IMPROVING ASSISTANCE TO ELDERLY VICTIMS OF VIOLENCE: HEALTHCARE PERSONNEL AS A WINDOW FOR OPPORTUNITY

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ABSTRACT

Introduction*: Nowadays, the world's population is ageing, causing the growth of a new category of patients: elderly people affected by a particular vulnerability due to the simultaneous presence of multiple chronic diseases, fragility, and disability. Because of the ageing population, elder abuse is dramatically increasing too. Despite its prevalence and serious negative consequences, and despite its recent emergence as a critical social and medical problem, abuse of older people often remains undetected and unrecognized.*

Material and methods: *We made a brief review of the Literature in order to search the most relevant and up to date publications related to the current situation of elder abuse worldwide, assess the major challenges in its recognition and management, and provide insights that may benefit the victims of elder abuse.*

Results: *Violence against older people also creates critical issues for care teams. Since technical expertise in abuse management depends on knowledge, expertise and preparedness, it is of fundamental importance for healthcare personnel who treat abused subjects and conduct the initial examination and evidence collection to identify and report mistreatment and to support the elderly as a vulnerable population. On the other hand, it is imperative that the structure be organized in such a way as to put at the disposal of the individual professional the time and methods of assistance that are necessary to ensure an adequate level of care.*

Conclusion: *The implementation of care and assistance, both for healthcare professionals and for healthcare facilities, plays a crucial role in the prevention of elder abuse.*

Keywords: *Elderly abuse, elderly maltreatment, healthcare training, professional dilemma, vulnerable populations, forensic medicine.*

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Introduction

Violence against older people has probably existed since antiquity, but societies worldwide have only recently acknowledged it as a serious global problem, requiring urgent actions by all governments, healthcare systems, and social welfare agencies. The phenomenon was first described in 1975 and, since then, as the population continued to age and the proportion of older people raised up in an exponential way, it has been receiving increasing attention and awareness[1-4]. The percentage of older people who are nowadays estimated to be victims of elder abuse varies in different studies, ranging from 1% to more than 30%[5]. In the future, if the rate of violence remains constant, the problem is expected to become ever more pressing and it is estimated to reach 330 million victims by 2050[6, 7].

According to the WHO, elder abuse is "a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" and it encompasses different forms:

• Physical;
• Sexual;
• Psychological;
• Financial and material exploitation;
• Neglect or abandonment, which can be intentional or unintentional[8-10].

It is not uncommon for the elderly person to fall victim to multiple forms of abuse, some types being more evident (such as physical violence), some others more concealed and difficult to identify (such as psychological violence).

Regardless of the type, the definition provided by the WHO underlines two key aspects of elder abuse:

• That it results in harm to an older person;
• That it occurs within a relationship of trust (i.e., the perpetrator is usually someone known by the victim)[11].

The typical victim is older than 75 and socially isolated, suffers from cognitive impairment or dementia, has a personal relationship with the perpetrator and finds himself/herself in a position of powerlessness and dependence on the abuser. The typical perpetrator is a person living with or near the victim, usually a relative, but family members are not the only ones that can perpetrate elder abuse, as neighbors, caregivers such as nurses, and family friends have also been identified as abusers. The perpetrator within an institution may be a staff member, another resident or a visitor[7].

Normal biological changes occurring in the ageing process (for instance, deterioration of the senses, physical strength and cognitive abilities) and illnesses typically affecting older people, can make them dependent on other people, placing heavy burdens on families and caregivers. The level of stress experienced by caregivers can sometimes contribute, along with other causes, to create a dangerous environment at risk of elder abuse[4]. Caregiver risk domains and care recipient vulnerability play the main roles in the development of the abusive relationship. Lack of interventions on education and training, scarce financial assistance for dependency cases, lack of adequate social support and respite periods for the caregiver can have significant impacts on the well-being of both caregivers and care recipients, thus enhancing the risk of abuse.

Elder abuse is a phenomenon which transversally affects all populations and cultural groups and is seen among all educational and socioeconomic levels in both developed and developing countries, this is the case despite much of the information coming from studies conducted in high-income countries, whereas data from low-income countries is still extremely scarce[12]. Notwithstanding this, its exact prevalence is not known, as reported prevalence rates vary from 2.2 per cent to 36.2 per cent according to the study and geographical factors. In 2013, the U.S. Department of Justice has estimated that, each year, older people accounted for approximately 4% of violence[13]. An Indian study revealed that 11% of 60+ years old have experienced at least one type of elderly abuse[14]. Another study conducted in Iran shown an overall prevalence of elder abuse of 48.3% and the highest prevalence of elder abuse was related to the care neglect (38.4% of the total abuse cases)[15]. In Italy, national studies on the prevalence of elder abuse have never been performed but, across regional studies, elder abuse prevalence ranged from 10 to 12.7%[16]. Moreover, studies come to different conclusions about the rates of the various types of elder abuse, depending on numerous factors including geographical settings, use of nonstandard definitions across countries, and methods of collecting data.

