement process (e.g. longer life history, likelihood of experiences of historical and possible traumatic nature)
  - Loss and bereavement common
  - Depression
  - Cognitive changes, sometimes dementia
  - Case management services for housing/assisted living/B&C, meals, financial benefits, transportation, IHSS common
General considerations for working with 65-80 age group

- **Prevention**
  - Similar to those services to younger OAs, increase awareness of physical changes, dealing with loss and bereavement, increase activities aimed at maintaining cognitive & physical abilities, as well as maintaining social ties

- **Outreach**
  - Senior apartments, primary care providers, senior assisted living, through paid and family caregivers

- **Assessment**
  - Thorough, with extra time dedicated for history-taking.
  - If given consent, could be useful to also interview family members

- **Interventions**
  - Depends on health status as well as availability of social supports— with decreased health status and social supports, need to provide additional resources to support
Older Old

- Aged 80+
- Fewer participants of this group in SWP
- In general, for all programs, likely to be more isolated
- Prevalent in Health Clinic
  - Usually multiple health issues
  - Some receive short-term MH health care with IBH program
- In MH program:
  - Longer engagement process (e.g. longer life history, likelihood of experiences of historical and possible traumatic nature)
  - Possible family involvement but need to remember older adult is focus of treatment
  - Less likely to comply with or stay in treatment
General considerations for working with Older Old OAs

- Prevention
  - Important to help OA maintain social engagement, physical activity, encourage regular check-ups with PCP, and other usual providers, maintain cognitive abilities

- Outreach
  - Senior apartments, primary care providers, senior assisted living, through paid and family caregivers, other OA providers, community at large

- Assessment
  - Thorough, with extra time dedicated for history-taking.
  - If given consent, could be useful to also interview family members
  - Sometimes requires cognitive assessments
  - Transportation needs

- Interventions
  - Depends on health status as well as availability of social supports—with decreased health status and social supports, need to provide additional resources to support
  - May need additional resources such as physical aids (hearing, vision, ambulation)
Cambodian Older Adults

- War and traumatic experiences (Khmer Rouge, Killing Fields, genocide)
- Immigration experiences; isolation in new culture
- Intergenerational differences
- Discrimination by other Asian groups
- Resilient but difficult to heal
General considerations working with Cambodian OAs

- Research and understand some of the historical atrocities faced by Cambodian clients; proceed with caution when asking client directly.
- Most Cambodians hold monks in high regard; collaboration with a temple/monk could prove helpful.
- Most Cambodian OAs are pre-literate and lack formal education, and would not understand writing even in native Khmer—use practical examples whenever available.
- Techniques such as grounding may work, but be aware of guided imagery exercises that could return a Cambodian client to a horror-inducing place (e.g. forest).
- Group wellness activities may enhance social support; but be aware different political affiliations may create in-group conflict.
Chinese Older Adults

- Different waves of immigration from different areas (e.g. China, Taiwan, Hong Kong, SE Asia)
- Mandarin and Cantonese are two common languages; other languages as well (e.g. Vietnamese-Chinese)
- Some may have experienced political and historical atrocities—useful to ask about these experiences but proceed with caution
- Some may still believe in traditional medical and mental health practices (acupuncture, use of herbs)
- Family is the center of life and the group/family is more important than the individual
- Chinese OAs may agree with treatment even if treatment has not been effective; would not want to create disharmony—provider would need to work proactively with other providers/family members to understand what is effective
General considerations working with Chinese OAs

- Exchange of pleasantries may help break the ice
- Mental health issues are typically handled within the home environment until issues become too severe for the family to handle; as a result, clients entering services may have more severe symptoms
- You may not get honest feedback about the treatment; the tendency would be for the OA to be agreeable; probe further to assess for effectiveness of treatment
- Ask about alternative treatments (e.g. acupuncture, herbs) being used in conjunction with what you and your team are providing
- Ask about immigration and acculturation status, as well as level of education—the more acculturated and educated the client, the more likely s/he will have some understanding already of treatment modalities and compliance
- Some may prefer to have individual treatment as opposed to group wellness activities
Vietnamese OAs

- Geographical and language differences amongst Vietnamese OAs
- Religious affiliation: some are Buddhist but many are Catholic
- Immigration experiences vary; assess for experiences in Vietnam War, as well as immigrating as “boat people”
- Similar to other Asian groups, the Vietnamese OA may be well revered, and may be accompanied to appointments by family members or close friends from the community
- Physicians and providers with advanced education are regarded highly in the Vietnamese community
- Mental illness is believed to be a supernatural phenomenon that could bring shame to the family
General considerations working with Vietnamese OAs

- Use of non-stigmatizing words is important
- Providers may need to consider geographical and political differences (e.g. communist affiliations)
- Information may sometimes be relayed by a person other than the client; indirect communication is common
- Cancer and heart diseases are two leading causes of mortality for Vietnamese men and women; yet this group has one of the lowest rates for screening; collaborations with primary care could provide more positive overall wellness outcomes
- Vietnamese OAs sometimes use traditional Chinese methods of treatment—ask about any alternative treatments used
- As with most Asian cultures, Vietnamese families prefer not to have an older adult relative enter senior assisted-living facilities due to the perception that the family is abandoning the OA
Healing Legacies (INN Project)

- Free support program for Senior 60+.
- 12 sessions: interactive activities where the seniors, ideally in the company of family members and caregivers, is encouraged to reminisce and capture significant memories and personal accomplishment.
- Improve mental health and overall well-being and quality of life.
- Reduce social isolation, anxiety, and depressive symptom.
- Stay actively engaged in the lives of family members, friends and community event.
- To honor the seniors and to share their stories with their families and the community at large to impart wisdom to the next generation.
- These narratives are taken the form of videos, audio recordings, memory books, photo albums, etc.
Cultural Considerations

- Program title “Chia Sẻ Tâm Tình”
- Outreach materials
- Language sensitivities
- Engagement process
- Subculture within culture
Summary

- OA population in US and in the world is increasing
- OAs tend to be healthy and active, despite general public perceptions
- However, there are considerations when working with different age groups comprising the OA years
- There are also other cultural considerations when working with OAs
- Santa Clara County is ethnically diverse, and ethnic seniors will comprise a large portion of OAs served
- Several ethnic groups are highlighted
- A successful Vietnamese OA project is highlighted
Questions/Comments?