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COMMENTARY

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Invisible and at-risk: older adults during the COVID-19 pandemic

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ABSTRACT

During the COVID-19 pandemic the risks to older adults of systemic abuse and neglect have become amplified, alongside increasing abuse and neglect in the community. Novel risks have also evolved involving cybercrime and the use of remote technologies in health and social care related to the pandemic. This commentary brings together lessons to be learned from these developments and initial ideas for actions to mitigate future risks.

KEYWORDS

Commentary; COVID-19; elder abuse and neglect; safeguarding

As the COVID-19 pandemic became reality globally and restrictions put in place, older adults at risk of abuse and neglect became invisible (Cooper, 2020). It quickly emerged that increasing age was associated with greater COVID-related mortality (Verity et al., 2020), and that increased COVID-related risk applied to other groups too, including people with learning disability, mental illness, and substance use disorders, many of whom were older adults. While partly determined by biological factors, the increased mortality associated with increasing age may have also been the culmination of societal ageism, systemic neglect, and compromised care and service delivery in older adult services (Fraser et al., 2020). In this paper we aim to describe some of the systemic impacts of the COVID pandemic which lay a fertile ground for neglect and abuse of older people, while exploring ideas for action to mitigate future risks. Here we use the World Health Organization (WHO) definition of abuse as "*an intentional act, or failure to act, by a caregiver or another person in a relationship involving an expectation of trust that causes harm to an adult 60 years and older*" (World Health Organization [WHO], 2021). Implicitly, this includes wider systemic and institutional caregivers, including government, health, and residential care.

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Systemic impacts of COVID

As the pandemic unfolded, social distancing became enforced and generally accepted in many countries, with the intention of restricting social interaction in order to curtail the spread of the virus. Its effect, however, was to mandate social isolation, to limit contact with friends, neighbors, and the local community, and to exacerbate invisibility, prime risk factors for elder abuse and neglect. In addition, with the focus on COVID and emergency care, access to mental and physical health services also became restricted (Ayalon & Avidor, 2021). Adults who experienced new or worsening physical health found it difficult to access health care and/or were reluctant to do so in the belief that it would increase the risk of contracting COVID. Discouraging help-seeking behavior led to further invisibility, with likely consequences for timely diagnosis, disease management, and ultimately, morbidity and mortality (Ayalon et al., 2021; United Nations, 2020).

Political responses to manage hospital overload may have also contributed to increased mortality. For example, despite the risks involved, in March 2020 the National Health Service in the United Kingdom (UK) advised hospitals to discharge older patients into community care, deeming pre-discharge COVID screening and personal protective equipment (PPE) for care staff in nursing and residential homes unnecessary if residents were asymptomatic. The result was predictable, and Amnesty International later called for an independent public inquiry into policies imposed by the UK Government that have "*directly violated the human rights of older residents of care homes in England*" resulting in excess deaths in this population (Amnesty International, 2020). Further manifestations of systemic abuse and neglect in the UK included blanket bans on cardiopulmonary resuscitation imposed by health care organizations and clinicians on certain groups of patients purely based on diagnosis or status alone (e.g., presence of disability) and without consulting them (British Medical Association, Care Provider Alliance, Care Quality Commission & Royal College of General Practitioners, 2020; Iacobucci, 2020). Triage for emergency care of any sort based on diagnosis or place of residence (e.g., living in a care home) per se is a clear act of neglect and in breach of good practice, human rights, and equality legislation (Peisah et al., 2020). These principles have been echoed in the United States (US) in the settlement between the US Department of Health and Human Services Office for Civil Rights, and Pennsylvania (U.S. Department of Health and Human Services, 2020).

Other manifestations of neglect included social isolation of older adults and neglect of their relational and leisure needs particularly in care settings, as well as overzealous use of physical and chemical restraint to enforce infection control and lockdown measures (Cooper, 2020). Howard et al. (2020) pointed out data supporting an increase in antipsychotic prescribing

to people with dementia during the pandemic. They hypothesize that, although some of the increase in anti-psychotic usage might be related to delirium management and end-of-life care, most was probably a response to agitation and/or psychotic symptoms secondary to COVID-related restrictions, including lack of activities and visits, and restrictions to movement in long-term care settings (Howard et al., 2020). Alongside these concerns there are obvious additional burdens for professional carers amongst whom stress and burnout levels are high (Morgantini et al., 2020). Without adequate support for staff who look after at-risk individuals, it is impossible to provide safe and effective care. Similar burdens were borne by family and informal carers of older adults living in the community, consequent upon reductions in respite care and other supports, which have created enormous care challenges.