One reason for this is that there is no shared and universal definition of elder abuse and, consequently, the range of harmful activities subsumed under the term "elder abuse" varies widely throughout the world[12]. This lack of consensus has important implications in the public health approach to prevent this type of violence as it constitutes the largest obstacle to protecting the rights of older people. Since the definition of elder abuse may vary from study to study, statistics obtained cannot be compared with each other, which makes it impossible for care team members to identify and, consequently, report abuse[17]. Most available data come from community-based studies, conducted on the homebound (or non-institutionalized) elderly, whereas there are only limited or non-reliable data about elder abuse in institutional settings. However, the prevalence of maltreatment is estimated to be much higher among this segment of the elderly population[18].

Moreover, the true prevalence of the phenomenon is likely largely underestimated since it is believed that only one out of 24 cases of elder abuse is reported[17]. Many elderly victims choose to remain silent and not report the abuse to anyone either because they are afraid of negative consequences, especially when the perpetrator is their caregiver, or because they are ashamed[19].

Regardless of the scope of the problem, elder abuse is more undetected, unrecognized and unre-

ported than any other form of violence (such as child abuse or woman abuse) and it has yet to achieve the same public health priority[5]. Although elder abuse has been defined as a violation of human rights, its legislative regulation shows significant differences among countries related to the state-specific laws, and, in many countries, there are no yet any specific regulations for older people.

Elder abuse can lead to serious, and sometimes long-lasting, consequences, both physical and psychological. Physical signs suggestive of elder abuse range from superficial wounds such as scrapes, abrasions, scratches, and bruises, to more disabling consequences like bones fractures. Other common physical findings include dehydration, lack of food, poor hygiene, and pressure sores. Psychological abuse, which is the most common type of elder abuse in many countries, represents also the most difficult to diagnose and prove through clinical examination. Recent changes in behavior and anomalous interactions with the caregiver may represent red flags indicating the presence of an abusive situation but, despite this, there do not exist specific forensic markers for psychological abuse. Furthermore, these symptoms can often be confused with frequent clinical manifestations in older people. Often, psychological abuse gives visible effects only in the long term and for this reason it can be misunderstood.

In response to the stressful experience, the abused elderly individual may develop fear, anxiety, depression or other mental health issues. Knowing the typical victim-perpetrator scenario, physical and laboratory findings are an essential prerequisite in order for healthcare personnel to be able to recognize elder abuse. However, it should always be considered that many conditions resulting from age-related physiological changes and organic disease may mimic and be mistaken for elder abuse. Thus, it is of vital importance for all healthcare providers to become familiar with these mimickers of abuse and the features that differentiate them from true elder abuse[7], and to carry out the most appropriate treatment as soon as possible, considering that, given the greater fragility and vulnerability of older people as compared to younger adults, any harmful act against them lead to an increased risk of morbidity, of mortality, institutionalization and hospitalization[18, 20, 21].

Laboratory testing is especially useful to identify suspect cases of elder abuse in the event of neglect or of physical abuse when performed through improper use of chemical restraints. Common laboratory manifestations of elder neglect are represented by signs of malnutrition (including low albumin and total protein levels, low cholesterol levels, iron deficiency, and nutritional-deficiency anemia), and dehydration (comprising high hematocrit level and electrolytes imbalance, such as hypernatremia, hyperchloremia, increased urea nitrogen and creatinine levels). Improper chemical restraint refers to the inappropriate administration of psychotropic drugs (usually sedatives or antipsychotics) to calm down older people exhibiting difficult behaviors such as agitation or aggressivity, resulting in over-dosage of medication routine, or in non-prescribed administration of psychoactive medications[3, 7, 20, 22].

For all the reasons expressed above, it is clear that violence towards older people constitutes an important public health issue, still largely ignored and underestimated, despite the general aging of the population, which is being witnessed above all in western countries. Being subjected to abuse has repercussions on both the health of the victim, with an increase in the rate of hospitalizations and mortality, and in economic terms due to the health expenditure necessary to deal with the short, medium and long-term consequences. It therefore becomes of paramount importance that healthcare professionals be prepared to diagnose and manage these situations.

