Resilience after elder abuse: Strategies to improve mental health built on community connection

Presenter: Melba A. Hernandez-Tejada, PhD, DHA
Associate Professor
Louis A. Faillace, MD, Department of Psychiatry and Behavioral Sciences | Trauma and Resilience Center
Melba.A.HernandezTejada@uth.tmc.edu

UTHealth® The University of Texas Health Science Center at Houston | McGovern Medical School

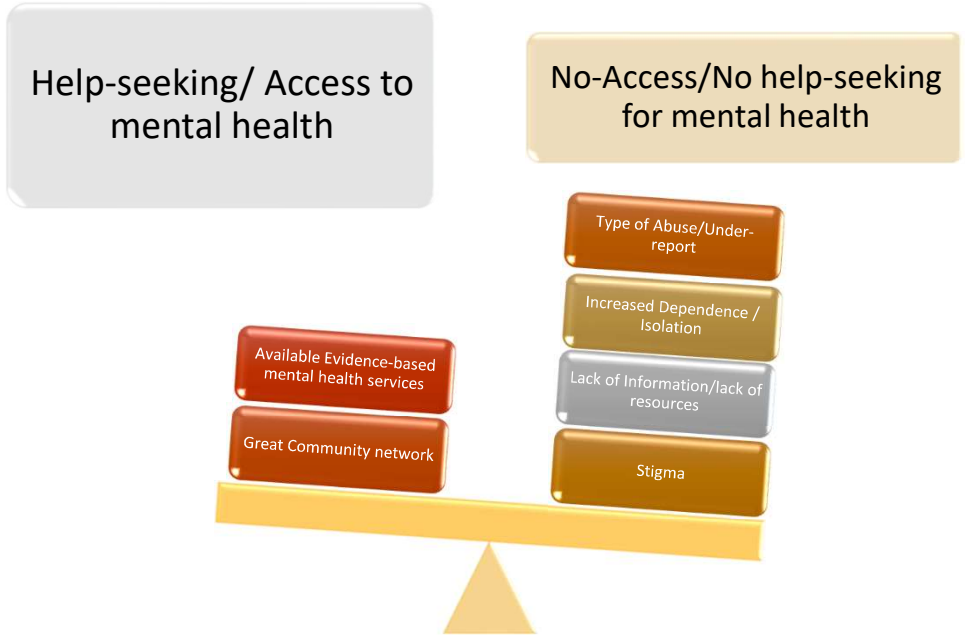
Learning Objectives

- *Discuss strategies to improve mental health in survivors of elder mistreatment.*

- *Discuss evidence in research and practice about social support as the key component to help older adults to overcome negative effects of mistreatment.*

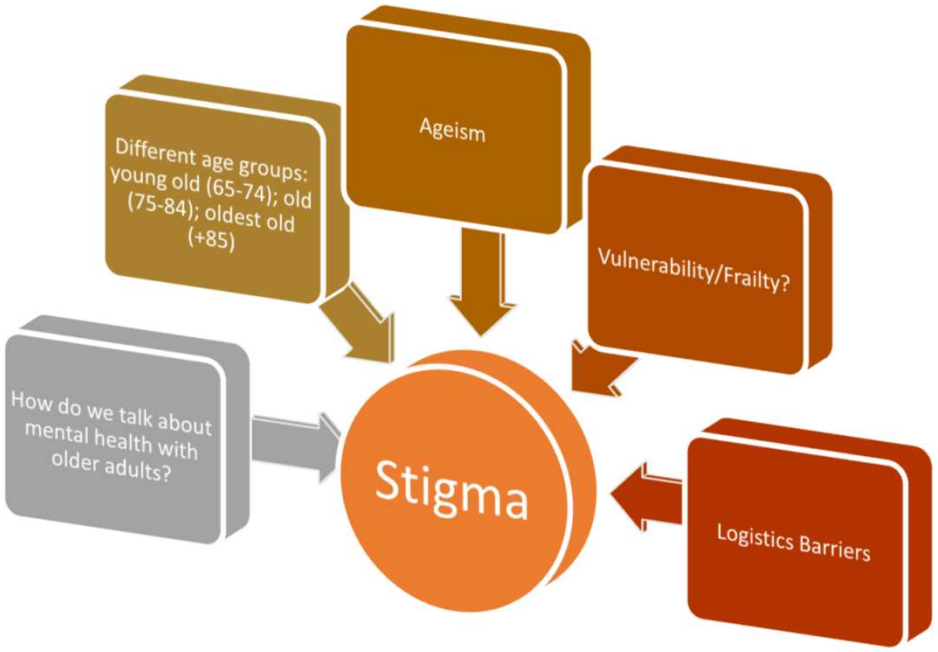
- Discuss how to implement social connection through each community.