Scams, abuse and neglect

Looking beyond systemic abuse and neglect, the pandemic has also seen a massive increase in reports of intentional acts of abuse (as opposed to neglect, a failure to act) ranging from financial abuse to family violence (Han & Mosqueda, 2020). With regards to financial abuse, safeguarding agencies have reported that community-dwelling adults have been targeted in a variety of COVID-related cyber-scams involving sales of personal protective equipment or other COVID-19 safety-related products such as hand gels, and counterfeit and unapproved equipment and products at astronomical prices (Hakak et al., 2020). Payne (2020) found that adults aged over 50 lost more to fraud than younger people, and lost more in 2020 than in 2019, with potential implications for their financial health. Furthermore, he found that they reported being targeted more often for certain types of cybercrime, particularly technical support scams, and writes that *"social distancing serves to displace criminal behavior from the streets into the safety of the places we live"* (Payne, 2020).

The introduction of new risks

The inevitable increased use of technology by older adults during lockdowns and social distancing may have exacerbated financial abuse associated with cybercrime, whilst simultaneously attempts to provide equitable, safe access to treatment using virtual health care have imposed new and inadvertent risks of abuse. Although innovative in terms of access, time, and cost effectiveness, virtual/ remote care has come with a cost with regards to risk assessment and safeguarding (Benbow & Bhattacharyya, 2020; Sorinmade et al., 2020). A number of questions have emerged relating to how to assess the unique risks of at-risk adults online, such as how to assess adequate food stores in the

house and other signs of neglect. Additionally, confidentiality and privacy cannot be ensured in such settings, including from potential abusers, who are most frequently family members (Sorinmade et al., 2020).

Learning and potential strategies for the future

We recommend adopting the frame proposed by Han and Mosqueda (2020), the Abuse Intervention/ Prevention Model, for approaching abuse of older adults. The model looks at mitigation in terms of three intersecting factors: the older adult; the "trusted other"; and the broader context within which abuse occurs. We explore potential recommended strategies for addressing each factor that have application during the pandemic and beyond:

(i) The older adult. Mitigating strategies which address marginalization and invisibility include regular contact and communication with older people, particularly those living alone (Han & Mosqueda, 2020) Additionally, proactive access to resources and support can be provided with dedicated access to shopping, health care, and helplines (D'cruz & Banerjee, 2020). Secondary and tertiary prevention strategies for early identification of loneliness (Hwang et al., 2020) and increasingly prevalent psychiatric symptoms of depression, anxiety (Age UK, 2020), and suicidal ideation (Asthana et al., 2021; Wand et al., 2020; Wand & Peisah, 2020) are also needed to offset neglect. Han and Mosqueda (2020) have recommended use of "individualized safety plans" that take into account will and preferences of the older person to maximize safeguarding while preserving autonomy;

(ii) The trusted other. Suggested strategies include alleviating carer burden while also increasing penalties for elder abuse (Han & Mosqueda, 2020). Viewing elder abuse in the context of relational autonomy is also helpful in understanding the nexus between dependency, undue influence, and abuse (Peisah et al., 2021; Wand et al., 2018). Furthermore, shame and self-blame perpetuate silence and invisibility. This suggests a role for family-based interventions in certain circumstances (Khanlary et al., 2016).

(iii) The broader context. First and foremost, societal ageism, more rampant with the COVID pandemic with soaring intergenerational tension almost sanctioning abuse, must be tackled (Ayalon, 2020; Ayalon & Avidor, 2021; Han & Mosqueda, 2020). Furthermore, safe access to help is integral. An innovative programme, ANI (Action Needed Immediately) is a codeword scheme for domestic abuse victims to discretely signal the need for emergency help from their local pharmacy. When triggered, a staff member accompanies the person to a consultation room, where help is offered in the way

of contact with a helpline, specialist support service, or police (Home Office, 2020). Such schemes might be extended to older adults. For mental health providers, an "eyes wide open" approach to identifying abuse must be adopted (Peisah et al., 2021). Such an approach relies on the effective use of screening tools that promote trust and rapport in clinical practice (Brijnath et al., 2020). Additionally, careful risk analysis of the use of telehealth is advised. Perhaps we need to hone our professional curiosity in the light of remote/ virtual contacts and recognize that concerns about abuse and neglect may in themselves justify a need for face-to-face assessments.

Finally, as governments across the world continue their endeavors to control the pandemic, increasing socio-economic, psychological and physical health impacts will start to emerge and older adults are likely to be affected in a range of ways. This might manifest as emerging new mental health conditions or exacerbations of existing mental health conditions as well as unobserved risks associated with abuse and neglect. With a range of human rights at stake here, including safeguarding against abuse, equitable access to health, meeting disability-related needs, and inclusive community living (United Nations, 2006), we need to learn from what has already transpired and from our diverse experiences, and engage in critical conversations. How do we safeguard while empowering older adults?

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