Violence as a matter of health: healthcare personnel as a window of opportunity

The healthcare sector plays an important role in preventing or reducing the mistreatment of older adults. The problem is so widespread that healthcare professionals dealing with older adults are likely to encounter it on a routine basis[12].

As violence against older people is associated with increased rates of hospitalization[23], hospital care providers have the opportunity to observe elderly patients when they arrive at the Emergency Department (ED), being in an ideal position to detect when older people are the victims of or at risk of maltreatment.Considering the complex nature of the phenomenon, a multidisciplinary evaluation is always recommended, since no single discipline or sector alone has the knowledge, competency and means required to effectively manage the issue, especially in complex cases of elder abuse[22, 24].

Nevertheless, there are just a few treatment protocols that provide a holistic approach to elder abuse, encountering simultaneously the physical, psychological, social, and legal issues, as it would be appropriate instead[24, 25]. The aim of medical and forensic examination is to describe the health sta-

tus of the person; to record all injuries, preferably through photographic documentation as well; to evaluate their potential evolution over time; to try to understand the production mechanisms of the lesions, in particular to establish whether they derive from an accidental event, from a malicious or negligent action by third parties, or from self-harm; and whether they are not consistent with the trauma history as recounted by the individual; and, finally, to collect medico-legal evidence which could be requested by the court[26]. Although a medico-legal assessment is recommended, the forensic expert is not always part of the usual ED care team. In these cases, it is important that ED staff members are prepared and trained to recognize the abuse, especially among older patients who have had frequent hospital visits due to dehydration, malnutrition, delirium, and skin ulcers. They should be familiar with risk factors and signs of elder abuse, as well as the basics of the medico-legal approach. They should also be aware that often the violence is denied by the victim and that sometimes the perpetrator proves himself to be cooperative and very attached to the victim, creating situations that are easily misinterpreted.

Healthcare providers also have a crucial role to play in collecting all relevant information and evidence to determine whether an elderly individual has been the victim of abuse: to collect a detailed description of the event; to undertake a full medical history; to perform a complete clinical examination, including gynecological/urological examination; to appropriately sample, collect and preserve all acquired evidence (e.g., photographs of injuries, vaginal and/or anorectal swabs, etc.); to request further ancillary investigation when necessary, according to the specificity of each case (such as a general blood test to assess the degree of malnutrition and dehydration, or toxicology for screening drug over- or under-dosage, etc.). The results of this assessment could be crucial for judicial authorities in a forensic setting and help in identifying the perpetrator.

Of course, informed consent must be obtained before performing any medical acts. If the older patient is incapable of giving a valid consent because of cognitive impairment, there are more possible strategies, according to the local laws and the specific circumstances of the individual case. When a legal representative has not been appointed, given that healthcare personnel have the moral and legal responsibility to act in the best interests of the patient, they can perform medical procedures even without the older adult's consent. If the safety of the patient is threatened it may also be necessary to disclose information and contact legal authorities, to protect the elderly person from further harm. Otherwise informed consent has to be obtained from the legal representative but, when the designated representative is the abusive caregiver, there may be opposition by the caretaker who attempt to prevent the disclosure of the abuse. In these situations, performing tests for detecting abuse without informing the caregiver of this purpose and without obtaining his/her informed consent could be justifiable under the provisions of "therapeutic privilege", according to which physicians may retain information on the grounds that its disclosure could be harmful for the older patient and even placing the patient's life at risk[27]. Alternatively, healthcare professionals should apply to judicial authorities. All these efforts could lead to the prevention of unnecessary suffering, maintenance of autonomy, and improvement in the quality of life, which represents the main goals in elder abuse response.

Despite surveys documenting physician exposure to increasing numbers of victims, the rate of elder abuse detection during the ED evaluation is under-recognized, due to the lack of awareness of the problem on the part of healthcare professionals (some studies have shown that healthcare personnel, and medical doctors more than any other healthcare worker category, have a poor knowledge of elder abuse) and non-application of standardized protocols in an ED setting[24, 28, 29]. As reported by Rosen[30, 31] elder mistreatment is almost never detected during an ED evaluation and even less reported to authorities (fewer than 5% of total cases comes to the authorities' attention). Available studies have shown that the total number of reports concerning victims older than 65 years remained low compared to younger victims[16].

For this reason, it is important that all healthcare staff - including both prehospital care providers such as family physicians, and hospital care providers like ED personnel - are provided with specific training covering all aspects of elder abuse, including its medico-legal aspects. Such training should provide healthcare workers with a greater knowledge of the problem, improve their ability to correctly identify victims of violence and to provide an effective and adequate response. Another duty of healthcare professionals involved in the care of abused elderly people is to give the victims adequate information regarding options available to remedy their situation. Whenever abuse is suspected, healthcare providers

should perform a thorough abuse assessment. Various instruments are available to identify elder abuse, but the optimal screening approach is not yet clear. Furthermore, it is not possible to recommend a single screening tool, as it has to be appropriate to the specific setting and situation[32].