The problem



*(Burnes et al., 2019a; Burnes et al.,2019b; Fraga Dominguez et al, 2019; Hernandez-Tejada et al., 2020; Podnieks, 2020)

Cont.



(Ilgili et al., 2014; Saunders et al., 2003)

Social support

- Lack of a support network increases risk for elder abuse (Choi & Mayer, 2000; Melchiorre et al., 2013) and its negative consequences.
- Greater social support may be a protective factor against elder mistreatment and mental health negative outcomes (Dong, Simon, 2008; Villar-Compte et al., 2017; Wong et al., 2020)
- Implementing social support may be challenging if the specific environment and needs of the older adult, their family dynamics, and the status of their challenges regarding the mistreatment are not taken into account.

Building Community Connection

Strategy 1: Building a Team

- Team Experience in working with the Community
  - Personnel are Key: a well-trained and EMPATHETIC team is even more valuable than a person who shares some similarities with the group…a role for young people too.
  - Need to create AND MAINTAIN connections in the community.
- How easy is for them to immerse in the specific target community?
  - What are their current relations with senior/community centers, other hospitals, assisted living facilities, low-income housing, respite centers, etc.?

Building Community Connection

Strategy 2: learn/understand the target community

- Community characteristics
- Generational differences are a reality: Views about health, mental health, authority, and seeking help?
- What do they want to talk about?
- Racial/Ethnic, Socio-economic background?

(Arean et al., 2003).

Strategy 3: Community Immersion

- Both in Charleston, SC and Houston, TX have dedicated experienced community liaisons/coordinators.
- Connections and trainings have been ***tailored*** according to the needs of the organization.
- Frequent delivery of screening / support and information materials (i.e. EASI, pathway map to help a suspicion or confirmed case of elder abuse).
- Creation of a mailing / emailing list.
- **Joining domestic violence/elder abuse interest groups/councils**.
- Direct connection with older adults: talks at libraries, senior centers, senior residents.
- For the patient: we have been using telepsychology with our patients since 2017. COVID restrictions "massified" the use.

Building Community Connection

Strategy 4: Training providers

- Healthcare providers, victims advocates and other community stakeholders experts in older population are more likely to be in contact with elder abuse victims.
- Build training adapted to the trainee needs (use online-based trainings, in person trainings, short or long versions of the information, materials that can be consulted online, or in brochures).
  - Offering CME credits was key to increase participation of healthcare providers in particular.

Cont.
Content of training

- The screening training:
  - elder abuse prevalence and risk factors,
  - perpetrator characteristics,
  - rationale and discussion of the screening techniques
  - available resources and how to do a referral.
- Mental Health Intervention training:
  - best practices treatments for PTSD, depression, and anxiety (e.g., Prolonged Exposure, Cognitive Processing Therapy, Behavioral Activation)

Strategy 5: Offer best practices

- What is your protocol for dealing with significant mental health problems…is it Evidence-Based?
- Evidence –based treatments for trauma related symptoms in patients who have suffered violence/abuse exist, and work with older adults (Egede, Acierno et al., 2016; Yoder et al., 2013).
  - 12-15 sessions in length (about 3 months),
  - delivered via televideo to minimize impact of logistic and health barriers,
  - are specifically augmented to connect with support from the community team to help them engage with other resources they may need besides mental health services.

Building Community Connection

Outcomes

- In Charleston, SC
- Before October 2017, 1% were older adults victims of abuse. By October 2018 an increase of 700% occurred in the referrals to our mental health services. Increase due to two major factors:
    - the work of our community liaison
    - the training that the team was conducting.
- From January 2018-February 2022, 5000 healthcare providers and victims advocates were trained.
- From July 2018 to December 2019, 349 older adults were referred to our program. 31 (9%) were identified with trauma-related symptoms (PTSD), GAD and/or depression and received treatment through our program. The rest were referred to other services.