However, based on screening instruments developed thus for elder abuse[33-35], we believe the following aspects to be fundamental requirements for an effective elder abuse screening:

• Initial evaluation of the elderly person should evaluate anamnestic and objective data in tandem; it is paramount that healthcare professionals have knowledge of typical indicators of abuse, regarding both typical injury pattern and suspicious past history, like recurrent visits to the ED; in this regard, a more effective surveillance system would require the establishment of an "elder-abuse warning network" where to bring together, and share among different hospitals of the same territory, all information about previous ED accesses of patients aged 65 or greater: health structures, hospital and territorial social services, law enforcement, and judicial authorities should be involved in this network;

• For a comprehensive clinical assessment, imaging studies and laboratory findings, including toxicological testing for drugs ,should be considered; although not specific, common laboratory findings are dehydration, anemia, dysionemia, malnutrition, inappropriate high- or low-medication levels, and the presence of illicit drugs;

• It is always important to contextualize clinical and laboratory signs with the patient's clinical condition, for example, consider age-related physiological changes and natural disease as alternative diagnoses to elder abuse;

• Always consider the possibility of psychological abuse when the older patient presents change in behavior (such as increasing fear, anxiety, depression, apathy, tendency to isolation, passivity, or aggressivity), change in sleeping or eating habits, evasiveness or reluctance to talk openly, contradictory statements, or anomalous, conflictual, and inexplicable interaction with the caregiver (such as avoidance of eye or verbal contact). The observation of any one of these indicators should prompt a more thorough evaluation of the older person's living situation. In these cases, psychiatric assessment, and evaluation of eventual past psychiatric history, may be useful. Also remember that psychological abuse may co-occur with other types of abuse;

• In suspect cases, self-administered or interview-based questionnaires about dependency and neglect could integrate the final judgment;

• In considering the patient's answers, healthcare personnel should take the elderly patient's cognitive status into account, for example through a brief cognitive assessment test (like Mini Mental Status Examination), as patients with dementia could lack the ability to report a clear and thorough medical history or eventual episodes of abuse. In case of cognitive impairment, it is proper to pay even more attention to the patient's examination as mental disability is an important risk factor for elder abuse. Most available screening tools (like questionnaires and observational checklists) have been developed for cognitively intact older adults and are not adequate for cognitively impaired older people. A recommended screening instrument for people with dementia is the methodology proposed by an expert panel called LAED[36];

• The patient's interview should preferably take place in a private place, so that the victims do not feel embarrassed or ashamed for others to know of their abuse;

• Although it may be viewed as discourteous, it is essential to ask the people accompanying the patient (familiars, hired caregiver or anyone else) to leave the room; this may promote a more open conversation on such a sensitive issue and increase the elderly patient's level of disclosure;

• Healthcare personnel should also demonstrate interest, a willingness to listen and empathy for the victim and take time to create a trust-based doctor-patient relationship. They should never have negative or stigmatizing reactions, like blaming or minimizing the abusive experience;

• The use of standardized flow-charts or algorithm could assist healthcare professionals in simplifying the decision-making process and clarifying the care planning.

Although healthcare professionals have the ethical and deontological task to protect their patients from harm, when a competent senior citizen decides to refuse intervention and help, it may be difficult for the care team to perform a successful intervention. Sometimes, some cases of abuse are not reported to the competent authorities due to the inability of the care team to interpret controversial ethical and legal principles and to the fear of the consequences if they violate the patient's right to confidentiality[37]. In some situations, the professional dilemma may lie in the healthcare professional's decision to

intervene-that is, both to take care of the victim and to report abuse to the judicial authorities-against the wishes of the abused senior, seeing that as a violation of the patient's right to autonomy, self-determination and confidentiality. In these hypothetical situations, to respect the patient's refusal with the idea of withholding any intervention, would leave the elderly patient in a situation where abuse is likely to reoccur: this, obviously, may violate the vulnerable patient's right to be protected and the ethical principles of beneficence and non-maleficence.