UTHealth Trauma and Resilience Center-Houston

- The year before October 2020, older adults account for less than 3% (3 patients per year) of the population we see at the Trauma and Resilience Center. After the program was implemented during the first quarter (October-December 2020) we observed an increase to 19 patients and ended the first year of the program with 151 patients. Currently we have about 53 patients actively receiving evidence-based mental health treatment since October 2021.

Conclusions

- Establishing direct connections with older adults in need of services.
- Meeting regularly with partners in the community who are in close contact with victims of elder abuse.
- Care about your team. Talk frequently and empower them to discuss weekly strategies they initiate.
- Diversify your strategies and funding mechanisms to keep the services active.

References

Areán, P. A., Alvidrez, J., Nery, R., Estes, C., & Linkins, K. (2003). Recruitment and retention of older minorities in mental health services research. *The Gerontologist*, *43*(1), 36-44.

Burnes, D., Acierno, R., & Hernandez-Tejada, M. (2019). Help-seeking among victims of elder abuse: Findings from the National Elder Mistreatment Study. *The Journals of Gerontology: Series B*, *74*(5), 891-896.

Choi, N. G., & Mayer, J. (2000). Elder abuse, neglect, and exploitation: Risk factors and prevention strategies. *Journal of gerontological social work*, *33*(2), 5-25.

Burnes, D., Acierno, R., & Hernandez-Tejada, M. (2019). Facilitators and barriers for elder abuse victims seeking help: Findings from the national elder mistreatment study. *Innovation in Aging*, *3*(Suppl 1), S476.

Dong, X., & Simon, M. A. (2008). Is greater social support a protective factor against elder mistreatment?. *Gerontology*, *54*(6), 381-388.

Egede, L. E., Acierno, R., Knapp, R. G., Walker, R. J., Payne, E. H., & Frueh, B. C. (2016). Psychotherapy for depression in older veterans via telemedicine: effect on quality of life, satisfaction, treatment credibility, and service delivery perception. *The Journal of Clinical Psychiatry*, *77*(12), 16304.

Fraga Dominguez, S., Storey, J. E., & Glorney, E. (2021). Help-seeking behavior in victims of elder abuse: A systematic review. *Trauma, Violence, & Abuse*, *22*(3), 466-480.

Hernandez-Tejada, M. A., Frook, G., Steedley, M., Watkins, J., & Acierno, R. (2020). Demographic-based risk of reporting psychopathology and poor health among mistreated older adults in the national elder mistreatment study wave II. *Aging & Mental Health*, *24*(1), 22-26.

İlgili, Ö., Arda, B., & Munir, K. (2014). Ethics in geriatric medicine research. *Turk geriatri dergisi*, *17*(2), 188. Podnieks, E. (2020). The power of elder abuse networks in Canada: A model for social change. In *International handbook of elder abuse and mistreatment* (pp. 111-136). Springer, Singapore.

Giraldo-Rodríguez, L., Ochoa-Laginas, A., & Gaitan-Rossi, P. (2018). Association between depression and elder abuse and the mediation of social support: a cross-sectional study of elder females in Mexico City. *Journal of aging and health*, *30*(4), 559-583.on strategies. *Journal of gerontological social work*, *33*(2), 5-25.

Melchiorre, M. G., Chiatti, C., Lamura, G., Torres-Gonzales, F., Stankunas, M., Lindert, J., ... & Soares, J. F. (2013). Social support, socio-economic status, health and abuse among older people in seven European countries. *PloS one*, *8*(1), e54856.

Podnieks, E. (2020). The power of elder abuse networks in Canada: A model for social change. In *International handbook of elder abuse and mistreatment* (pp. 111-136). Springer, Singapore.

Saunders, S. D., Greaney, M. L., Lees, F. D., & Clark, P. G. (2003). Achieving recruitment goals through community partnerships: The SENIOR Project. *Family and Community Health*, 194-202. Vilar-Compte, M.,

Wong, J. S., Breslau, H., McSorley, V. E., Wroblewski, K. E., Howe, M. J., & Waite, L. J. (2020). The social relationship context of elder mistreatment. *The Gerontologist*, *60*(6), 1029-1039.

Yoder, M. S., Lozano, B., Center, K. B., Miller, A., Acierno, R., & Tuerk, P. W. (2013). Effectiveness of prolonged exposure for PTSD in older veterans. *The International Journal of Psychiatry in Medicine*, *45*(2), 111-124.

THANK YOU

Comments, Questions?

Email. Melba.A.Hernandez-Tejada@uth.tmc.edu

- Office: 713-486-2729