If the victim is in imminent danger or where a serious harm has been caused, it is necessary to intervene immediately and without delay, in order to guarantee the safety of the victim. In contrast, if the reported injuries are not immediately life-threatening, it is more appropriate to develop a strategy based on mutual trust, to educate the victim on elder abuse and to provide him/her with emergency information. Sensitivity to the patient's refusal, however, does not mean that professionals give up or detach themselves from the senior's decision-making process and does not preclude other forms of action. Indeed, they should continue conversation, show persistence and care for their plight; probe for the values underlying the choice; help to clarify the patient's anxiety or awareness of what is at stake; provide supportive counselling; and plan follow-up visits to monitor the situation, because elder abuse rarely ends simply or speedily. Indeed, it is important that physicians, as any other healthcare worker, report to the judicial authorities any situation in which elder abuse is perpetrated. These efforts are needed to improve awareness, knowledge, and the overall strategic approach on elder abuse, following the example taken in other abusive situations (minors or women), and to promote the right to health protection.

In addition to the implementation of screening tools aimed at boosting elder abuse detection and disclosure, it would be useful to act at different levels (with both top-down and bottom-up strategies) in order to improve the therapeutic management and follow-up over time:

• First, there is a need, where it is lacking, for a special legislative intervention addressing this issue, i.e. implementation of protective laws against elder abuse, aimed both at countering, preventing and managing the phenomenon;

• University courses in the health-related field should introduce specific educational programs, both at an undergraduate and postgraduate level, targeted to a better understanding of elder abuse among future healthcare staff;

• The development of national or regional guidelines to adopt in the management of suspected or confirmed cases of elder abuse would be desirable; different protocols should be developed for different healthcare settings, i.e. out-of-hospital reality versus hospital- and facility-based care, taking into account the differences existing in terms of resource availability (both instrumental and human), level of competence and the possibility of getting evaluations from other specialists. For instance, it is self-evident that out-of-hospital settings are more resource-constrained than hospital ones and that first-level hospitals can rely on more highly specialized staff than tertiary-level hospitals;

• To establish ad hoc clinical pathways for elder abuse and to provide anti-violence support centers similar to those already existing for the abuse of women and children. It is important to stress that elderly people deserve the same social and legal attention that other vulnerable groups get;

• In long-term facilities, where there is a higher elder abuse rate especially on the part of nurses or other staff members, healthcare personnel should be encouraged to report every suspicious situation involving co-workers;

• Healthcare structures should start an ongoing systematic collection of epidemiological data about in-house cases of elder abuse; this could go some way toward making up for the lack of updated and precise data and, hopefully, foster further research (which is currently low). The poor interest of research on this phenomenon has been recently highlighted by Corbi et al: comparing the available literature for "elderly abused" with the "child abused" one, they obtained a ratio child/elderly equal to 1/0.04[37];

• Finally, social media may be a powerful tool for improving public confidence towards healthcare personnel, which is essential in establishing a trustful elder patient-physician relationship.

Conclusions

Maltreatment of older people is a pressing public health problem, affecting millions of older people worldwide with enormous individual and socioeconomic costs, but the phenomenon is still largely unrecognized, unreported, and untreated.

Being subjected to abuse has repercussions on both the health of the victim, with an increase in the rate of hospitalizations and mortality, and in eco-

nomic terms due to the health expenditure necessary to deal with the short, medium and long-term consequences. We need urgent actions to protect an ageing population at risk and to reduce the prevalence of elder abuse, including a comprehensive training program on abuse for healthcare providers, more prosecution and greater investment in developing effective prevention strategies. Healthcare workers, in particular ED practitioners and family physicians, are on often on the frontline against elder abuse as they may be the only person with whom an abuse victim come into contact apart from the abuser, and they can play an important role in prevention, diagnosis and treatment. In order to do so, they should be aware that older people, especially those socially isolated or with cognitive impairment, might be victims of mistreatment and they should be able to recognize risk factors for elder abuse and signs of abusive situations, nevertheless they do not always possess adequate levels of awareness or knowledge. It therefore becomes essential that all healthcare providers are provided with adequate specific training concerning elder abuse, including both its clinical and medico-legal consequences, in order to be able to identify cases of abuse of elderly patients and, consequently, to activate all the resources and services required for dealing with and solving (or, at least, ameliorating) the situation. Moreover, they ought to be encouraged to always perform screening for elder abuse as a routine practice when dealing with patients older than 65.

It is important that healthcare professionals create a therapeutic alliance with their abused elderly patients by using a multidisciplinary approach. Alongside this, access to services and community support must be improved in order to ensure continuity of care and security, by respecting the right to privacy and self-determination of the patient. The interventions designed with the aim of preventing or reducing the abuse of older people can operate at different levels in order to positively influence the protection of their health and their lives. It is therefore a phenomenon that must be recognized as a serious global problem that requires urgent action by all governments, health systems and social assistance.

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